



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

July 30, 2012

The Honorable Sam Johnson  
Chairman  
Subcommittee on Social Security  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Johnson:

Thank you for your Questions for the Record in follow-up to the Subcommittee's June 27, 2012 hearing on "Securing the Future of the Disability Insurance Program" looking at the Social Security Disability Appeals Process.

**1. One suggested solution to improve the disability process is to hire Social Security Judges who are Administrative Judges like those on the Appeals Council, at the Veterans Administration and at the Merit Systems Protection Board. Another solution is to change the Social Security Act so that the Social Security Administration (SSA) can hire Administrative Law Judges (ALJ) directly, with term limits, and then give the SSA the authority to discipline them. The ALJ union believes that these hearings should be adversarial. What do you think about these options and are there any other options you would suggest?**

**SSA should continue to use ALJs.** We believe that ALJs and their decisional independence play a critical role in protecting the rights of claimants. A claimant's right to a *de novo* hearing before an ALJ is central to the fairness of the SSA adjudication process. This right guarantees that individuals with disabilities have a full and fair administrative hearing by an independent decision-maker who provides impartial fact-finding and adjudication, free from agency coercion or influence. The ALJ questions and takes testimony from the claimant and other witnesses, and considers and weighs the evidence, all in accordance with relevant law and agency policy. For claimants, a fundamental principle of this right is the opportunity to present new evidence to the ALJ, testify in person before the ALJ, and receive a decision based on all available evidence.

The critical role that ALJ decisional independence plays in protecting the rights of claimants cannot be underestimated. In the early to mid-1980s, the SSA disability claims adjudication process was in turmoil. In the most detrimental example for beneficiaries, the agency had changed its policy regarding the cessation of disability. As a result, between 1981 and 1984, nearly 500,000 severely disabled beneficiaries who continued to meet the statutory eligibility requirements had their benefits terminated. Legal advocates

represented thousands of individuals in appeals of SSA's decision to terminate their benefits because their disabilities had allegedly "ceased." Many ALJs agreed with their arguments that the agency's policy was inconsistent with the Social Security Act and due process and reversed the termination of benefits. Thus, beneficiaries were able to retain the cash and medical benefits vital to their well-being.

There are other examples from this period of ALJs confronting agency policies they considered inconsistent with the Social Security Act, including a clandestine policy to deny and terminate benefits to tens of thousands of claimants with serious mental illness who did not meet the then-outdated Listings of Impairments. SSA no longer follows these policies. However, the importance of maintaining the APA-protected ALJs in the SSA adjudication process was brought to light within the past few years regarding actions at the U.S. Department of Justice (DOJ).

Some federal agencies use non-ALJs as adjudicators and their independence, as a general rule, is less protected than ALJs, for example, Immigration Judges (IJs) in the DOJ. The process for selecting IJs provides a stark contrast to that for ALJs, since, as noted in a recent report by the DOJ Office of Inspector General, the Attorney General of the United States has the authority to manage the selection process and appoint IJs.<sup>1</sup> The report documented an investigation by the DOJ Office of the Inspector General and the DOJ Office of Professional Responsibility regarding possible political influence in the hiring of IJs.<sup>2</sup>

**ALJs should continue to be selected by the Office of Personnel Management.** ALJs in federal agencies are appointed under the Administrative Procedure Act (APA), which guarantees their independence from undue agency influence, as demonstrated by the following requirements:

- The Office of Personnel Management (OPM) – not SSA – conducts the competitive ALJ selection process. While SSA ultimately appoints ALJs, it can only do so from a list of eligible candidates created by OPM.
- ALJs can be removed only for "good cause."
- Most disciplinary actions may be taken only according to standards and procedures established by the Merit Systems Protection Board (MSPB).
- The pay classification system for ALJs is set by OPM, not by SSA, and is separate from the agency's performance rating process.

**The process should not be adversarial.** The issue of having SSA represented at the ALJ hearing was raised at a July 2011 House hearing held by this Subcommittee and the House Judiciary Subcommittee on Courts, Commercial and Administrative Law.<sup>3</sup> Agreeing with Commissioner Astrue's testimony at that hearing, we do not support proposals to have SSA represented at the ALJ hearing.

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<sup>1</sup> *An Investigation of Allegations of Politicized Hiring by Monica Goodling and Other Staff in the Office of the Attorney General* (July 28, 2008), p. 71. Available at <http://www.usdoj.gov/oig/special/s0807/final.pdf>.

<sup>2</sup> *Id.* at 137.

<sup>3</sup> Joint Oversight Hearing on the Role of Social Security Administrative Law Judges, July 11, 2011, <http://waysandmeans.house.gov/Calendar/EventSingle.aspx?EventID=249734>.

In the 1980s, SSA tested, and abandoned, a pilot project to have the agency represented - the Government Representation Project (GRP). First proposed by SSA in 1980, the plan encountered a hostile reception at public hearings and from Members of Congress and was withdrawn. The plan was revived in 1982 with no public hearings and was instituted as a one-year “experiment” at five hearing sites. The one-year experiment was terminated more than four years later following congressional criticism and judicial intervention.<sup>4</sup>

Based on the stated goals of the experiment, i.e., assisting in better decision-making and reducing delays, it was a failure. Congress found that: (1) processing times were lengthened; (2) the quality of decision-making did not improve; (3) cases were not better prepared; and (4) the government representatives generally acted in adversarial roles. In the end, the GRP experiment did nothing to enhance the integrity of the administrative process.

The GRP caused extensive delays in a system that was overburdened, even then, and injected an inappropriate level of formality, technicality, and adversarial process into a system meant to be informal and non-adversarial.

The longstanding view of the courts, Congress, and the agency is that the Social Security claims process is informal and non-adversarial, with SSA’s underlying role to be one of determining disability and paying benefits. Proponents of representing the agency believe that SSA is not being fairly represented in the determination process. It is important to note that SSA and the claimant are not parties on opposite sides of a legal dispute. SSA already plays a considerable role in setting the criteria and procedures for determining disability by establishing regulations, Rulings, and other policy guidance; by providing more detailed internal guidance for SSA and DDS workers; and by hiring ALJs. To establish disability, the claimant must follow the rules set by SSA.

In the current non-adversarial process, SSA’s role is not to oppose the claimant. SSA’s role is to ensure that claimants are correctly found eligible if the statutory definition of disability, as contemplated by Congress, is met, whether or not a representative is involved. ALJs, like all adjudicators, have a duty to develop the evidence and investigate the facts. Nevertheless, they should view the claimant’s representative as an ally in collecting necessary and relevant evidence and focusing the issues to be addressed.

In addition to radically changing the nature of the process, the financial costs of representing the agency at the hearing level would be very high. In 1986, SSA testified in Congress that the cost was \$1 million per year for only five hearings offices in the Project (there currently are more than 140 offices). Also, given that the hearings would be adversarial, SSA would be subject to paying attorneys’ fees under the Equal Access to Justice Act in appropriate cases.

Given the past experience with government representation and the enormous cost, we believe that the limited dollars available to SSA could be put to better use by assuring adequate staffing at field offices, at the DDSs, and at hearings offices, and developing

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<sup>4</sup> In *Sallings v. Bowen*, 641 F. Supp. 1046 (W.D.Va. 1986), the federal district court held that the Project was unconstitutional and violated the Social Security Act. In July 1986, it issued an injunction prohibiting SSA from holding further proceedings under the Project.

better procedures to obtain evidence, including reasonable payment for medical records and examinations.

**Other options.** We support Agency review of ALJ decisions in a manner that is consistent with the Administrative Procedure Act. While ALJs have decisional independence, they must follow SSA law and policies. SSA has implemented a quality review process for ALJ decisions. In FY 2011, the SSA Office of Disability Adjudication and Review (ODAR) established a Quality Review (QR) initiative and opened four new Branches in the Office of Appellate Operations. The QR Branches review a computer-generated sample of unappealed favorable ALJ decisions (almost 3,700 in FY 2011) before they are effectuated. Cases are then referred to the Appeals Council for possible review. If the Appeals Council accepts review, it can remand or issue “corrective” decisions, which may involve changing the favorable ALJ decision to a “partially” favorable decision or to an unfavorable decision. There also is some post-effectuation review of ALJ decisions. While these ALJ decisions cannot be changed, post-effectuation review looks for policy compliance and can focus on cases where there is a recurring problem and on specific situations. Policy guidance can then be provided.

The Agency could expand its review of ALJ decisions, so long as that expansion is consistent with the law. For instance, a significant percentage of claimants, for the most part unrepresented, do not appeal their unfavorable ALJ decisions. SSA could review a sample of these cases to see whether these claimants differ from those who do request review by the Appeals Council. It is quite possible that *pro se* claimants who do not appeal their unfavorable ALJ decisions are as disabled as those claimants who do appeal.

Much of the recent media and Congressional scrutiny of variations in ALJ decisions has been on ALJs with what are considered “high” allowance rates. However, there are many ALJs with extremely low allowance rates, undoubtedly resulting in “errors,” which in many cases, are never reviewed. In order to be even-handed, SSA could look at extreme deviations from the average on both ends of the “bell curve” for ALJ allowance rates.

Finally, we want to mention that variations in allowance rates are not in and of themselves “wrong.” We recognize that in our system of justice, where judges are human beings, variations in favorable decision rates, whether in the judicial or administrative process, are a given.

## **2. During calendar year 2011, the SSA withheld over \$1.4 billion from past due benefits to pay representatives their fees. What can Social Security employees do to help claimants minimize the need for representatives in the first place?**

We support initiatives to improve the process at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process. Often, claimants are denied not because the evidence establishes that the person is not disabled, but because the limited evidence gathered cannot establish that the person is disabled. Inadequate case development at the DDS level means that ALJs will need to spend more time reviewing cases prior to the hearing. This leads to longer processing times at the hearing level.

We strongly support full development of the record at the earliest point possible. This benefits the claimant and avoids unnecessary appeals, which contribute to the backlog. As detailed in our testimony before the Subcommittee, there are a number of ways that SSA and the state agencies could improve the process, none of which requires regulatory changes:

- Provide more assistance to claimants including: better explanation of the evidence that is necessary and relevant to the claim; and assistance with completing application paperwork so that all impairments and sources of information, including non-physician treating sources, are identified.
- DDS examiners should obtain necessary and relevant evidence. The DDSs generally do not use questionnaires or forms that are tailored to the specific type of impairment or ask for information that addresses the disability standard as implemented by SSA. This “language” barrier causes delays in obtaining evidence, even from supportive and well-meaning doctors.
- Electronic records, like paper records, need to be adapted to meet the needs of the SSA disability determination process. Many providers are submitting evidence electronically but these records are based on the providers’ needs and often do not address the SSA disability criteria.
- Increase reimbursement rates for providers. To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts who testify at hearings.
- Provide better explanations to medical providers. SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and ask for evidence relevant to the standard.
- Improve the quality of consultative examinations. Steps should be taken to improve the quality of the consultative examination (CE) process. There are many reports of inappropriate referrals and short perfunctory examinations. In addition, there should be more effort to have the treating physician conduct the consultative examination, as authorized by SSA’s regulations.<sup>5</sup>
- Provide more training and guidance to adjudicators. This training and guidance should focus on policies that are frequently misapplied, e.g., standards for weighing medical evidence, the role of nonphysician evidence, evaluation of subjective symptoms, etc.
- Expand use of existing methods of expediting disability determinations. SSA already has in place a number of procedures including “Quick Disability Determinations,” Presumptive Disability” in SSI cases, Compassionate Allowances, and terminal illness (“TERI”) cases.

**3. Last December, the Wall Street Journal wrote an article entitled “Two Lawyers Strike Gold in U.S. Disability System.” The article is about the law firm of Binder and Binder, which collected \$88 million in fees, all paid from awarded claimant benefits. Is it true that the longer it takes to get a decision for a**

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<sup>5</sup> 20 C.F.R. § 404.1519h and 416.919h.

**claimant, the higher the representative's fee will be? What would happen if legal fees were fixed at some nominal amount per case?**

Providing that claimants' representatives will be paid a fee for successful work on a claimant's behalf helps to ensure that a knowledgeable, experienced pool of representatives is available to represent claimants.

The fee process for representatives in Social Security claims is highly regulated. Under the most frequently used "fee agreement" process (described below), there is a cap on the amount of fees. In addition, a user fee is charged when SSA withholds and pays the fee (\$86 per case in calendar year 2012).

- **Fees at the administrative levels.** Fees for representatives' services must be approved by the Social Security Administration. The Act sets out the two processes from which representatives can choose. 42 U.S.C. § 406(a). The processes are mutually exclusive.<sup>6</sup>

**(1) The fee agreement process.** Most representatives choose to use the fee agreement process. Fees are 25% of past-due benefits or \$6,000, whichever amount is smaller. The statute gives claimants and adjudicators the opportunity to object to the amount of the fee. The statute does permit representatives to seek permission to charge more than \$6,000 under the fee petition process, but this happens rarely.

**(2) The fee petition process.** Some representatives will choose to use the fee petition process. They submit time records along with their fee requests. In fee petition situations, the adjudicator will set the fee in each individual case.

- **Fees at the federal court levels.** In federal court, fees in Social Security cases are regulated pursuant to 42 U.S.C. § 406(b). They must be contingent, and they are set by the federal judge.

If an ALJ believes that a representative has acted contrary to the interests of the client/claimant, remedies exist to address the representative's actions. SSA's current "Rules of conduct and standards of responsibility for representatives" set both affirmative duties and prohibited actions. For example, the Rules require representatives to act with "reasonable diligence and promptness in representing a claimant" and "provide competent representation to a claimant." A representative may not "[t]hrough his or her own actions or omissions, unreasonably delay or cause to be delayed, without good cause ... the processing of a claim at any stage of the administrative decisionmaking process."

The Rules of Conduct establish a procedure for handling violations, which can result in suspension or disqualification from practice before the SSA. 20 C.F.R. §§ 404.1740 and 416.1540. If a representative acts to unreasonably delay the proceedings against the

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<sup>6</sup> At the hearing, Professor Pierce stated that fees in VA cases are limited to \$10.00. That statement was true until 2006 when Congress enacted legislation that became effective in 2007 to amend the fee structure. Since 2007, fees in VA cases are tested for "reasonableness." Fees are 20% of past-due benefits if the representative asks for withholding and direct payment. See 38 U.S.C. § 5904; 38 C.F.R. § 14.636(h). Unlike Social Security and SSI claims, there is no cap in VA cases. If the representative does not ask for withholding and direct payment, the fee must meet the test for "reasonableness"; there is no cap. See 38 C.F.R. § 14.636(f).

claimant's interests, we believe that it is rare and unjustifiable. But SSA has the tools to penalize a representative for this behavior. In addition to the SSA Rules of Conduct, attorneys are subject to the Professional Rules of Conduct of their respective State Bars and, ultimately, could be sanctioned, leading to the suspension of the right to practice law.

#### **4. Why are lawyers needed to assist claimants? Could law school clinics and legal services provide representation to claimants?**

Claimants' representatives, both attorneys and nonattorneys, play an important role in assisting claimants for Social Security and SSI disability benefits.

The Social Security Administration's disability determination system is a complex, multi-level process. Appealing the denial of an application for disability benefits can be a daunting task for anyone who does not have experience with the process, but for individuals who are in poor health or disabled, the procedural hurdles that must be cleared in order to obtain disability benefits can seem insurmountable. As a result, many individuals applying for Title II or SSI disability benefits choose to obtain a representative to help with the appeal.

It is not surprising that individuals seek representation, given the individual challenges in each case and the undeniable importance of the outcome. Exactly why a claim has been denied is frequently a mystery to the claimant who receives an initial denial notice. Claimants often have been out of work for many months and have no income other than the financial support they receive from their friends, family, or non-profit organizations. Most have no health insurance and cannot pay for the medical treatments necessitated by their disability. They also understand that their family's welfare may be dependent on receiving disability benefits and the accompanying Medicare or Medicaid health insurance coverage.

The ability to have an experienced professional provide legal assistance is certainly valuable for claimants. SSA's own statistics show that claimants who are represented have a significantly higher allowance rate at the hearing level than claimants who do not have representation. Given the importance of representation, the Social Security Act requires SSA to provide information on options for seeking representation, whenever the agency denies a claimant's application for benefits.<sup>7</sup>

Most representation occurs at the hearing level. A major reason is that it is only at that level, after the request for hearing is filed, that claimants are given concrete information regarding local and national resources to contact. However, many claimants' representatives represent claimants prior to the hearing level, by helping them file their applications, obtain medical evidence in support of the application, and assist in appealing if their applications are denied.

We believe the main reason for the higher allowance rate of represented claimants is due to the assistance of a knowledgeable representative who is familiar with the sequential evaluation process set forth in the regulations and Social Security Rulings. The representative marshals evidence from doctors and hospitals, other treating professionals

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<sup>7</sup> 42 U.S.C. §§ 406(c) and 1383(d)(2)(D).

(e.g., therapists, social workers, nurse practitioners), school systems, vocational testing centers, previous employers, and others who can shed light on the claimant's entitlement to disability benefits.

These trained and experienced representatives can also thoroughly examine vocational and medical witnesses during the hearing before the Administrative Law Judge (ALJ). These are daunting tasks for *pro se* claimants, especially when we consider that they are in poor health and many often have only a limited education.

Experienced representatives also are a valuable resource for SSA by helping to streamline the disability determination process. Attorneys and other representatives routinely explain the disability determination process and procedures to their clients with more specificity than SSA. In addition, they ensure a more efficient system by developing an accurate and complete medical and vocational record and presenting the supporting documentation and statements that the adjudicators require for a full and fair evaluation of the claim. Often, the evidence obtained by representatives and the legal briefs they prepare on behalf of their clients contain the requisite evidence to support a finding of disability by an ALJ without the necessity of a hearing, thereby saving time and expense for both the Social Security Administration and the claimant.

**Legal services and law school clinics cannot provide wide-scale representation to claimants.** Legal services programs provide civil legal assistance to low income individuals. Funding to local legal services programs has been reduced drastically, despite the fact that those eligible for services has increased significantly. Between FY 2010 to 2012, federal funding was reduced by 18 percent and is now at the same level as in FY 2007, even though the population eligible for services has grown by more than 15 million people since 2007. In addition, funding from state and local government appropriations and private donations has decreased. As a result of the funding reduction, legal services around the program are experiencing significant reductions in staffing and operations, including office closures.<sup>8</sup> Local legal services programs rely on private attorneys and nonattorneys to represent claimants in Social Security and SSI disability claims. That allows the programs to allocate their limited resources to areas where there are no options available.

Law school clinic programs do provide limited representation to claimants. However, that representation is not extensive and cannot substitute for representation by claimants' representatives who practice in this area: Not all law schools have clinical programs; even if they have programs, they may not represent individuals in Social Security and SSI cases; law schools are not located in widespread geographic areas; and clinic programs may be limited by the academic year.

**5. Earlier this year, the agency established a new policy of not identifying the ALJ who would be holding the hearing until the day of the hearing because representatives were declining hearings before certain ALJs. According to the**

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<sup>8</sup> See Legal Services Corporation FY 2013 Budget Request, available at: <http://www.lsc.gov/congress/lsc-funding/lscs-fiscal-year-2013-budget-request>.

**Social Security Inspector General, declined hearings create processing delays and extra work for the hearing office staff. Why would your members decline or even cancel hearings for claimants who have been waiting in line to be heard?**

Claimants' representatives are encouraged to seek postponements as infrequently as possible because of the length of time claimants must wait for a hearing date and because of the potential disruption to the overall hearings process. However, there are circumstances when a postponement is necessary to adequately represent the claimant. One of the main reasons that a representative may seek a postponement of a scheduled hearing is when the claimant seeks and obtains representation shortly before the hearing or after receiving the hearing notice, frequently fewer than 20 days before the hearing date.<sup>9</sup> Based on the experience of representatives, this is not an uncommon occurrence since the ALJ hearing is the claimant's first in-person contact with an adjudicator. It should be noted that the current regulations state that a good reason for requesting a postponement is when the representative is appointed within 30 days of the scheduled hearing date and needs additional time to prepare.<sup>10</sup>

Under this circumstance, whether a representative and claimant decide to proceed with the scheduled hearing or request a postponement will normally depend on the quality of the records already in the hearing record file. After representation is obtained, the representative will need time to review the file in order to formulate legal arguments and, most importantly, develop additional evidence. If further evidence is needed to fully develop the claim, which is typically the case, then additional time will be required to request and obtain the records and other information.

The other most frequent reason for requesting a hearing postponement is that the claimant is ill or hospitalized. SSA's regulations require the ALJ to reschedule the hearing in this circumstance.<sup>11</sup> Other reasons for requesting a postponement include:

- Serious illness or death of a family member.
- Lack of transportation to the hearing site. This is a problem not only in urban areas where there is mass transportation but the claimant lacks funds to pay the fare, but also is a problem for claimants who reside in rural areas and small towns and must travel some distance to a hearing site.
- The claimant is homeless or is being evicted.
- The representative has a scheduling conflict.
- The claimant cannot be located.

SSA's regulations<sup>12</sup> provide a nonexhaustive list of reasons, including many listed above, for requesting that the hearing be rescheduled.

Factors considered by representatives in deciding whether to seek a postponement include:

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<sup>9</sup> Under current regulations (in all areas of the country except for SSA Region I), only a 20-day notice is required. 20 C.F.R. §§ 404.938(a) and 416.1438(a).

<sup>10</sup> 20 C.F.R. §§ 404.936(f)(2) and 416.1436(f)(2).

<sup>11</sup> 20 C.F.R. §§ 404.936(e)(1) and 416.1436(e)(1).

<sup>12</sup> 20 C.F.R. §§ 404.936 and 416.1436.

- The length of time the claimant has waited for a hearing.
- The claimant’s medical condition.
- The claimant’s financial situation.
- Whether further development is needed.
- The impact on the system.
- What the client/claimant wishes to do.

Decisions will not necessarily depend on a single factor but will involve a discussion with the claimant. Ultimately, the decision rests with the client, after the benefits and risks have been explained.

### **6. Do claimant’s representatives present all evidence to ALJs, including evidence that might not be supportive of an allowance?**

Under current regulations, a claimant is required to disclose material facts in his or her claim for benefits and to prove disability.<sup>13</sup> This duty extends to the representative under SSA’s “Rules of conduct and standards of responsibility for representatives.”<sup>14</sup> We believe that the current regulations regarding the duty of claimants and representatives to submit evidence work well, especially when combined with the duty to inform SSA of all treatment received.

A requirement to provide “all” evidence may conflict with state bar ethics rules which limit the submission of evidence that could be considered adverse to a client. In every state, attorney representatives are currently bound by state bar rules that forbid an attorney from engaging in professional conduct involving dishonesty, fraud, deceit, or willful misrepresentation. SSA’s Rules of Conduct for all representatives impose similar prohibited actions.<sup>15</sup>

### **7. Why do claimants need four levels of appeal? Why is the record not developed more fully earlier in the process?**

**Eliminate reconsideration.** For many years, the CCD Social Security Task Force has been on record as supporting elimination of the reconsideration level and providing more time and effort to better develop disability claims at the initial level. As long ago as May 1994, in response to SSA’s “reengineering” proposal,<sup>16</sup> the Task Force submitted comments in favor of eliminating reconsideration, while urging SSA to “collect the correct information at the earliest possible time in the process to ensure that correct decisions are made the first time. SSA must improve the collection of medical and nonmedical evidence by explaining what is needed and asking the correct questions, with appropriate variations for different sources.”

<sup>13</sup> 20 C.F.R. §§ 404.1512(a) and 416.912(a).

<sup>14</sup> 20 C.F.R. §§ 404.1740(b)(1) and 416.1540(b)(1).

<sup>15</sup> SSA previously proposed adding a requirement 20 C.F.R. §§ 404.1512(a) and 416.912(a) that the claimant submit all evidence “available to you.” 70 Fed. Reg. 43590 (July 27, 2005). This proposed change was rejected when the final rule was published. 71 Fed. Reg. 16424 (Mar. 31, 2006).

<sup>16</sup> 59 Fed. Reg. 18188 (Apr. 15, 1994).

These comments, made 18 years ago, still remain true today. While the 1994 reengineering proposal was not implemented, it seems to have evolved into a ten-state prototype, which eliminates reconsideration. The prototype was announced in 1999 and started in October 2000. It continues in those ten states and was recently extended into September 2013.<sup>17</sup>

Over the years, the Task Force has continued to support elimination of the reconsideration level. We have stated many times in testimony before this Subcommittee<sup>18</sup> and in comments to SSA that elimination of reconsideration with better development of evidence and some type of pre-decision contact with the claimant will create a more streamlined process and better serve individuals with disabilities applying for benefits.

**Retain claimant-initiated review by the Appeals Council.** We recommend retention of a claimant's right to administrative review of an unfavorable ALJ decision. The Appeals Council currently provides relief to over twenty percent of claimants who request review, either through outright reversal or remand back to the ALJ. While the vast majority of Appeals Council actions are remands back to the hearing level, claimants clearly benefit from Appeals Council review – over 60 percent of remands result in favorable decisions.

The Appeals Council has made significant improvements in reducing its backlog and processing times. When it is able to operate properly and in a timely manner, the Appeals Council provides claimants with effective review of ALJ decisions. A major basis for remand is not the submission of new evidence, but rather legal errors committed by the ALJ, including the failure to consider existing evidence according to SSA regulations and policy, the failure to apply correct legal standards, and the failure to follow procedural requirements. By providing relief in these cases, the Appeals Council allows the Commissioner to rectify errors administratively, rather than relying on review in the federal courts. The Appeals Council can act as an effective screen between the ALJ and federal court levels and prevent a significant increase in the courts' caseloads.

In addition, the procedure to request review is relatively simple. SSA has a one-page form that can be completed and filed in any Social Security office, sent by mail or faxed. In contrast, the procedure for filing an appeal to federal district court is much more complicated and, unless waived, there is a filing fee, which may be cost-prohibitive for a claimant. Under the current process, there is a large drop-off in appeals from the Appeals Council to federal court. There are a number of factors contributing to this lower rate of appeal, including the fact that some attorneys do not take cases to federal court; some representatives are not attorneys; many attorneys do not take cases to federal court if they did not represent the claimant at the hearing; and *pro se* claimants are intimidated by the process. As a result, having an administrative mechanism to correct injustices is essential.

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<sup>17</sup> 77 Fed. Reg. 35464 (June 13, 2012).

<sup>18</sup> For a more detailed discussion of our reasons supporting the elimination of reconsideration, see Testimony of Nancy G. Shor, On Behalf of the CCD Social Security Task Force, "Joint Hearing on Social Security Disability Claims Backlogs," House Ways and Means Subcommittees on Income Security and Family Support (now the Human Resources Subcommittee) and on Social Security, April 27, 2010.

**Why evidence is not developed earlier in the process.** The answer to question two addresses gaps in collection of evidence earlier in the process and recommendations for ways to improve the process.

### **8. What are your views on the efficacy and fairness of video hearings?**

Video hearings allow ALJs to conduct hearings without being at the same geographical site as the claimant and representative and have the potential to reduce processing times and increase productivity. We support the use of video hearings so long as the right to a full and fair hearing is adequately protected; the quality of video hearings is assured; and the claimant retains the absolute right to have an in-person hearing as provided under current regulations<sup>19</sup> and SSA policy.

The claimant makes the ultimate decision whether to accept the video hearing. In general, representatives report that video hearings are usually accepted, primarily because they lead to faster adjudication. However, there are a number of reasons why a claimant may decline and choose to exercise the right to an in-person hearing, e.g., the claimant's demeanor is critical (e.g., respiratory impairments, fatigue caused by impairment); the claimant has a mental impairment with symptoms of paranoia; the claimant has a hearing impairment.

Several years ago, SSA established National Hearing Centers (NHCs) to help reduce the hearings backlog. Cases are transferred from "brick and mortar" hearing offices to the five NHCs, where hearings are handled exclusively by video. If claimants exercise their right to an in-person hearing, the claim is transferred back to the geographic hearing office where a local ALJ will hear the case. However, we have recently heard that NHC ALJs, in some cases, will travel to the local hearing offices to hear cases in person.

The Representative Video Project (RVP) is another initiative that has been instituted to help reduce the disability claims backlog. Under RVP, the representative purchases video equipment that allows the claimant and representative to be in the representative's office with the ALJ in a hearing office location.

### **9. What are the pros and cons of closing the record either just before the hearing or at the close of the hearing before an ALJ issues a decision?**

Closing the record before the hearing or at the close of the hearing before the ALJ issues a decision conflicts with the goal of ensuring that there is a complete record, especially since the evidence provided may be valuable and probative in determining disability.

There are many legitimate reasons, often beyond the claimant's or representative's control, why evidence is not submitted earlier and thus why closing the record or creating unreasonable procedural hurdles is not beneficial to claimants. We have many concerns – both legal and practical – if the record is closed at any point before the ALJ issues a decision, which is the current rule.

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<sup>19</sup> 20 C.F.R. §§ 404.936 and 416.1436.

**Closing the record before the hearing is inconsistent with the Social Security Act.**

The Act provides the claimant with the right to a hearing with a decision based on “evidence adduced at the hearing.”<sup>20</sup> Current regulations comply with the statute by providing that “at the hearing” the claimant “may submit new evidence.”<sup>21</sup>

**Closing the record is inconsistent with the realities of claimants obtaining**

**representation.** As discussed above in the response to question 5, many claimants seek and obtain representation shortly before, or even after, the ALJ hearing date. Many claimants do not understand the complexity of the rules or the importance of being represented until just before their hearing date. Many are overwhelmed by other demands and priorities in their lives and by their chronic illnesses. As a practical matter, when claimants obtain representation shortly before the hearing, the task of obtaining medical evidence is even more difficult.

**Closing the record is inconsistent with the realities of obtaining medical evidence.**

We strongly support the submission of evidence as early as possible, since it means that a correct decision can be made at the earliest point possible. However, representatives have great difficulty obtaining necessary medical records due to circumstances beyond their control. There are many legitimate reasons why the evidence is not provided earlier. There is no requirement that medical providers turn over records within a set time period. In addition, cost or access restrictions may prevent the ability to obtain evidence in a timely way.

Another factor, often outside the claimant’s control, is the problem with obtaining records and information from medical sources. Legitimate reasons why evidence is not submitted earlier include:

- DDS examiners fail to obtain necessary and relevant evidence. Further, the DDSs do not use questionnaires or forms that are tailored to the specific type of impairment or ask for information that addresses the disability standard as implemented by SSA. Witnesses at the Compassionate Allowances hearing noted this “language” barrier and how it causes delays in obtaining evidence, even from supportive and well-meaning doctors.
- Neither SSA nor the DDS explains to claimants or providers what evidence is important, necessary and relevant for adjudication of the claim.
- Claimants are unable to obtain records either due to cost or access restrictions, including confusion over HIPAA requirements. We have heard from representatives that medical providers have different interpretations of HIPAA requirements and as a result require use of their own forms for authorization to disclose information. Frequently, if the medical records staff finds a problem with the request for information, e.g., it is not detailed enough or a different release form is required, the new request goes to the end of the queue when it is resubmitted.

Claimants – and many representatives – also face difficulties accessing medical evidence due to the cost charged by providers. Medical facilities often require upfront payment for

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<sup>20</sup> 42 U.S.C. § 405(b)(1).

<sup>21</sup> 20 C.F.R. §§ 404.929 and 416.1429.

medical records, which many claimants cannot afford. Some states have laws which limit the charges that can be imposed by medical providers; however, many states have no limits. And while some representatives have the resources to advance the costs for their clients, some representatives and many legal services organizations do not.

- Medical providers delay or refuse to submit evidence. Disability advocates have noted that requests for medical evidence are given low priority by some providers. The primary reasons are inadequate reimbursement rates and lack of staff in non-direct care areas, such as medical records. Despite extensive efforts by representatives, such as hiring staff whose sole job is to obtain medical evidence, numerous obstacles and lengthy delays are still encountered in a significant number of cases. Even those representatives who have staff solely dedicated to obtaining medical evidence encounter problems.
- Reimbursement rates for providers are inadequate.

**Closing the record is inconsistent with the realities of claimants’ medical conditions.** Claimants’ medical conditions may worsen over time and/or diagnoses may change. Claimants undergo new treatment, are hospitalized, or are referred to different doctors. Some conditions, such as multiple sclerosis, autoimmune disorders or certain mental impairments, may take longer to diagnose definitively. The severity of an impairment and the limitations it causes may change due to a worsening of the medical condition, e.g., what is considered a minor cardiac problem may be understood to be far more serious after a heart attack is suffered. It also may take time to fully understand and document the combined effects of multiple impairments. Further, some claimants may be unable to accurately articulate their own impairments and limitations, either because they are in denial, lack judgment, simply do not understand their disability, or because their impairment(s), by definition, makes this a very difficult task. By their nature, these claims are not static and a finite set of medical evidence does not exist.

Also, as with some claimants who seek representation late in the process, their disabling impairments make it difficult to deal with the procedural aspects of their claims. Claimants may have difficulty submitting evidence in a timely manner because they are too ill, or are experiencing an exacerbation, or are simply overwhelmed by the demands of chronic illness, including the time and logistical demands of a caregiver or advocate to help submit evidence.

**Current law sets limits for submission of new evidence after the ALJ decision is issued and these rules should be retained.** Under current law, an ALJ hears a disability claim *de novo*. Thus, new evidence can be submitted and will be considered by the ALJ in reaching a decision. However, the ability to submit new evidence and have it considered becomes more limited at later levels of appeal.

At the Appeals Council level, new evidence will be considered, but *only* if it relates to the period before the ALJ decision and is “new and material.”<sup>22</sup> While the Appeals Council remands about one-fourth of the appeals filed by claimants, it is important to note that a major basis for remand is not the submission of new evidence, but rather legal errors

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<sup>22</sup> 20 C.F.R. §§ 404.970(b) and 416.1470(b).

committed by the ALJ, including the failure to consider existing evidence according to SSA regulations and policy and the failure to apply the correct legal standards.

At the federal district court level, the record is closed and the court *will not consider* new evidence. Under the Social Security Act,<sup>23</sup> there are two types of remands:

(1) Under “sentence 4” of 42 U.S.C. § 405(g), the court has authority to “affirm, modify, or reverse” the Commissioner’s decision, with or without remanding the case; and

(2) Under “sentence 6,” the court can remand (a) for further action by the Commissioner where “good cause” is shown, but only before the agency files an Answer to the claimant’s Complaint; or (b) at any time, for additional evidence to be taken by the Commissioner (*not* by the court), but only if the new evidence is (i) “new” and (ii) “material” and (iii) there is “good cause” for the failure to submit it in the prior administrative proceedings.

While there is a fairly high remand rate at the court level, the vast majority of court remands are not based on new evidence, but are ordered under “sentence 4,” generally due to legal errors committed by the ALJ. Because courts hold claimants to the stringent standard in the Act, remands under the second part of “sentence 6” for consideration of new evidence submitted by the claimant occur very infrequently.

On the other hand, remands under the first part of “sentence 6” occur with some frequency. In these cases, SSA may move for a voluntary remand before it has filed an Answer to the claimant’s Complaint because a file or hearing tape is lost and the administrative record cannot be completed. Or, SSA may reconsider its position on the merits of the case, realizing that the Commissioner’s final administrative decision is not defensible in court.

#### **10. What more can be done to ensure deserving claims are awarded as early in the process as possible, specifically at the State Disability Determination Services level?**

As discussed in our response to question 2, CCD supports initiatives to improve the process at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process.

**Screening Initiatives.** We support SSA’s efforts to accelerate decisions and develop new mechanisms for expedited eligibility throughout the application and review process. We encourage the use of ongoing screening as claimants obtain more documentation to support their applications. However, SSA must work to ensure that there is no negative inference when a claim is not selected by the screening tool or allowed at that initial evaluation. Initiatives include:

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<sup>23</sup> 42 U.S.C. § 405(g).

- **Quick Disability Determinations.** We have supported the Quick Disability Determination (QDD) process since it first began in SSA Region I states in August 2006 and was expanded nationwide by Commissioner Astrue in September 2007. The QDD process has the potential of providing a prompt disability decision to those claimants who are the most severely disabled. Since its inception, the vast majority of QDD cases have been decided favorably in less than 20 days, and sometimes in just a few days.

- **Compassionate Allowances.** This initiative allows SSA to create “an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both...” SSA published an initial list of 50 conditions on its website. There are currently 113 conditions on the list, with 52 to be added in August 2012. Unlike the QDD screening, which occurs only when an application is filed, screening for compassionate allowances can occur at any level of the administrative appeals process. SSA has held seven Compassionate Allowance outreach hearings with expert panels to consider additional impairments including autoimmune disorders, schizophrenia, early onset Alzheimer’s Disease, and cardiovascular disorders.

**Improve development of evidence earlier in the process.** In testimony for this hearing and many previous hearings, CCD has made a number of recommendations to ensure that disability claims are properly developed at the beginning of the process. Claimants’ representatives are often able to provide evidence that we believe could have been obtained by the DDSs earlier in the process. Our recommendations include:

- **Provide more assistance to claimants at the application level.** At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing the application, particularly in light of electronic filings, so that all impairments and sources of information are identified, including non-physician and other professional sources.

- **DDSs need to obtain necessary and relevant evidence.** Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. However, DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating and examining doctors. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to the vocational professionals at DDSs and hearing offices.

**Increase reimbursement rates for providers.** To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts.

**Provide better explanations to medical providers.** SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and ask for evidence relevant to the standard.

**Provide more training and guidance to adjudicators.** Many reversals at the appeals levels are due to earlier erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as: weighing medical evidence, including treating source opinions; the role of non-physician evidence; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings.

**Improve the quality of consultative examinations.** Steps should be taken to improve the quality of the consultative examination (CE) process. There are far too many reports of inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's.

**Incorporate vocational expertise into the DDS levels.** This could have the effect of providing a more complete evaluation at the DDS level than currently occurs. A significant number of ALJ decisions are based on medical-vocational factors, i.e., step 5 of the sequential evaluation process. A certain percentage of these cases could be allowed earlier in the process if the medical-vocational rules were applied properly. Also, it may result in greater agreement between DDS and ALJ decision-making, as ALJs already generally consider vocational evidence and expertise in making their decisions.

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Thank you again for the opportunity to testify at the hearing on June 27, 2012. If you or your staff would like further information or discussion on any issues involving the Social Security disability appeals process, I would be happy to respond, as would my co-chairs from the Consortium for Citizens with Disabilities (CCD) Social Security Task Force. Please let us know if we can be of further assistance. I can be reached directly at (202) 457-7775 or [nosscrdc@att.net](mailto:nosscrdc@att.net).

Sincerely,

Ethel Zelenske  
Co-Chair, Social Security Task Force  
Consortium for Citizens with Disabilities