



Research and Statistics Note

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Identifying SSA's Sequential Disability Determination Steps Using Administrative Data

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Introduction

Under the disability determination process used by the Social Security Administration (SSA), each determination that an applicant is either eligible (allowed) or ineligible (denied)—under Disability Insurance (DI) and/or Supplemental Security Income (SSI)—has a specific regulatory basis that is cited by program administrators. Decomposing broad disability trends requires identification of those bases and the steps of the determination process at which they are cited. For example, the recent increase in the number of allowances has been accompanied by a change in the composition of allowances. For DI, the percentage of allowances based on vocational, educational, and age-specific factors increased from 28 percent to 47 percent in the 10 years prior to 2009 (SSA 2011a). In this case, decomposing recent program growth permits researchers to identify subcategories driving the growth. To give another example, decomposing trends in denials at various steps of the determination process may permit researchers to consider to what extent the process counterbalances increases in applications during recessions, keeping program costs in check.

The purpose of this note is to facilitate research on trends in allowances and denials by documenting how the steps of the determination process and the bases for medical eligibility decisions can be identified in administrative data. Specifically, the steps in the initial determination process can be identified using the Regulation Basis Code (RBC), which appears in Social Security's administrative data systems as well as related research data sets. The RBC documents the detailed reason for each SSA determination, in terms of medical, medical-vocational,¹ and other criteria. The RBC is recorded in the National Disability Determination Service System (NDDSS); in turn, the NDDSS is used to construct the so-called

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The findings and conclusions presented in this note are those of the authors and do not necessarily represent the views of the Social Security Administration.

¹ Program administrators differentiate “medical allowances” (based solely on the medical Listings) from “medical-vocational allowances” (which require a severe impairment, but also take into account residual functional capacity, age, past work, and education).

831 disability applicant files (from Form SSA-831 data) as well as related research files. We classify the RBCs by program and age (DI, SSI adult, SSI child) and step of the determination process at which they are invoked. Our frequency tabulations show that some codes are numerically important at a given step and others represent a range of technical denials, rare findings, or data errors. Further, we provide the proportions of determinations observed for each basis code at each step, using the 831 file for 2010 as a benchmark.

Selected Abbreviations

DDS	Disability Determination Service
DI	Disability Insurance
NDDSS	National Disability Determination Services System
RBC	Regulation Basis Code
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income

Program Background

The two disability programs administered by SSA have financial and nonfinancial criteria for eligibility. In the case of the DI program, financial eligibility is based on (1) past earnings criteria involving the total number of quarters worked while making Federal Insurance Contributions Act (FICA) contributions, and (2) the number of quarters worked in years immediately before disability onset. Both criteria are used to define the applicant’s insured status. For SSI, financial eligibility is based on current income and resources² to target payments to individuals with limited financial means.

While the nonfinancial criterion for SSA’s retirement program is straightforward (if the applicant’s age is greater than or equal to the full retirement age or the early retirement age, then the applicant is eligible), the nonfinancial (largely medical) criteria for DI benefits (or for SSI disability payments) are complex. In fact, there are multiple medical criteria—or combinations of medical and vocational criteria—under which an applicant can be found medically eligible or medically ineligible. In addition, there are outcomes that are not medical in nature; for example, an applicant can be denied if he or she refuses to submit to a consultative examination or refuses to follow prescribed treatment.

SSA uses the same disability determination process in administering the two disability programs, DI and SSI. Financial and other nonmedical screens are implemented by SSA field offices. For applicants found eligible under those screens, the initial medical determinations are made by Disability Determination Service (DDS) agencies in each state. However, if an applicant is denied at the initial DDS level, he or she has the option of pursuing a sequence of appeals, including appealing to (1) the DDS itself, known as reconsideration;³ (2) an administrative law judge (ALJ); (3) the Appeals Council; and finally (4) a federal court.

The RBC records information about the determinations made by the DDS, including initial determinations and reconsiderations. The purpose of this note is to help researchers and program analysts interpret the particular medical, medical/vocational, or other criterion that is invoked by the DDS in its allow/deny determination of a given applicant. The importance of the RBC is that it permits an analyst to parse program outcomes in terms of the effects of the particular medical, medical/vocational, or other criterion used to determine medical eligibility. Next, we outline the sequential disability determination process used by SSA and DDS agencies—the decision-making structure underlying field office intake decisions and the detailed DDS determination outcomes represented in the RBC.

² Program administrators typically use “resources” to refer to financial assets such as savings or stocks. Administrators implement a limitation on financial assets, and they refer to it as the “resources test.”

³ In 1999, SSA began the Prototype pilot in 10 states, whereby claims can be appealed directly to the administrative law judge level without going through the reconsideration phase.

SSA's Disability Determination Process

The disability determination process described in this study is used by Social Security field offices and state DDS agencies to make initial disability determinations. Field offices implement step 1 of the five-step disability determination process, and DDS agencies are responsible for the medical determinations at steps 2–5. The specific criteria used by the DDS in its allow/deny determinations are identified in the RBC, which is included in the NDDSS data generated by DDS agencies. The RBC describes the basis for initial determinations and reconsiderations. Outcomes of higher-level appeals, such as decisions of ALJs, are in principle, based on the same criteria as DDS determinations, but such appeals decisions are not included in the NDDSS data generated by DDS agencies. ALJ-level decisions are recorded in the Case Processing and Management System.

Former Commissioner Robert M. Ball (1978) provides an insight that is useful in trying to understand the design of the determination process. For the sake of efficiency, the process implies a screening strategy:

The idea was to screen quickly the large majority of cases that could be allowed on reasonably objective medical tests and then deal individually with the troublesome cases that didn't pass the screen. (157)

For example, the first three stages of the adult disability determination process represent screens:

- claimants who are engaging in substantial gainful activity (SGA) are denied (step 1) without any consideration of medical criteria,
- those without severe impairments are denied (step 2), and
- those with the most highly disabling or fatal impairments are allowed (step 3).

In Ball's characterization, the "troublesome" cases are the residual, which are evaluated on a case-by-case basis using both medical and vocational factors (step 4 and possibly step 5).⁴

Because the processes for adults and children differ, we discuss them separately.

Adults

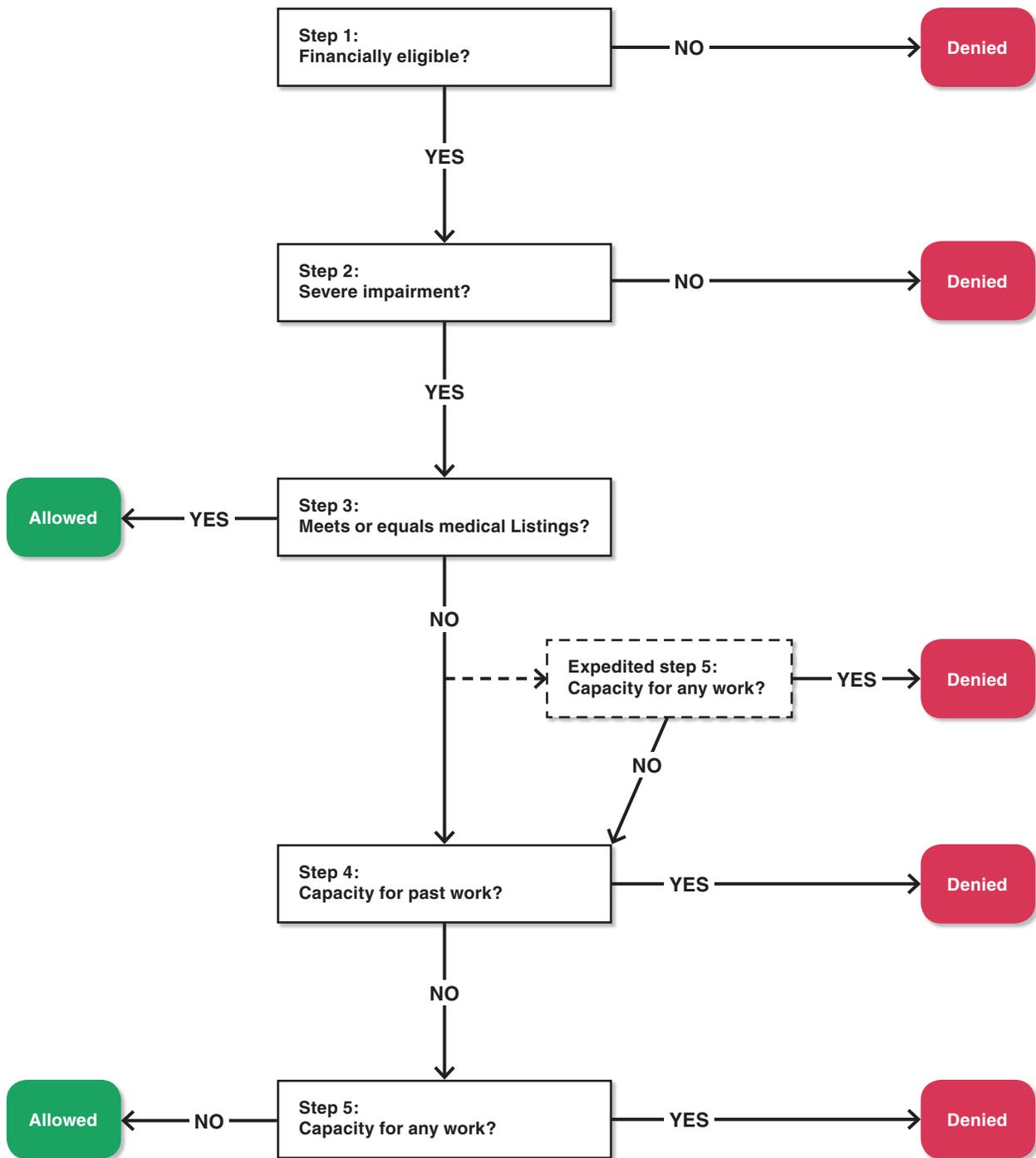
The steps in the disability determination process for adults are diagrammed in Chart 1, adapted from Lahiri, Vaughan, and Wixon (1995).

Step 1: Financial screens. For both DI and SSI, Social Security field offices screen out applicants who work and have earned income above the SGA limit. Those claims are denied on the basis of applicants' work activity. SGA is "work that involves doing significant and productive physical or mental duties and is done (or intended) for pay or profit."⁵ In most cases, applicants with earnings above the SGA threshold amount are denied on grounds that their earnings indicate that they are not permanently and totally

⁴ In describing the disability determination process, "medical" is used in two ways. First, it is used to distinguish the determination of medical eligibility using the five-step sequential process described in this note from the determination of financial eligibility, such as insured status (for DI) or income and resource eligibility (for SSI). Second, in discussing the five-step process, program administrators differentiate *medical allowances* (based solely on the medical Listings) from *medical-vocational allowances* (which require a severe impairment, but also take into account residual functional capacity, age, past work, and education); see note 1.

⁵ For example, activities involving self-care, household tasks, unpaid training, hobbies, therapy, school attendance, clubs, or social programs are not generally considered to be SGA. For more detail, see the publicly available *Program Operations Manual* (POMS), <https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501001>, or the *Code of Federal Regulations* (CFR), <http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=efc4db7ae17950f4db4dddf34e13c74&n=20y2.0.1.1.5.16&r=SUBPART&ty=HTML#20:2.0.1.1.5.16.188.10>.

Chart 1.
Disability determination process for adults



SOURCE: Authors' illustration adapted from Lahiri, Vaughan, and Wixon (1995).

work disabled; otherwise, the application is referred to the DDS.⁶ The SGA amount for nonblind beneficiaries was \$1,010 per month in 2012.

In addition, field offices verify insured status for DI applicants. Analogously, field offices ensure that countable income and resources are below the relevant thresholds for SSI applicants. These financial determinations are not technically part of the sequential determination process and thus are not represented in the RBC, but for the sake of efficiency, they are normally undertaken (at least on a preliminary basis) by field offices as part of the step 1 process.⁷

Step 2: A medical screen to deny applicants without a severe impairment. An applicant is denied at step 2 if his or her impairment(s) is considered *not severe*. According to SSA's Program Operations Manual System (POMS), under step 2:

“it must be determined whether medical evidence establishes a physical or mental impairment or combination of impairments of sufficient severity as to be the basis of a finding of inability to engage in any substantial gainful activity (SGA). When medical evidence establishes only a slight abnormality or a combination of slight abnormalities which would have no more than a minimum effect on an individual's ability to work, such impairment(s) will be found “not severe,” and a determination of “not disabled” will be made...”⁸

Applicants are also denied if their impairments fail the *duration test*; that is, if the impairment (1) is not expected to result in death, and (2) has neither lasted 12 months nor is expected to last for a continuous period of 12 months. The duration test is typically invoked at step 2, but may also be invoked at step 3, 4, or 5.

Step 3: A medical screen to allow applicants who are the most severely disabled. Medical evidence on an applicant's impairment is assessed under step 3 using codified clinical criteria called the *Listing of Impairments*, which includes over 100 impairments. Applicants with impairments that “meet” the Listings are allowed with no further evaluation, based solely on medical criteria. Moreover, if an applicant has an impairment not included in the Listings, but considered medically equivalent to a listed impairment, the impairment is said to “equal the Listings” and the applicant is allowed.⁹ Applicants who are not allowed at step 3 have impairments that, although severe, are not severe enough to consider the applicants disabled purely on medical grounds. Such applicants are evaluated further at step 4 and, possibly, step 5.

⁶ Applicants are also screened with respect to a host of other nonmedical requirements. For example, for Title II dependent benefits, spouses and children must provide proof of their relationship to the wage earner and, when applicable, their age. Survivors must provide death certificates. Proof of citizenship or permanent residence is required according to statute. Proof that the claimant is not incarcerated may be required. In addition, Title II spousal benefits may require demonstration that the ex-spouse has not remarried. These and other nonmedical factors are checked by field offices, typically before the case is referred to the DDS.

⁷ Claims denied at the SSA field office level are not referred to the DDS agencies, so 831 records are not typically created. Hence, for example, field office denials for insured status, income test/resources test, incarceration, or noncitizenship are all considered technical denials, but they are not represented in the RBC. A small percentage of SGA denials may be included in the RBC—typically those remanded from the DDS to the field office. Researchers interested in field office determinations should access the Title II Disability Research File or the Title XVI Disability Research File.

⁸ See the publicly available *Program Operations Manual*, <https://secure.ssa.gov/apps10/poms.nsf/lnx/0424505001>.

⁹ For more detail on the Listings, see the publicly available *Program Operations Manual*, <https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=04340> or see <http://www.socialsecurity.gov/disability/professionals/bluebook/listing-impairments.htm>.

Step 4: Can severely impaired applicants work in their past jobs? At this step, the DDS considers whether an applicant's *residual functional capacity* (RFC) meets the skill and task requirements of his or her past relevant work. The evaluation of RFC determines to what extent the applicant can perform basic work-related activities associated with jobs previously held—usually jobs held in the 15 years before adjudication.¹⁰ Applicants who are judged able to perform past work are denied; the claims of remaining applicants are passed on for evaluation under step 5.

Step 5: Can severely impaired applicants do other work in the national economy? At step 5, the applicant's RFC is considered, along with *vocational factors*—specifically, age, education, and work experience—to determine whether he or she can work in jobs other than those previously held. The vocational factors are used to determine whether the applicant can work in employment consistent with his or her residual capacity. This determination often involves the use of a set of tables referred to as the *medical-vocational guidelines* (sometimes known as the *vocational grid*¹¹) and medical vocational profiles.¹² At step 5, remaining applicants are either allowed or denied.

Beginning in 1999, SSA implemented modifications to the disability determination procedures in states known as prototype states.¹³ One modification was to allow DDS decision makers the discretion to proceed directly to step 5 when there is insufficient evidence about the claimant's work history to make the evaluation at step 4. Under this procedure, referred to as expedited vocational assessment, applicants may be denied if they are judged able to perform work in the national economy. However, if they are judged unable to do that, the DDS is required to return to and complete step 4. Expedited vocational assessment was extended to the other states in August 2012.¹⁴

SSI Children

Some of the steps in the disability determination process for children are similar to those for adults. Steps in the process for children are diagrammed in Chart 2.

Step 1: Financial screens. Children may not qualify for DI benefits on their own earnings record.¹⁵ However, they may qualify for SSI payments on their own in some cases or as part of a unit including their parent(s). For SSI, field offices evaluate income and resource eligibility under a complex set of rules.

¹⁰ In some cases, the analysis of past work can extend further than 15 years back into the claimant's work history. See <https://secure.ssa.gov/apps10/poms.nsf/lnx/0425005015>.

¹¹ In certain cases, including mental impairments, the vocational grid is not used or it is used as a general framework. For more detail on the vocational grid, see the publicly available *Program Operations Manual*, <https://secure.ssa.gov/apps10/poms.nsf/subchapterlist?openview&restricttocategory=04250>, or the *Code of Federal Regulations*, <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=ece928d7f4cda42f9d9a43f83b661174&rgn=div8&view=text&node=20:2.0.1.1.5.16.194.35&idno=20>.

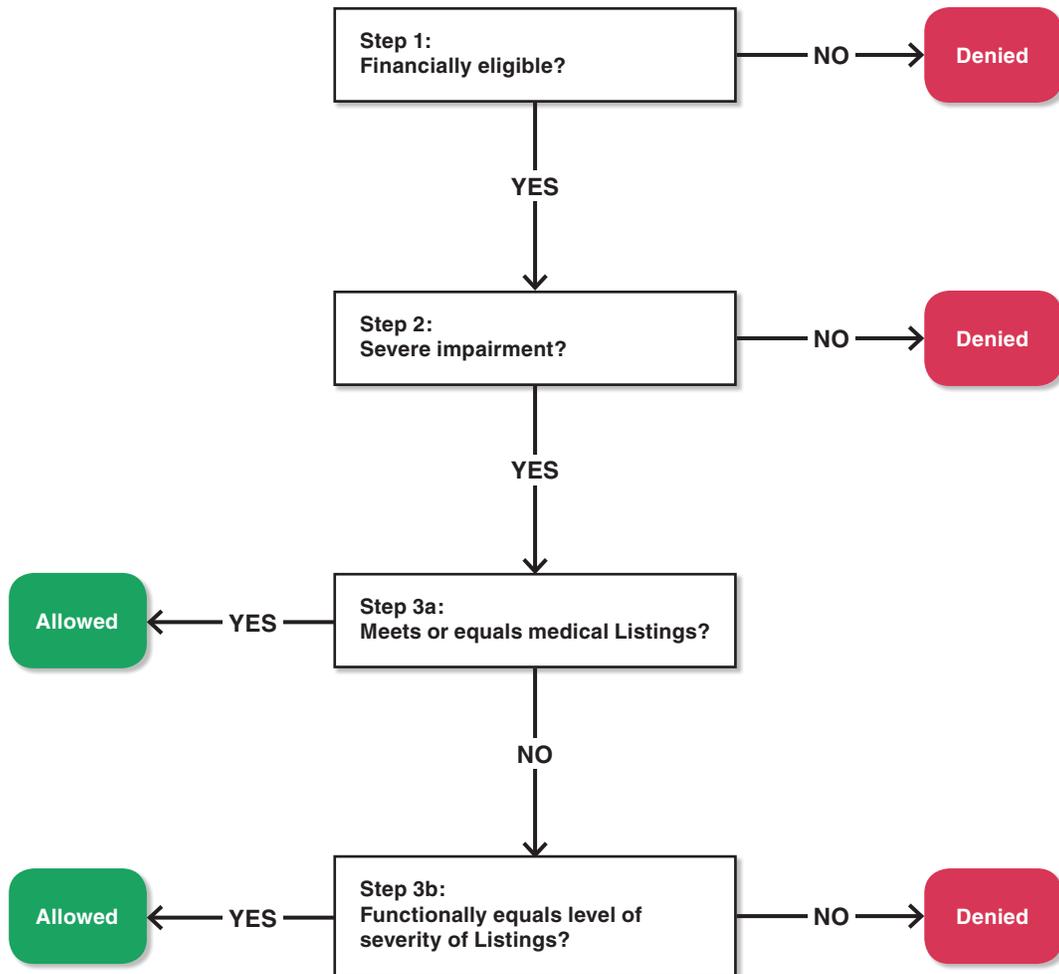
¹² See the *Code of Federal Regulations*, http://www.socialsecurity.gov/OP_Home/cfr20/404/404-1562.htm and http://www.socialsecurity.gov/OP_Home/cfr20/416/416-0962.htm.

¹³ Alabama, Alaska, part of California, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania.

¹⁴ See the publicly available *Program Operations Manual*, <https://secure.ssa.gov/apps10/poms.nsf/lnx/0425005005>, the *Code of Federal Regulations*, <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=ece928d7f4cda42f9d9a43f83b661174&rgn=div8&view=text&node=20:2.0.1.1.5.16.194.35&idno=20>, and the *Federal Register*, Vol. 76, No. 177, Tuesday, September 13, 2011, <http://www.gpo.gov/fdsys/pkg/FR-2011-09-13/pdf/2011-23396.pdf>. For implementation of expedited vocational assessment in prototype states, see http://www.socialsecurity.gov/disability/Documents/Prototype_Operating_Instructions.doc (p. 17).

¹⁵ However, children's insurance benefits under Title II are available for a child of a parent who is entitled to retirement or disability benefits or who is deceased. Generally, benefits are available after the age of 18 for a disability that began prior to that age. For more information, see <https://secure.ssa.gov/poms.nsf/lnx/0410115001>.

Chart 2.
Disability determination process for children



SOURCE: Authors' illustration.

NOTE: Although the disability determination process for children includes a medical screen and a functional assessment as a single step (step 3), for analytical purposes we discuss them separately as step 3a and step 3b.

Field offices also verify whether the child is working at SGA because those up to age 18, some of whom may be working, are evaluated under the determination process for children. If a child is engaging in SGA, the claim is denied and not referred to the DDS.

Step 2: A medical screen to deny applicants without a severe impairment. The DDS denies a child applicant at step 2 if he or she does not have a medically determinable impairment or if his or her impairment(s) is considered *not severe*. Child applicants are also denied if their impairments fail the *duration test*; that is, if the impairment (1) is not expected to result in death, and (2) has neither lasted 12 months nor is expected to last for a continuous period of 12 months. If the impairment(s) is considered severe and if any impairment meets the duration test, the claim will proceed to the next step.

Step 3a:¹⁶ A medical screen to allow the most severely impaired applicants. If the child has one or more severe impairments, the DDS will decide if any severe impairment meets one of the Listings for children. The Listings cover the major body systems and include descriptions of common physical and mental impairments (such as cerebral palsy, mental disorders, and asthma), along with specific medical severity criteria. As with adults, if the impairment does not meet the Listings, the DDS decides if it medically equals the Listings. If the child has one or more impairments that meet or medically equal the requirement of a Listing and meet the duration requirement, the DDS will find the child disabled and the determination is complete.

Step 3b: Can a severely impaired child function at home, at school, and in the community? If the child has one or more impairments that are severe but do not meet or medically equal a Listing, the DDS will decide whether the impairment or impairments “functionally equal” the Listings. That means that the DDS assesses the effects of any impairment on the child’s ability to function at home, at school, and in the community. In particular, the DDS considers questions such as—

- What activities is the child able or not able to perform?
- Which activities are limited in comparison with children of the same age without the impairment?
- What type and amount of help does the child need to complete age-appropriate activities?

Once the DDS has evaluated the extent to which the child can perform activities, it evaluates how much the child is limited in each of six domains. The domains are broad areas of functioning intended to capture all that a child can or cannot do. The six domains are as follows:

1. Acquiring and using information,
2. Attending to and completing tasks,
3. Interacting and relating with others,
4. Moving about and manipulating objects,
5. Caring for himself or herself, and
6. Maintaining health and physical well-being.

If a child’s impairment or combination of impairments results in “marked” limitations in two or more of these domains of functioning, or an “extreme” limitation in one domain, then his or her impairment(s) functionally equals the Listings. A *marked* limitation in a domain is one in which a child’s impairment interferes seriously with his or her ability to independently initiate, sustain, or complete activities. An *extreme* limitation in a domain is one in which a child’s impairment interferes very seriously with those abilities.

¹⁶ Although the disability determination process for children includes a medical screen and a functional assessment as a single step (step 3), for analytical purposes we discuss them separately as step 3a and step 3b.

Identifying the Sequential Steps Using Regulation Basis Codes

The detailed RBC values are somewhat different for DI (under Title II—Old-Age, Survivors, and Disability Insurance—of the Social Security Act) and SSI (under Title XVI of the Act) and, because they include a number of administrative outcomes, are considerably more detailed than the sequential determination steps might suggest.

We recode the individual regulation basis values into sequential disability determination steps in Tables 1 through 3. In deriving the recode, we consulted program experts and the documentation from Social Security administrative sources—the basis for day-to-day use of RBCs by program administrators. We also compared coding from other sources by examining the coding that is used in annual SSA publications. Specifically, the *Annual Statistical Report on the Social Security Disability Insurance Program* (SSA 2011a, Tables 63 and 64) classifies medical decisions at step 2 onward for DI determinations. The *SSI Annual Statistical Report* (SSA 2011b, Tables 73 and 74) does a similar classification for SSI determinations. In addition, we prepared the coding that was used in several analytical studies, including Lahiri, Vaughan, and Wixon (1995); Hu and others (2001); Dwyer and others (2002/2003); Lahiri, Song, and Wixon (2008); and Autor and others (2011). We also compared those different coding schemes and consolidated differences.¹⁷ These comparisons establish the broad consistency of the recode presented here with documentation from program administrators, published tables, and recent analyses.

The frequencies of the sequential disability determination steps are shown in Tables 1 through 3 using the 831 file for 2010.¹⁸ When comparing those results to frequencies based on other data sources, several features of the sample universe used in our tabulations should be noted. First, data are shown for primary DI and SSI disability claims, where the claimant is a worker (for DI claims), an SSI adult, or an SSI child. Second, step 1 determinations are generally not included because the majority of those decisions are made in the field offices. Denials made at the field office level are not referred to the DDS and are not represented in the NDDSS data. Third, researchers often remove 831 observations that can functionally be considered duplicates. For example, because the 831 data are transaction based, if an applicant filed more than one claim for the same program, each claim would generate a new record. Moreover, if the researcher is undertaking a person-based analysis, he or she may choose to purge records so that each person is represented by a single record. We show frequencies with duplicates included as a benchmark that could be easily replicated. Finally, our frequency tabulations include only DDS initial determinations; that is, for DDS denials that are appealed, our tabulations do not represent the final determination made by SSA.

¹⁷ The three recodes were quite consistent, though not identical. However, the reasons for the slight differences fall into three categories. First, the coding for Lahiri, Vaughan, and Wixon (1995); Hu and others (2001); Dwyer and others (2002/2003); and Lahiri, Song, and Wixon (2008) was derived from an analytical sample of 831 records, and several very low-frequency code values that did not occur in the sample were not classified. Second, because of the nature of the tables used in the DI and SSI statistical reports (SSA 2011, 2011b), the recode did not include step 1 outcomes relating to financial eligibility determination, in contrast to the other studies. Third, the analytical studies excluded children from their recodes, whereas the annual SSA publications include children.

¹⁸ The codes shown in Tables 1 through 3 are those used in the 831 files; other data sets that are derived from the NDDSS may use RBCs that are not identical to those used in the 831 data. For example, the Disability Operational Data Store (DIODS), a data base constructed from the NDDSS system, uses a three-character variable for its Title XVI RBCs—a letter prefix, followed by the two-place numerical code used in the 831 data. However, the Disability Research File uses the same RBC found in the 831 data.

Table 1.
Classification of Regulation Basis Codes into sequential disability determination steps for DDS
decisions, with frequency distribution: Title II disabled workers in 2010

Code	Decision	Basis	Number	Percent
Step 1: Engaging in SGA? ^a			165	0.0
N1	Deny	Engaging in SGA ^b —ER/PP met ^c	152	0.0
N2	Deny	Engaging in SGA—ER/PP not met	13	0.0
Step 2: Severe impairment?			384,175	15.8
Severity				
F1	Deny	Impairment not severe—ER/PP/reentitlement period met	115,287	4.7
F2	Deny	Impairment not severe—ER/PP/reentitlement period not met	185,324	7.6
Duration ^d				
E1	Deny	Impairment prevented SGA < 12 months—ER/PP/reentitlement period met	2,796	0.1
E2	Deny	Impairment prevented SGA < 12 months—ER/PP/reentitlement period not met	453	0.0
E3	Deny	Impairment not expected to last 12 months—ER/PP/reentitlement period met	78,184	3.2
E4	Deny	Impairment not expected to last 12 months—ER/PP/reentitlement period not met	2,131	0.1
Step 3: Meets or equals the Listings?			330,383	13.6
A1	Allow	Impairment meets the Listings	271,278	11.1
B1	Allow	Impairment equals the Listings	59,105	2.4
Step 4: Capacity for past work?			499,238	20.5
H1	Deny	Capacity for SGA, past relevant work—ER/PP met	448,993	18.4
H2	Deny	Capacity for SGA, past relevant work—ER/PP not met	50,245	2.1
Step 5: Capacity for any work?			1,042,622	42.8
C1	Allow	Medical vocational considerations	408,301	16.8
D1	Allow	Medical vocational considerations—arduous unskilled work	310	0.0
G1	Deny	Capacity for SGA, vocational considerations—reentitlement period met	34,131	1.4
G2	Deny	Capacity for SGA, vocational considerations—reentitlement period not met	1,225	0.1
J1	Deny	Capacity for SGA, other work—ER/PP met	529,680	21.7
J2	Deny	Capacity for SGA, other work—ER/PP not met	68,975	2.8
Other			180,961	7.4
CE	Allow	Collateral estoppel ^e	7,141	0.3
K1	Deny	Failure to follow prescribed treatment—ER/PP/reentitlement period met	161	0.0
K2	Deny	Failure to follow prescribed treatment—ER/PP/reentitlement period not met	42	0.0
L1	Deny	Failure/refusal to submit to CE—ER/PP/reentitlement period met	57,612	2.4
L2	Deny	Failure/refusal to submit to CE—ER/PP/reentitlement period not met	5,470	0.2
M3	Deny	Does not want to continue claim development; use evidence in file— ER/PP/reentitlement period met	5,522	0.2
M4	Deny	Does not want to continue claim development; use evidence in file— ER/PP/reentitlement period not met	473	0.0
M5	Deny	Insufficient evidence—ER/PP/reentitlement period met	74,711	3.1
M6	Deny	Insufficient evidence—ER/PP/reentitlement period not met	21,885	0.9
M7	Deny	Does not want to continue claim development; do not use evidence in file— ER/PP/reentitlement period met	826	0.0
M8	Deny	Does not want to continue claim development; do not use evidence in file— ER/PP/reentitlement period not met	100	0.0
S1	Deny	Res judicata ^f —ER/PP not met	2,191	0.1
X3	Deny	Medicare only ^g —AOD on or after age 62 years and 7 months/or not disabled, whereabouts unknown	9	0.0
Z1	Deny	DAA ^h is material to the determination of disability—ER/PP/reentitlement period met	3,839	0.2
Z2	Deny	DAA is material to determination of disability—ER/PP/reentitlement period not met	968	0.0
ZZ		Regulation Basis Code is unknown	2	0.0
[blank]		Regulation Basis Code is not available	9	0.0
Total			2,437,544	100.0

Continued

Table 1.
Classification of Regulation Basis Codes into sequential disability determination steps for DDS decisions, with frequency distribution: Title II disabled workers in 2010—Continued

SOURCES: Frequency data was obtained from the 2010 SSA-831 file. Basis information was obtained from RAND's *SSA Program Data User's Manual* (Panis and others 2000) and exchanges with disability experts at SSA.

NOTES: Values may not sum to 100 because of rounding.

- AOD = alleged onset date;
CE = consultative examination; CE is also a Regulation Basis Code;
DAA = drug addiction and/or alcoholism;
DDS = Disability Determination Service;
DI = Disability Insurance;
ER = expedited reinstatement;
PP = provisional period;
SGA = substantial gainful activity;
SSA = Social Security Administration;
SSI = Supplemental Security Income.
- a. Financial eligibility for DI or SSI is usually determined at the SSA field office before the claim is referred to the DDS. For that reason, most cases determined financially ineligible are not referred to the DDS and are not represented in the 831 data created by the DDS. However, in a few cases, claims referred to the DDS can be sent back to the field office or recalled by the field office; such cases may be found in the 831 data. Some cases may also be for applicants alleging blindness, but the higher blind SGA cannot be used until the DDS establishes blindness.
 - b. SGA is an earnings threshold used to determine eligibility for both DI benefits and SSI payments. In calendar year 2012, the SGA threshold was \$1,010 per month for the nonblind and \$1,690 for the blind. Someone engaging in SGA is denied at the field office and not evaluated further. And, a DI beneficiary receives no benefits for any month in which he or she has earnings above the SGA threshold (with some exceptions for work incentives). The SGA threshold is wage-indexed.
 - c. ER/PP/reentitlement period met (or not met): Based on the 1999 Ticket to Work Legislation, Ticket to Work clients who have made a work attempt but are unable to work because of their impairments may be eligible for ER to benefit status. ER applicants receive temporary benefits for a PP, until a medical evaluation of their reinstatement request is completed.
 - d. Duration denials are typically made at step 2, but may also be made at steps 3, 4, or 5. The duration test does not apply to the statutorily blind, aged 55 or older.
 - e. Collateral estoppel: If there has been a prior favorable determination by SSA or the court, it must be adopted for the same period on the new claim, with certain exceptions.
 - f. Res judicata (denial): The finding for a prior denial is adopted under two assumptions: (1) that the relevant facts about an applicant's disability have not changed and (2) that the criteria under which the earlier determination was made have not become less restrictive.
 - g. Medicare-only case: Federal workers ineligible for DI, but eligible for Medicare.
 - h. Prior to 1996, DI beneficiaries and SSI recipients could receive benefits based on an impairment associated with DAA, provided they fulfilled treatment requirements. After passage of Public Law 104-121 in 1996, such benefits were ended although some beneficiaries continued to receive benefits based on impairments not associated with DAA.

Table 2.
Classification of Regulation Basis Codes into sequential disability determination steps for DDS
decisions, with frequency distribution: Title XVI adults in 2010

Code	Decision	Basis	Number	Percent
Step 1: Engaging in SGA? ^a			0	0.0
33	Deny	Engaging in SGA ^b	0	0.0
Step 2: Severe impairment?			215,282	10.1
Severity				
30	Deny	Impairment not severe—no visual allegation ^c	139,524	6.6
41	Deny	Impairment not severe—visual allegation	6,999	0.3
Duration ^d				
34	Deny	Impairment prevented SGA < 12 months—no visual allegation	2,315	0.1
35	Deny	Impairment not expected to last 12 months—no visual allegation	65,082	3.1
45	Deny	Impairment prevented SGA < 12 months—visual allegation	97	0.0
46	Deny	Impairment not expected to last 12 months—visual allegation	1,265	0.1
Step 3: Meets or equals the Listings?			261,750	12.3
61	Allow	Impairment meets the Listings	220,310	10.3
62	Allow	Impairment equals the Listings	41,440	1.9
Step 4: Capacity for past work?			402,416	18.9
31	Deny	Capacity for SGA, past relevant work—no visual allegation	386,411	18.2
42	Deny	Capacity for SGA, past relevant work—visual allegation	16,005	0.8
Step 5: Capacity for any work?			993,844	46.7
63	Allow	Medical vocational considerations	271,022	12.7
64	Allow	Medical vocational considerations—arduous unskilled work	1,080	0.1
32	Deny	Capacity for SGA, other work—no visual allegation	690,181	32.4
43	Deny	Capacity for SGA, other work—visual allegation ^e	31,561	1.5
Other			255,560	12.0
CE	Allow	Collateral estoppel ^f	356	0.0
36	Deny	Insufficient evidence—with/without visual allegation	123,799	5.8
37	Deny	Failure/refusal to submit to CE—with/without visual allegation	116,635	5.5
38	Deny	Does not want to continue development of claim—with/without visual allegation	4,768	0.2
39	Deny	DAA or failure to follow prescribed treatment—with/without visual allegation ^g	7,104	0.3
Data errors ^h			2,898	0.1
Total			2,128,852	100.0

Continued

Table 2.
Classification of Regulation Basis Codes into sequential disability determination steps for DDS decisions, with frequency distribution: Title XVI adults in 2010—Continued

SOURCES: Frequency data was obtained from the 2010 SSA-831 file. Basis information was obtained from RAND's *SSA Program Data User's Manual* (Panis and others 2000) and exchanges with disability experts at SSA.

NOTES:

- CE = consultative examination; CE is also a Regulation Basis Code;
 - DAA = drug addiction and/or alcoholism;
 - DDS = Disability Determination Service;
 - DI = Disability Insurance;
 - RB = Regulation Basis;
 - RBC = Regulation Basis Code;
 - SGA = substantial gainful activity;
 - SSA = Social Security Administration;
 - SSI = Supplemental Security Income.
- a. Financial eligibility for DI or SSI is usually determined at the SSA field office before the claim is referred to the DDS. For that reason, most cases determined financially ineligible are not represented in the 831 data created by the DDS.
 - b. SGA is an earnings threshold used to determine eligibility for both DI benefits and SSI payments. In calendar year 2012, the SGA threshold was \$1,010 per month for the nonblind and \$1,690 for the blind. Someone engaging in SGA is denied at the field office and not evaluated further. And, a DI beneficiary receives no benefits for any month in which he or she has earnings above the SGA threshold (with some exceptions for work incentives). The SGA threshold is wage-indexed.
 - c. No visual allegation means the applicant does not have a visual impairment that requires a determination under statutory criteria for blindness.
 - d. Duration denials are typically made at step 2, but may also be made at steps 3, 4, or 5. The duration test does not apply to SSI applicants who are statutorily blind.
 - e. Code 43 has dual meanings. For child applicants it indicates that the claim is denied at step 3 because it neither meets, nor equals, nor functionally equals the Listings.
 - f. Collateral estoppel: If there has been a prior favorable determination by SSA or the court, it must be adopted for the same period on the new claim, with certain exceptions.
 - g. Code 39 has the same meaning and use for adult and child SSI applicants. It signifies denial for failure to follow prescribed treatment or, following a 1996 Congressional Act, denial of applicants for whom DAA was found material to the finding of disability.
 - h. Includes records with unknown RB (RBC = ZZ), RB not available (RBC = [blank]), obsolete codes, and other data errors.

Table 3.
Classification of Regulation Basis Codes into sequential disability determination steps for DDS
decisions, with frequency distribution: Title XVI children in 2010

Code	Decision	Basis	Number	Percent
Step 1: Engaging in SGA? ^a			0	0.0
33	Deny	Engaging in SGA ^b —with/without visual allegation ^c	0	0.0
Step 2: Severe impairment?			34,030	6.4
Severity				
44 ^d	Deny	Impairment not severe—with/without visual allegation	31,527	5.9
Duration ^e				
34	Deny	Impairment prevented SGA < 12 months—no visual allegation	317	0.1
35	Deny	Impairment not expected to last 12 months—no visual allegation	2,071	0.4
45	Deny	Impairment prevented SGA < 12 months—visual allegation	37	0.0
46	Deny	Impairment not expected to last 12 months—visual allegation	78	0.0
Step 3a: ^f Meets or equals the Listings?			87,683	16.5
61	Allow	Impairment meets the Listings	75,466	14.2
65	Allow	Medically equals the Listings	12,217	2.3
Step 3b: Functionally equals severity of the Listings?			379,298	71.5
66	Allow	Impairment functionally equals the Listing requirements	109,849	20.7
43	Deny	Neither meets, nor medically equals, nor functionally equals the Listings ^g	269,449	50.8
Other			29,167	5.5
CE	Allow	Collateral estoppel ^h	21	0.0
36	Deny	Insufficient evidence—with/without visual allegation	10,440	2.0
37	Deny	Failure/refusal to submit to CE—with/without visual allegation	14,710	2.8
38	Deny	Does not want to continue development of claim—with/without visual allegation	678	0.1
39	Deny	DAA or failure to follow prescribed treatment—with/without visual allegation ⁱ	55	0.0
Data errors ^j			3,263	0.6
Total			530,178	100.0

Continued

Table 3.
Classification of Regulation Basis Codes into sequential disability determination steps for DDS decisions, with frequency distribution: Title XVI children in 2010—Continued

SOURCES: Frequency data was obtained from the 2010 SSA-831 file. Basis information was obtained from RAND's *SSA Program Data User's Manual* (Panis and others 2000) and exchanges with disability experts at SSA.

NOTES: Values may not sum to 100 because of rounding.

CE = consultative examination; CE is also a Regulation Basis Code;

DAA = drug addiction and/or alcoholism

DDS = Disability Determination Service;

DI = Disability Insurance;

RB = Regulation Basis;

RBC = Regulation Basis Code;

SGA = substantial gainful activity;

SSA = Social Security Administration;

SSI = Supplemental Security Income.

- a. Financial eligibility for DI or SSI is usually determined at the SSA field office before the claim is referred to the DDS. For that reason, most cases determined financially ineligible are not represented in the 831 data created by the DDS.
- b. SGA is an earnings threshold used to determine eligibility for both DI benefits and SSI payments. In calendar year 2012, the SGA threshold was \$1,010 per month for the nonblind and \$1,690 for the blind. Someone engaging in SGA is denied at the field office and not evaluated further. And, a DI beneficiary receives no benefits for any month in which he or she has earnings above the SGA threshold (with some exceptions for work incentives). The SGA threshold is wage-indexed.
- c. No visual allegation means the applicant is not alleging blindness.
- d. Code 44 was initially used to indicate a Title XVI SGA denial, but in the early 1990s it was redefined to indicate a nonsevere denial for SSI children.
- e. Duration denials can be invoked at step 2 or step 3. The duration test does not apply to SSI applicants who are statutorily blind.
- f. Although the disability determination process for children includes a medical screen and a functional assessment as a single step (step 3), for analytical purposes we discuss them separately as step 3a and step 3b.
- g. Code 43 has dual meanings. For SSI adults it indicates the applicant was determined to be able to perform some work in the national economy and was denied.
- h. Collateral estoppel: If there has been a prior favorable determination by SSA or the court, it must be adopted for the same period on the new claim, with certain exceptions.
- i. Code 39 has the same meaning and use for adult and child SSI applicants. It signifies denial for failure to follow prescribed treatment or, following a 1996 Congressional Act, denial of applicants for whom DAA was found material to the finding of disability.
- j. Includes records with unknown RB (RBC = ZZ), RB not available (RBC = [blank]), obsolete codes, and other data errors.

In this note, we describe the steps in the initial disability determination process and provide a classification of RBCs for DDS decisions made in 2010.¹⁹ This will allow researchers to create classifications that are comparable to official SSA publications and previous analytical studies. We hope this facilitates research about trends in disability claims and the outcomes of those claims.

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¹⁹ Note that the great recession may have affected both the number and composition of determinations made in 2010.