The Bellmon Report *

EXECUTIVE SUMMARY

Section 304(g) of P.L.96-265, the "Social Security Disability Amendments of 1980," requires that the Social Security Administration (SSA) institute a program of ongoing review of administrative law judge (ALJ) decisions on claims for Social Security disability benefits. This section—commonly referred to as the Bellmon amendment—is intended to ensure that hearings decisions by ALJs conform to statute, regulations, and binding policy. Decisions which do not meet these criteria are to be administratively reversed.

Section 304(g) further requires that the Secretary of Health and Human Services submit to the Congress by January 1982 a report on progress toward implementing the ongoing review. This report has been prepared to fulfill that requirement. As requested by the Conference Committee on P.L. 96-265, it also attempts to identify the effect of certain factors on ALJ decisions.

Initial decisions on applications for disability benefits and reconsiderations of those decisions are made by SSA district offices and State disability determination services (DDSs). Denials may be appealed sequentially to an ALJ, to the Appeals Council in SSA's Office of Hearings and Appeals (OHA), then to Federal district courts. The requirement for this report arose from congressional concern with the increasing number of denials being appealed to ALJs and the high percentage of DDS denials that were being overturned by ALJs.

SSA has now completed an initial review that is the basis of this report and that provided guidance for an ongoing review, which was begun in October 1981.

Findings of the Initial Review

The initial review was based on a sample of 3,600 recent ALJ decisions on disability cases. The case folders were reviewed by two different units within SSA: the Office of Assessment (OA), which operated under the standards governing the DDSs, and the Appeals Council, which applied the standards and procedures governing ALJ decisions. Each unit made new decisions on each case without being aware of the original ALJ decision or the decision of the other reviewing organization. These new decisions were used only for analytical purposes; they were not used to actually alter the original ALJ determination.

The major finding of the initial review was that significant differences in decision results were produced when these different decisionmakers were presented with the same evidence on the same cases. **The ALJs allowed 64 percent of the cases. The Appeals Council, applying ALJ standards, allowed 48 percent. OA, applying DDS standards, allowed only 13 percent.**

An examination of the standards and procedures governing the ALJs and DDSs indicates distinct differences. In certain instances, operational definitions are not identical. In other instances, ALJ procedures permit a finding of disability that is not possible under the DDS standards. Finally, in some areas the definitions contained in the standards are the same, but procedures differ for evaluating evidence of impairment.

Initial review data also indicated that, even when decisionmakers were applying the same standards, they were not applying them consistently. The Appeals Council denied 37 percent of the cases which ALJs allowed, and allowed 21 percent of the cases which ALJs denied. A detailed examination of the cases on which both the ALJs and the Appeals Council agreed shows that the Council agreed with the ALJs as to the basis for an allowance or denial much less frequently than it agreed on whether the case should be allowed or denied. Moreover, if the Appeals Council decision is taken as the "correct" decision under the rules governing ALJs, the review indicates that decisions to allow cases by ALJs with high allowance rates are more often "incorrect" than the decisions of ALJs with lower allowance rates.

There are also indications that varying quality control procedures and management emphases, in combination with the subjective element in the disability determination process, may contribute to the distinct differences and trends in disability decisions made at the different organizational levels.

Results from the review suggest that the in-person appearance of claimants at ALJ hearings may make a difference. The ALJ hearing is the first time that the

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claimant appears before a decisionmaker. As part of the review, all information related to the claimant's in-person appearance was removed from a special subsample of case folders and these folders were then distributed to other ALJs for readjudication based on the case record. The original ALJ allowance rate of more than 60 percent dropped to 46 percent when the in-person information was removed from the case.

Data from this special subsample also show that additional medical evidence submitted after the DDS decision significantly affects ALJ allowance rates. The ALJ allowance rate dropped from 46 percent to 31 percent when all evidence added after the final DDS decision was deleted from folders in the sample.

The Ongoing Review

SSA's ongoing review, implemented in October 1981, will identify ALJ decisions that are inconsistent with SSA policy and standards and revise those decisions as appropriate.

The review is being conducted by the Appeals Council, which has the authority to review all ALJ decisions and dismissal actions at the request of the claimant or on its own motion. The current review sample of about 7 1/2 percent of total ALJ allowances in Disability Insurance cases has been selected from the decisions of ALJs and hearing offices with the highest allowance rates. In addition to enabling SSA to correct erroneous decisions, this review will provide SSA with the ability to continuously monitor the disability adjudication process to ensure that problems identified in the initial review are corrected and that any additional areas of weakness are identified and acted upon.

Later in fiscal year 1982, the ongoing review will be expanded; by the end of the fiscal year, we plan to review 15 percent of ALJ allowance decisions on Disability Insurance claims.

Other Initiatives at the Hearing Level

To address the problem of different adjudicative standards and procedures being used by DDSs and ALJs, the Social Security Administration will disseminate a single set of standards to be followed at all levels of adjudication. These standards will be based on those currently governing the DDSs.

The Office of Hearings and Appeals also has established a special staff in its central office to develop new and more extensive training programs for ALJs and their staffs. Through its training initiatives, OHA expects to promote among ALJs and their support staffs a better understanding and application of both current and revised standards and procedures, resulting in greater consistency and accuracy in decisionmaking.

OHA is discontinuing the current allowance decision forms used by ALJs. A revised format has been developed to ensure not only that allowance decisions contain specific explanations for the favorable conclusions, but also that they reflect adherence to the process of sequential disability evaluation directed by the regulations.

Further, an experiment will be undertaken later this year to determine whether participation of an SSA representative at ALJ hearings in which the claimant is represented will improve the quality and timeliness of hearing decisions.

Initiatives to Improve DDS Performance

As required by the 1980 Disability Amendments, SSA has begun a preeffectuation review of DDS disability allowances. This preeffectuation review, in which incorrect decisions made by the DDSs are reversed prior to notification of the claimant or payment of any benefits, is intended to promote the uniformity and accuracy of disability allowances made by the DDSs.

SSA is also conducting three experiments that test various changes in the DDS reconsideration process. These changes may result in more consistent decisions when cases move on to ALJ hearings.

In summary, SSA has undertaken a number of activities designed to respond to the problems identified in the initial review. The most significant are probably the ongoing review of ALJ decisions required by P.L. 96-265, and the initiation of changes required to ensure that all SSA disability decisionmakers are governed by the same standards. These actions, in conjunction with the other initiatives discussed in this report, should greatly improve the accuracy and consistency of disability decisions made throughout the SSA adjudicative system.

Introduction

During the past decade, the Social Security Disability Insurance program has come under considerable congressional scrutiny. This decade of review culminated in Public Law 96-265, the "Social Security Disability Amendments of 1980."

The primary purpose of these amendments was to strengthen the integrity of the disability programs by placing a limit on the amount of Disability Insurance benefits in those cases where the benefits tend to exceed the net predisability earnings of the disabled worker, by providing positive incentives (as well as removing disincentives) for disability beneficiaries to return to work, and by improving accountability and uniformity in the administration of the disability programs.

Section 304(g) of the 1980 Amendments required the Secretary of Health and Human Services to review, on

his own motion, disability decisions made by administrative law judges (ALJs). This provision—commonly referred to as the Bellmon Amendment—arose out of the congressional concerns about the increasing number of disability decisions being appealed to the hearing level, the high percentage of allowances at that level, and the accuracy and consistency of ALJ decisions. ALJs were allowing a larger proportion of cases than they had in the past, and the backlog of cases awaiting hearing was rapidly increasing.

This report was prepared in response to the congressional requirement to initiate a review of disability decisions at the hearing level and to report on that review. Chapter I presents the details of the congressional mandate. Chapter II provides background information on the disability benefit programs and the process of adjudicating disability claims. Chapter III discusses the findings of the Social Security Administration's initial review of ALJ decisions. Chapter IV discusses the progress in implementing an ongoing review of ALJ decisions. In addition, this final chapter also discusses other initiatives undertaken by the Secretary to improve the quality of disability adjudication at both the hearing and prehearing levels.

I. The Congressional Mandate

Section 304(g) of P.L. 96-265 (the Bellmon Amendment) provides that:

> The Secretary of Health and Human Services shall implement a program of reviewing, on his own motion, decisions rendered by administrative law judges as a result of hearings under section 221(d) of the Social Security Act, and shall report to the Congress by January 1, 1982, on his progress.

The Conference Committee agreed to this provision after striking language which specified what was to be included in the required report. The discussion of this provision contained in the Conference Report, however, states the conferees' belief that the Secretary's report should include the percentage of ALJ decisions being reviewed and should describe the criteria for selecting the decisions to be reviewed. The conferees also indicated that the Secretary's report should identify the effects of five specific factors on ALJ decisions:

(1) Claimants' first appearance in person before a decisionmaker;
(2) Additional evidence submitted at the hearing level;
(3) Significant changes in State agency denial rates;
(4) Differences between State agency (DDS) and ALJ policy guidelines;
(5) Differences in standards applied by ALJs.

To respond to the congressional mandate for a review program and for a report to address the above factors, SSA decided on a dual approach: an initial review designed to collect necessary data and an ongoing review designed to ensure that hearing decisions conform to statute, regulations, and binding policy. The initial review collected information on differences in adjudication between the prehearing and hearing levels and on the degree of uniformity at the hearing level. The information obtained from the initial review was also used to develop an ongoing program of own-motion review, which began October 1, 1981.

II. Background

The Social Security Disability Insurance (DI) program, providing cash benefits to disabled workers age 50 and older, was established by Congress in 1956. Dependents' benefits were added in 1958 and the age-50 requirement was eliminated in 1960.

To qualify for benefits an individual must meet certain insured status requirements. These requirements have been modified over the years, but still require that workers (other than the blind) who are disabled after age 31 must have worked in employment or self-employment covered by Social Security for 5 out of the last 10 years prior to their disability. For workers under age 25 the minimum requirement is 1 1/2 years of work out of the 3 years prior to disability; for workers age 25 through 31, progressively more years of coverage are required. A worker is required to wait 5 full calendar months after the onset of disability before benefits are payable.

The Social Security Amendments of 1972 "federalized" the State public assistance programs for the needy aged, blind, and disabled into the Title XVI Supplemental Security Income (SSI) program. This program pays Federal benefits, under uniform rules, financed from general revenues. Payments under the SSI program, which started in January 1974, may be supplemented by the individual States. Under SSI, disabled or blind persons on the State programs before July 1973 were automatically "grandfathered in" under the States' own definitions of disability. New applicants and applicants who came on the welfare rolls after June 1973 must meet the same definition of disability as applicants under the Disability Insurance program. They are not subject, however, to any waiting period.

A. Definition of Disability

The statutory definition of disability originally required that the worker must be unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration." In 1965, the statutory language

was changed to stipulate a duration requirement of at least 12 months in place of the previous "long-continued and indefinite duration" requirement. Amendments in 1967 further specified that an individual's physical or mental impairment(s) must be ". . . of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." (Sections 223 and 1614 of the Social Security Act.)

B. The Disability Decision—A Sequential Evaluation Process

The standards for evaluating disability claims are not further defined in the statute itself, but rather are set forth in SSA regulations (20 C.F.R. parts 404 and 416, subparts P and I, respectively) and written guidelines. The regulations are intended to ensure uniformity and fairness in the disability determination process. They set out a sequence of steps and criteria for determining whether or not an applicant meets the definition of disability in the law.

The first step in the sequential evaluation is to determine whether the claimant is currently engaged in substantial gainful activity (SGA). The law requires the Secretary of HHS to prescribe, by regulation, the criteria for determining when services or earnings from services demonstrate an individual's ability to engage in SGA. The regulations establish dollar amounts of earnings; earnings above these amounts ordinarily show that an individual is engaged in SGA and therefore is not disabled for purposes of the Social Security definition. This amount is currently $300 a month.

The next step in the sequence is to determine whether the claimant has a "severe" impairment. The regulations define "severe" impairment as one that "significantly limits physical or mental ability to do basic work activities." (Sections 404.1520(c) and 416.920(c).) If the claimant does not have an impairment that is considered severe, the claim is denied on medical considerations alone.

If the claimant does have a severe impairment that meets the duration requirement, the next step is to determine whether the impairment meets or equals the degree of severity in the Medical Listing of Impairments. This rule, commonly referred to as the "Medical Listings," is published in regulations (Appendix 1 of subpart P of part 404 of the Social Security regulations). The Medical Listings describe specific diagnostic signs, symptoms, and clinical laboratory findings for various common impairments which are considered severe enough to ordinarily prevent a person from doing any gainful activity on an ongoing basis. If the signs, symptoms, and findings for the claimant's impairment meet those listed in the regulations, the claimant is allowed benefits on the basis of meeting the Listings. If not, but the claimant suffers from several impairments, the claimant may be found to be disabled on the basis that, in combination, these impairments equal in severity an impairment found in the Medical Listings.

If the claimant is not found to be disabled on the basis of the medical criteria in the Listings, a determination is made of the claimant's residual functional capacity (RFC). Residual functional capacity is the claimant's physical and mental ability to perform various types of work-related functions. Assessment of residual functional capacity requires consideration of both exertional impairments (those limiting strength) and nonexertional impairments (e.g., mental, sensory, or skin impairments). Once the claimant's RFC has been established, a judgment is made as to whether the claimant is able to perform his or her relevant past work. If it is found that the past work can be performed, the claim will be denied.

If the claimant is found to be unable to do his or her previous work, the next step in the process is to evaluate the factors of age, education, training, and work experience in conjunction with whatever residual functional capacity the claimant has been found to possess. This assessment, in turn, is used in deciding whether the claimant can perform any other jobs which exist in significant numbers in the national economy. The medical-vocational rules that guide this last step in the evaluation are set forth in regulations.

There are three tables in the medical-vocational rules, one for each of three levels of RFC—ability to do medium work, light work, or only sedentary work. (Impairments which do not preclude performance of heavy work are generally considered to be nondisabling.) Administrative notice has been taken of the fact that a number of jobs exist in the national economy that can be performed by persons with each level of RFC. The tables, in addition, relate the requirements of such jobs to the vocational factors of age, education, and prior work experience. The regulations specify that the medical-vocational rules will direct decisions on cases in which a claimant's RFC is significantly affected only by exertional impairments and the claimant's RFC, age, education, and work experience match those attributes in the table. They do not direct decisions on disability for claimants with solely nonexertional impairments, and do not specifically direct conclusions on disability for claimants with combinations of exertional and nonexertional impairments. In these types of cases, the

medical-vocational rules are to be used as a guide, or general framework, for determining disability.

C. The Disability Decision System—Structure and Process

The disability determination process, which is essentially the same for both DI and SSI disability and blindness claims, can involve decisions at five distinct levels. The structure and procedures of each decision level (prior to P.L. 96-265) are discussed briefly below.

1. Initial Determination by SSA District Offices and State Agencies

Applications for DI and SSI disability benefits are filed by claimants in one of SSA's district offices. The district offices accept applications, obtain the names of the physicians, hospitals, or clinics that have treated the claimants, and make all the nonmedical eligibility determinations based on such factors as insured status, work activity, and for SSI claims, income and resources. If the claim is denied because the applicant does not meet these nonmedical eligibility requirements, a formal notice is sent.

A claimant's application, any medical records he or she may have provided, lists of sources of medical evidence, and other background information obtained during the district office interview are forwarded to the disability determination service (DDS) in the claimant's home State. The DDSs are State agencies and are usually components of State vocational rehabilitation agencies. Their total operating costs are paid by SSA.

The DDS requests detailed medical reports from physicians who have treated the claimant. This procedure uses clinical and laboratory findings in the files of treating physicians and has been successful in expediting the gathering of complete medical information and in limiting the need for purchased examinations. However, if sufficient medical information cannot be obtained in this manner, the DDS may purchase a consultative examination—that is, ask the claimant to be seen by a private physician selected by the DDS. The DDS may also seek more information pertaining to the claimant's education and work experience from the claimant.

After the required evidence has been obtained, a two-person DDS team consisting of a physician and a lay disability examiner makes a decision on the claim. The DDS physician determines from the medical evidence the extent to which physical or mental limitations exist, whether the impairment meets or equals the Medical Listings and, when required, assesses residual functional capacity. The DDS lay examiner determines whether, with those limitations, the claimant can or cannot perform substantial gainful activity in jobs that exist in the national economy, based on the claimant's age, education, and work experience. DDS determinations are then issued as Federal decisions and the claimant is notified of the decision. If the claim is denied, the formal notice indicates why and advises the applicant of his or her appeal rights.

2. Reconsideration by State Agencies

Claimants whose applications are denied have a right to have their claims reconsidered, but must file for reconsideration within 60 days after receiving notice of the denial. The reconsideration decision is also made by the DDS. Additional evidence may be submitted by the claimant or requested by the DDS. The reconsideration decision process is similar to the initial disability decision process except that, after the district office updates the claimant's file, a different DDS team reviews the claim. If denied again, the claimant is given notice and advised of further appeal rights.

3. Hearing Before an Administrative Law Judge

If the DDS reconsideration team upholds the initial denial, the claimant may request a formal hearing before an administrative law judge in the SSA Office of Hearings and Appeals (OHA). The claimant must file a request for the hearing within 60 days after receiving notice of the reconsideration determination. These requests are forwarded to one of SSA's hearing offices located across the nation and are assigned to individual ALJs. Hearings are held as soon after the request as possible.

The ALJ is an experienced attorney who has received training in adjudicating disability claims. The ALJ is responsible for perfecting the evidentiary record, holding face-to-face nonadversary hearings, and issuing decisions. At the hearing, the claimant appears for the first time before a decisionmaker. Testimony is taken under oath and recorded verbatim. The ALJ may request the appearance of medical and vocational experts at the hearing and can require claimants to undergo consultative medical examinations. Claimants may submit additional evidence, produce witnesses, and be represented by legal counsel or lay persons. The hearing is nonadversarial whether or not the claimant is represented. There is no charge for requesting a hearing.

4. Appeals Council Review

Following an ALJs decision to deny a claim, the claimant may, within 60 days after receiving notice, request the Appeals Council to review the decision. The Appeals Council is a 15-member body located in

the Office of Hearings and Appeals. The Appeals Council may deny or grant a request for review of an ALJ's action. If the Council agrees to review, it may uphold or change the ALJ's action or it may remand the case to an ALJ for further consideration. It may also review any ALJ action on its own motion within 60 days after the date of the ALJ's action.

5. Federal District Court

The Appeals Council review represents the Secretary's final decision and is the claimant's last administrative remedy. If the Council affirms the denial of benefits or refuses to review the claim, further appeal may only be made through the Federal district courts.

D. Adjudicative Standards, Instructions, and Procedures

In adjudicating disability claims, the DDSs, the ALJs, and the Appeals Council are all governed by the provisions of the Social Security Act, the regulations that have been published in the Code of Federal Regulations, the Social Security Rulings, and decisions of the Supreme Court. Social Security Rulings amplify SSA's policies and provide interpretations of the Act and regulations. Rulings are based on case decisions, program policy statements, decisions of the administrative law judges and the Appeals Council, opinions of the Secretary's Office of the General Counsel, Social Security Commissioner's decision, Federal court decisions, and other interpretations of the law and regulations. The Rulings are used to make precedential decisions available to adjudicators and the public. Like the regulations, they are binding on all adjudicators.

In order to explain and further clarify the provisions of the law, regulations, and rulings, SSA issues to the DDSs a detailed set of administrative instructions known as the Program Operating Manual System (POMS). These guidelines are an amplification of, and are consistent with, the law, regulations, and rulings. The POMS sets forth the objectives and requirements of the disability programs and furnishes specific standards and procedures with which the DDS must comply in reaching a disability determination. These administrative instructions have been developed to ensure the uniformity of DDS and SSA operations and include, for example, standards for developing and evaluating disability evidence. The DDSs, but not the ALJs, are required to use the POMS in making disability determinations. The result has been that in certain policy areas the two adjudicative levels operate with different standards.

SSA also supplements the POMS by supplying the DDS with an Informational Digest. The Digest contains a collection of discussions and resolutions of questions concerning various disability policy and procedural statements. Although it is not to be cited as authority or as a basis for adjudicating claims, the Digest is designed to provide more detailed discussion of the meaning and intended application of disability program provisions.

While the POMS contains the standards used by the DDSs in adjudicating disability claims, it does not have the force or effect of law, as do the regulations. Therefore, in reaching a decision of a claim, an ALJ is not bound by the administrative instructions and guidelines that SSA issues in the POMS to the DDS. Instead, ALJs rely on the law and SSA's regulations and rulings in making disability decisions.

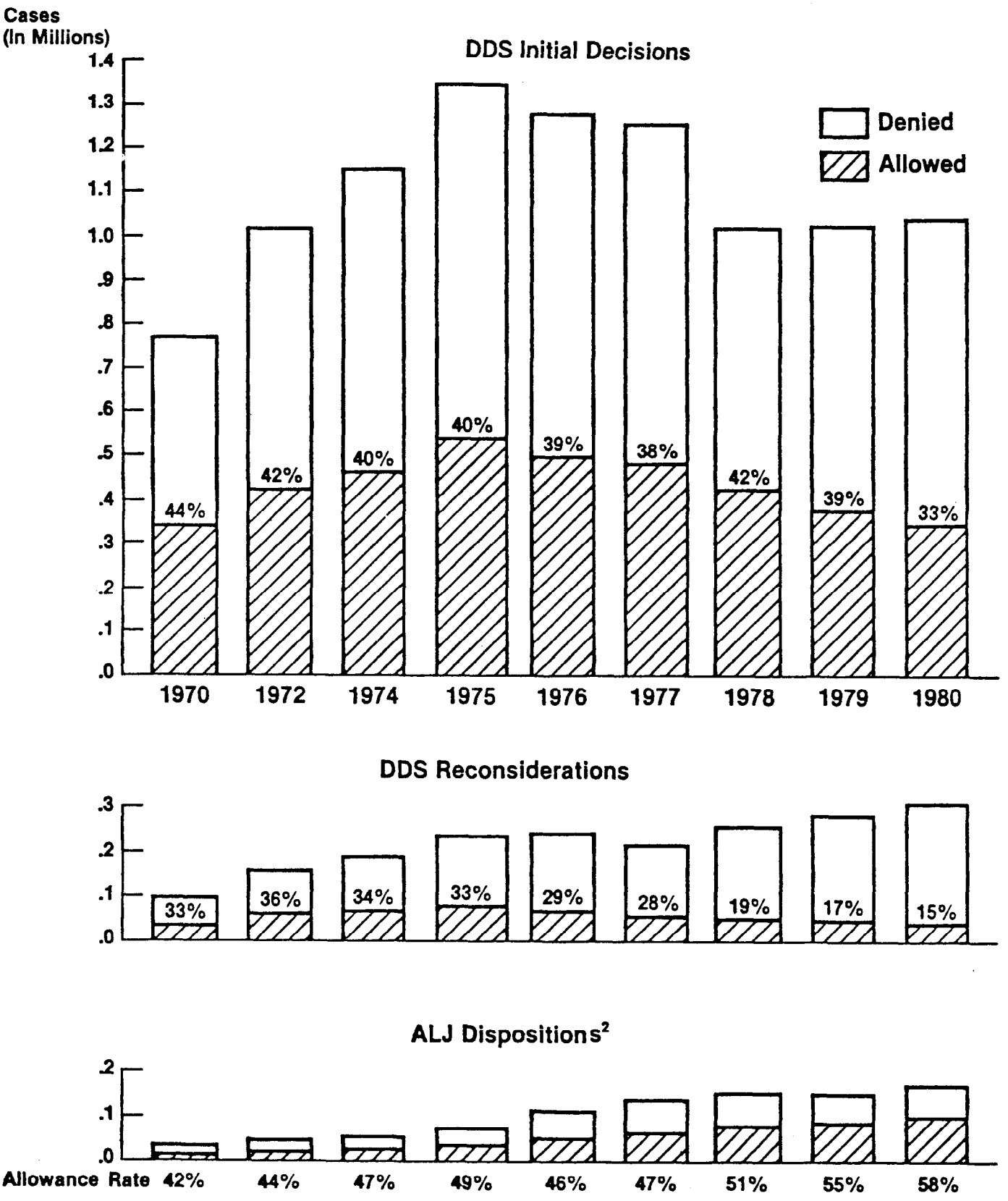
E. Trend Data on Disability Insurance Decisions and Allowance Rates

During the early and mid-1970's the volume of Disability Insurance claims rose sharply. The number of initial disability decisions increased from about 800,000 in 1970 to about 1,350,000 in 1977. During the period 1978–80, initial decisions were stable at just over 1,000,000 per year, somewhat lower than the level of the mid-1970's but above the level experienced in 1970. Between 1970 and 1978, DDSs allowed around 40 percent of the initial claims they received and denied around 60 percent. However, beginning in 1979 the DDS allowance rate declined substantially, to about 37 percent in 1979 and 33 percent in 1980. The trends in volume and outcome of both DDS and ALJ decisions are shown in Charts 1 and 2.

The greater volume of initial Disability Insurance claims and higher denial rate at the initial level has been accompanied by an increase in the volume of reconsideration requests at the State agency level. In 1970, DDSs made just under 100,000 reconsideration determinations. The number rose to over 200,000 in 1975 and was about 300,000 in fiscal year 1980. Between 1970 and 1975, the DDSs allowed at reconsideration roughly one-third of the claimants who had appealed the initial decision. This reconsideration allowance rate declined somewhat in 1976 and 1977 and it has declined again in the years since 1978. In 1980 only 15 percent of the reconsideration requests resulted in allowance of the claims.

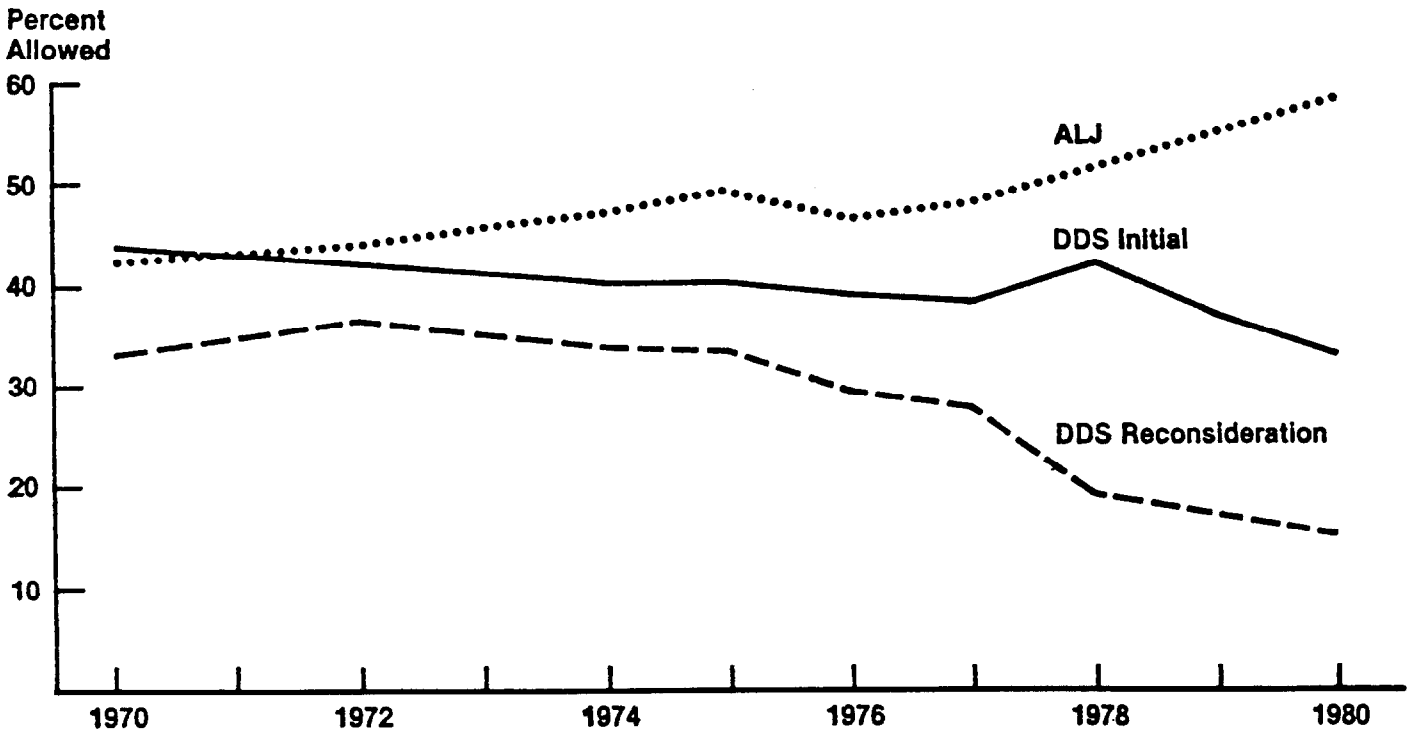
Over the past decade there was a sharp increase in the number of denied applicants requesting a hearing before an ALJ. The number of ALJ dispositions rose from about 34,000 in fiscal year 1970 to about 75,000 in 1975 and then to 172,000 in 1980. During this period the ALJ

Chart 1. — Number of Disability Insurance Determinations[1] and Number Allowed by DDSs and ALJs, 1970-1980



[1]Includes DI/SSI concurrent claims but excludes claims which are solely for SSI disability benefits.
[2]Cases not allowed include denials, dismissals and remands to the DDS.

Chart 2. — Disability Insurance Allowance Rate* for DDSs and ALJs, 1970 — 1980



*For DDSs, percent allowed of determinations made.
For ALJs, percent allowed of dispositions.

allowance rate rose from 42 percent in 1970 to 49 percent in 1975 and to 58 percent in 1980.[1]

The trend in the number of Disability Insurance benefits awards from all sources (initial and reconsideration allowances and allowances by ALJs, the Appeals Council, or the Courts) has shown a continuing decline since the record high in 1975. Between fiscal year 1971 and 1975, the annual number of disabled worker benefit awards rose from 406,000 to 603,000. This dropped to 392,000 in fiscal year 1980 and to 358,000 in fiscal year 1981.

III. Findings of an Initial Review of ALJ Decisions

Prior to implementing the ongoing review of ALJ decisions on disability claims required by section 304(g) of P.L. 96-265, SSA conducted an initial review of a representative sample of ALJ disability decisions. (A detailed technical description of the initial review is provided in the Technical Appendix to this report.) The purpose of the initial review was to provide information on the sources of differences among ALJ, Appeals Council, and DDS decisions. This information was intended both to serve as the basis for a report to the Congress on own-motion review, and to provide base-line data for developing an effective, ongoing own-motion review program and improving the consistency and accuracy of the disability adjudicative process.

A. Overall Differences in Disability Decisions

The first phase of the initial review was designed to determine whether, and to what extent, the standards, procedures, and practices of the DDSs, the ALJs, and the Appeals Council produce different results when the same cases are adjudicated by these different decision-making units. This phase involved a review of 3,600 recent ALJ decisions on Disability Insurance and SSI claims, of which approximately two-thirds were allowances and one-third were denials. The cases were randomly selected to represent a cross-section of all ALJ decisions made during the period September 1980–January 1981. The case files were reviewed by two different units within SSA: the Office of Assessment (OA), which

[1] ALJ allowance rates represent cases allowed as a percent of total ALJ dispositions, which include dismissals and remands. When allowance rates are expressed as a percent of total ALJ decisions, excluding dismissals and remands, they are higher (e.g., around 62 percent in 1980).

operated under the rules governing the DDSs; and the Appeals Council, which applied the standards governing ALJ decisions. Neither of these units was aware of the ALJ decision on any case which they reviewed, nor did they see the claimant. Their review did not alter the formal agency decision on any of the cases.

The Office of Assessment review was conducted by disability examiners in that office, working in conjunction with physicians on the Medical Consultant Staff in the SSA Office of Disability Programs. This team of examiners and physicians, in most respects similar to the adjudicative team employed in the DDS, made decisions on each case by applying the POMS guidelines that all DDS agencies are required to use. Because the Office of Assessment, assisted by the Medical Consultant Staff, is the SSA organization responsible for assessing the quality and accuracy of DDS disability determinations on an ongoing basis in the Disability Insurance and SSI disability programs, and because they apply the same standards and procedures employed by the DDSs in adjudicating cases, their decisions on cases in this initial review were used to represent the "correct" application of DDS standards.

After the Office of Assessment determined that a case should be allowed or denied, that decision was compared with the original ALJ decision on the case. All cases in which OA disagreed with the original ALJ decision were sent to the Appeals Council for review. In addition, 300 cases in which there was no disagreement between OA and the ALJ were also sent to the Appeals Council. This procedure was designed to prevent any inadvertent bias in the Appeals Council review and to insure statistical comparability with the original sample. Because of the mixture of cases being sent to it, the Appeals Council was not aware of either the original ALJ decision or the OA decision on a case it was reviewing.

The Appeals Council conducted a de novo review of each case sent to it, applying the standards governing ALJ decisions. The Council reached a decision to allow or deny on each of the 2,183 cases it reviewed. Since the Appeals Council employs the same standards as those governing the ALJs and is the Secretary's final review authority on all disability decisions, its decision on a case was used to represent the "correct" application of the standards and procedures under which ALJs adjudicate claims.

This first phase of the review, therefore, produced three different decisions on the same cases: the OA decision, representing the "correct" application of DDS standards; the Appeals Council decision, representing the "correct" application of ALJ standards; and the original ALJ decision itself. The major finding—which dominates both this and other portions of the review—was that significant differences in decision results were produced when these different decisionmakers were presented with the same evidence on the same cases. The most striking finding is that ALJs allowed 64 percent of the cases while OA allowed only 13 percent. The disparity between the original ALJ decision and the Appeals Council decision was not as great: the Appeals Council allowed 48 percent of the cases. Thus, the Appeals Council occupied a "middle ground," but one which was markedly closer to the ALJ decisions than to the OA decisions.

The allowance and denial rates of these three groups of decisionmakers, broken down by basis for decision, are shown in Table 1.

A comparison of the extent of agreement or disagree-

Table 1. Percent Distribution of Sample Case Allowances and Denials, by Decisionmaker and Basis for Decision [1]

	Original ALJ Decision	Appeals Council Decision	Office of Assessment Decision Using DDS Standards
ALLOWANCES			
Total	64%	48%	13%
Medical alone	18	15	6
Medical/Vocational inability to engage in SGA:			
Directed by medical-vocational rule	14	11	5
Specific reasons: RFC less than sedentary	18	9	0
Pain combined with significant impairment(s)	5	3	0
Mental disorders combined with significant physical impairment(s)	5	4	(2)
Other medical/vocational	5	6	2
DENIALS			
Total	36	52	87
Impairment not severe	11	16	39
Impairment does not prohibit past work	9	13	28
Directed by medical-vocational rule	13	19	13
Impairment does not prohibit other work	1	2	4
Other	2	3	3

NOTE: Detail may not add to totals due to rounding.

[1] Percentages shown are for the combined total of DI and SSI claims. Although there are some differences between the allowance/denial rates for DI claims and SSI claims (e.g., the Appeals Council would have allowed about 49% of DI claims and 45% of SSI claims), these differences do not appear to be significant and do not affect the findings of the review.

[2] About 0.4%.

ment on individual cases reveals even greater differences among the decisionmakers. The original ALJ allowance rate was 64 percent and the Appeals Council allowance rate was 48 percent. This does not mean, however, that the Appeals Council simply denied all the cases which the ALJs denied and, in addition, denied a proportion of the cases which the ALJs allowed. Had this been the case, the Appeals Council allowance rate of 48 percent would have resulted from denying about one-quarter of the ALJ allowances. What actually happened, as shown in Table 2, is that the Appeals Council denied 37 percent of the cases which ALJs allowed and allowed 21 percent of the cases which ALJs denied. Conversely, the Council agreed with the original ALJ decision to allow in only 63 percent of the cases, and agreed with the ALJ decision to deny in 79 percent of the cases. The Office of Assessment decisions on ALJ (Table 2) and Appeals Council (Table 3) denials reflect much greater agreement. Nonetheless, OA would have allowed 4 percent of the cases which the ALJs denied and 7 percent of the cases which the Appeals Council would have denied.

Table 2. Tabulation of Appeals Council and Office of Assessment Decisions by Type of ALJ Decision

	ALJ Allowances	ALJ Denials	All Cases
Decision of Reviewers			
Appeals Council			
Allow	63%	21%	48%
Deny	37	79	52
Office of Assessment			
Allow	18	4	13
Deny	82	96	87

A similar comparison of OA decisions on cases allowed and denied by the Appeals Council is shown in Table 3.

Table 3. Office of Assessment Decisions on Appeals Council Decisions to Allow or Deny (Appeals Council Subsample) [1]

	Appeals Council Allowances	Appeals Council Denials	All Cases [1]
Office of Assessment Decision			
Allow	22%	7%	14%
Deny	78	93	86

[1] Totals differ slightly from those shown in Tables 1 and 2 because Tables 1 and 2 are based on full sample while Table 3 is based on smaller Appeals Council subsample.

B. Explanation of Differences

From the data presently available, there is no way to account precisely for all the causes of the differences or their relative importance. Based on what we know about the disability program and what the initial review data tell us, it is clear, however, that there is more than one cause. The initial review was structured to identify significant reasons for the differences, although it cannot establish conclusively all the various contributing factors. In the sections that follow we will discuss some of these possible causes, explain each, and review the evidence available.

1. Differences in Standards and Procedures

SSA has long recognized that the standards and procedures governing decisions by DDSs and ALJs are not entirely consistent. Where inconsistencies exist, they are, at least in part, an outgrowth of two somewhat different systems of adjudication. The rules governing DDSs, on the one hand, have developed over time as detailed instructions governing an administrative system. This system is not an independent adjudicative body, and the decisionmaker has no direct face-to-face contact with the claimant. The standards and procedures followed by ALJs, on the other hand, to some degree reflect the status of the ALJ as an adjudicator having decisional independence, conducting hearings in a quasi-judicial setting involving face-to-face contact with claimants, their representatives, and expert witnesses, and taking cognizance of rulings of the U.S. District and Circuit Courts on individual disability claims.

The ALJs are governed by the law, program regulations, and Social Security Rulings. Guidance is also provided by various handbooks issued by the Social Security Administration. The DDSs must follow the POMS, which amplify the basic standards contained in the law and regulations, and are also governed by policy interpretations contained in the SSA Rulings. A review of the standards and procedures governing the ALJs and the DDSs indicates that there are distinct differences in certain key areas. These differences are of several kinds. In certain instances, as for example the definition of "impairment not severe," the actual definition contained in the standards governing the ALJs and the DDSs is not precisely the same. In other instances, ALJ practices result in findings that are not possible under the DDS standards. Finally, in some areas the definitions contained in the standards may be the same—the Medical Listings are the primary case in point—but the procedures actually used for evaluating evidence to determine whether or not an individual's impairment meets the definitions are often quite different. Major areas in which the DDS and ALJ standards and procedures differ are discussed below.

a. Medical Definitions and Evidence

The first step in adjudicating a disability claim, provided the claimant is not working, is to determine the individual's medical condition. If the individual's impairment is found to be medically "not severe," the claim is denied. Conversely, if the individual meets or equals the Medical Listings, the claim is allowed, since the impairments listed are considered severe enough to prevent any substantial work (substantial gainful activity). If either of these two sets of medical criteria are met, no further development of the claim is required. Our evaluation of the review data revealed the following pattern of decisions based on medical evidence alone.

Table 4. Decisions Based Solely on Medical Evidence (Percentage of All Decisions)

	Original ALJ Decision	Appeals Council Decision	Office of Assessment (DDS) Decision
Allowance—Meets or Equals Medical Listings	18%	15%	6%
Denial—Impairment Not Severe	11	16	39
TOTAL	29	31	45

Table 4 illustrates that the Office of Assessment made substantially more decisions based on medical evidence alone than did the ALJs or the Appeals Council, and that the OA interpretation of the medical evidence was much different, particularly with regard to a finding of "impairment not severe." Although there may be a variety of factors which influence these outcomes, we believe that two are particularly significant.

First, there appear to be differences in the operational definitions of "impairment not severe" which are applied by the two sets of decisionmakers. The regulatory definition used by the ALJs and Appeals Council is:

> A condition which does not "significantly limit your physical or mental ability to do basic work activities . . . ."

The POMS guidelines used by the DDSs and OA are more inclusive:

> "When there is no significant limitation in the ability to perform these basic work related functions, an impairment will not be considered to be severe even though it may prevent the individual from doing a highly selective group of jobs, including work that the individual has done in the past."

Judging from the review data, these two standards, as they are interpreted by the adjudicators, result in widely different findings based on the same evidence. Because the standards, while different, are not widely divergent, the disparities in decisions reflected in the review data would suggest that the views of and procedures used by the different adjudicative bodies in applying the standards are not the same.

Second, although the Medical Listings used by all adjudicators are the same, the evaluation of medical evidence can be quite different. Under the POMS procedures applicable to the DDSs and OA, a physician in the employ of the government must review objective medical findings supplied by a claimant's treating physician or other medical source and make an independent judgment as to whether or not these objective findings indicate that the claimant does not have a severe impairment or is medically disabled. The findings of the government physician, who is trained in the application of the medical criteria used in the disability program, provide the medical basis for disability determinations made by the DDSs and OA. These findings are not supposed to be influenced by a treating physician's conclusions that a claimant is "disabled" or "unable to work."

In contrast, it appears that many ALJs give considerable evidentiary weight to a conclusion reached by a claimant's treating physician or a consulting physician that the individual is medically disabled. This practice may be due, in part, to the fact that ALJs are lawyers, not physicians, and are therefore reluctant to reach an independent medical conclusion (despite the fact that program regulations specify that medical determinations should be based on the adjudicator's review of medical findings and other medical evidence). This practice may also be influenced by the approach required to be taken by the Federal courts. The courts apply a "substantial evidence" rule, under which the conclusion of a physician who has examined the claimant will generally be accorded more weight than the conclusion of a government physician who has only reviewed the paper record, provided that the examining physician's conclusion is supported by substantiating medical data.

Thus, in assessing medical evidence provided by treating or consulting physicians, the DDS and OA will give primary weight to objective evidence and only limited weight to any conclusions as to disability made by the medical source, relying instead on the government physician's conclusions. The conclusions of the treating physician, on the other hand, are often given significant evidentiary weight by the ALJ.

b. Ability or Inability to Engage in Substantial Gainful Activity

If an individual's disability claim cannot be allowed or denied based on medical factors alone, the DDS must go further to determine whether or not a combination of medical and vocational factors prevent the claimant from engaging in substantial gainful activity. A finding of inability to engage in SGA results in an allowance; ability to engage in SGA results in a denial.

The first step in cases of this type is to perform an assessment of *the claimant's residual functional* capacity—his or her ability to perform a variety of work-related activities. (The RFC determination is basically a medical determination, subject to the same difference in procedures between DDSs and ALJs cited earlier.) A determination is then made as to whether or not the RFC will permit the individual to perform work done in the past. Ability to do past work results in a denial.

If past work cannot be performed, the adjudicator is required to make a medical-vocational determination as to whether or not the claimant can perform other work in the economy. This is usually done through application of medical-vocational rules which take into account residual functional capacity and the vocational factors of age, education, and previous work. When an individual's impairments are entirely of an exertional nature—limitations in meeting the strength requirements of jobs—the medical-vocational rules generally direct a determination as to whether or not an individual is able to engage in SGA. When the impairments are both exertional and nonexertional (e.g., physical limitations combined with sensory impairments), the medical-vocational rules are first used to determine whether an individual is precluded from engaging in SGA based on exertional impairments alone. If not, the rules are then used by the adjudicator only as a "framework" for determining whether or not the combination of exertional and nonexertional impairments is disabling. They do not direct a finding of disabled or not disabled.

The regulatory standards governing the DDSs and the ALJs provide for this same basic determination process. ALJ practice also permits a determination of inability to engage in SGA if the individual:

(1) has a residual functional capacity less than sedentary (i.e., the individual cannot perform even sedentary work);
(2) suffers from severe pain which, combined with significant impairment(s), precludes performance of SGA; or
(3) suffers from a nonsevere mental disorder which, combined with significant physical impairment(s), precludes performance of SGA.

These three categories either do not exist, or are used infrequently, in the DDS determination process. The first two categories are not provided for in regulations or in the POMS, and are not used at all by the DDSs. Under the DDS standards, the category "RFC less than sedentary" is nonexistent; to have less than sedentary residual functional capacity means that an individual has impairments which should meet or equal the Medical Listings. The DDSs do consider *pain in making a medical-vocational determination. The regulations require that they treat pain as a symp*tom associated with certain physical impairments, not as an impairment itself, and take it into account when determining residual functional capacity. Thus, pain could be a factor in a determination of disability made by the DDSs using the medical-vocational rules, but would not be a basis for a separate finding of disability under a special "pain" category.

Finally, although the third category—the combination of mental disorders with significant physical impairments—is provided for in the regulations and can appropriately be used by the DDSs, its use in making a medical-vocational allowance appears to be infrequent. (Of course, if the combination of impairments is sufficiently severe, it will result in a medical allowance based on equaling the Medical Listings.) A medical-vocational finding of disability resulting from this combination of exertional and nonexertional impairments is judgmental, not one which is directed by the medical-vocational rules.

These three categories are, however, used extensively by ALJs and the Appeals Council. This is clearly shown in Table 1, where the initial review data indicate that 28 percent of the ALJ cases and 16 percent of the Appeals Council cases were allowed based on a finding that an individual could not engage in SGA due to one of these three causes. The preponderance of such allowances by both sets of decisionmakers was based on a finding of "RFC less than sedentary." In contrast, the Office of Assessment, applying the DDS standards, made no allowances in the "RFC less than sedentary" and "pain" categories, and allowed only 0.4 percent of the cases under the third, or "mental," category. Although pain or mental illness may have been a factor in some OA allowances recorded under other categories in Table 1 (e.g., the "Other medical/vocational" category generally used by OA when a decision was not directed by the medical-vocational rules), the overall OA allowance rate of 13 percent suggests that pain and mental illness could have not been significant factors—particularly when compared with an ALJ allowance rate of 10

percent and an Appeals Council rate of 7 percent in these categories.

It should be noted that eliminating the ALJ practice of using the first two categories would not necessarily convert allowances under these categories to denials. A preliminary and informal study by the SSA Office of Hearings and Appeals has indicated that most of the claims allowed on the basis of "RFC less than sedentary" might be allowed under other categories. In any event, we cannot say with any certainty what the effect of elimination of the categories would be.

The data in Table 1 also appear to indicate that the evaluation of residual functional capacity, as it applies to a claimant's ability or inability to do past work, is viewed quite differently by the various adjudicatory authorities. The ALJs denied claims on the basis of ability to do past work in 9 percent of the cases, and the Appeals Council denied in 13 percent. The Office of Assessment denial rate, 28 percent, was 2 to 3 times higher. There is no clear explanation for this difference, but it may be related to such factors as the differences in treatment of medical evidence used to determine an individual's RFC, and differences in the findings of vocational experts available to or used by the adjudicators.

In summary, an evaluation of the standards and procedures governing the ALJs and DDSs suggests that variations in definitions and procedures may well be an important cause of the difference in findings, based on the same evidence, observed in the data from the initial review shown in Table 1. It is important to note, however, that differences in allowance and denial rates among the various adjudicators are not solely a product of differences in standards and procedures.

2. Inconsistencies in the Application of Standards

The initial review indicates that, even when decisionmakers are supposed to be applying the same standards, they are not applying them consistently. Data presented in Tables 1 and 2 show that ALJs and the Appeals Council arrive at different conclusions when reviewing the same cases, even though they are using the same standards. In the aggregate, the Appeals Council would have allowed significantly fewer cases than ALJs.

In addition to studying overall allowance and denial rates, the initial review attempted to measure the consistency of decisionmaking among ALJs. The SSA corps of ALJs was divided into three groups of approximately equal size. Each group was composed of ALJs whose overall allowance rate fell within a given range. The sample of ALJ decisions selected for the first phase of the review was structured so that about one-third of the cases came from each group of ALJs. The three groups of ALJs, classified by their allowance rate levels, were:

ALJ Allowance Rate Group	ALJ Allowance Percentage	ALJ Median Allowance Rate
Low Allowance Rate	0–55%	47%
Medium Allowance Rate	56–70%	63%
High Allowance Rate	71–100%	77%

The initial review was not designed to take into account all of the factors that might account for differences in ALJ allowance rates (e.g., the possibility of significant differences in the types of cases assigned to high or low allowance ALJs, or differences in attorney representation of claimants among the three ALJ strata). Initial evaluation of the data, however, suggests that while it is possible that some biases exist, they would not be significant enough to alter the nature of the results found when the original ALJ allowance rates are compared with the Appeals Council rates for the three groups of ALJs. These results are shown in Table 5.

Table 5 shows that the Appeals Council allowed roughly 50 percent (ranging from 46–51 percent) of

Table 5. Appeals Council Allowance Rate for ALJ Groups with Low, Medium, and High Allowance Characteristics (Appeals Council Subsample)

ALJ Allowance Rate Group	Original ALJ Decision on Sample Cases		Appeals Council Allowances: Percent of ALJ Decisions Allowed		Appeals Council Allowance Rate
	(1)	×	(2)	=	(3)
Low Allowance Rate Group					
Allow	50%		70%		35%
Deny	50		24		12
Total					47
Medium Allowance Rate Group					
Allow	65		68		44
Deny	35		19		7
Total					51
High Allowance Rate Group					
Allow	81		52		43
Deny	19		17		3
Total					46
Total, All ALJs					
Allow	64		63		40
Deny	36		21		8
Total					48

the cases from each of the three groups of ALJs. This relatively consistent Appeals Council allowance rate across the groups does not follow the pattern of high, medium, and low allowance rates that characterize the groups, and suggests that there are not major variations in the characteristics of cases decided by each group. The Appeals Council allowance rates for cases that the low and medium allowance rate ALJs originally allowed were consistent: 70 and 68 percent, respectively. However, the Appeals Council allowance rate for cases originally allowed by ALJs with high allowance rates dropped to 52 percent.

If the Appeals Council decision is taken as the "correct" decision under the standards and procedures governing ALJs, these findings would indicate that decisions to allow cases by ALJs with high allowance rates are more often "incorrect" than the decisions of ALJs with medium and low allowance rates. By the same token, no significant difference is found in Appeals Council decisions on cases originally decided by the ALJ groups with medium and low allowance rates. These two groups appear to be relatively homogeneous, using Appeals Council decisions as the criterion. This clearly suggests that the ongoing, own-motion review mandated by P.L. 96-265 should place the most emphasis on a review of cases decided by ALJs with high allowance rates.

The initial review also indicates that a more subtle form of inconsistency, or subjectivity, exists in disability decisions. Its essence is that while two different decisionmakers or sets of decisionmakers may often make the same decision to allow or deny a particular case, their reasons for making that decision and their view of the evidence on which the decision is based may be quite different. When the Appeals Council reviewed the ALJ decisions in the initial review, they allowed 63 percent of the cases which the ALJs allowed and denied 79 percent of the cases which the ALJs denied (see Table 2). A detailed examination of the cases on which both groups agreed, however, shows that the Council agreed with the ALJs as to the basis for an allowance or denial much less frequently than it agreed on whether the case should be allowed or denied. The Council agreed that a case should be allowed because the claimant met or equaled the Medical Listings in 41 percent of the cases that the ALJs allowed on this basis, and agreed with an ALJ allowance based on vocational rules in 38 percent of the cases. The rate of agreement on the basis for allowance due to all other allowance criteria was significantly lower. The same phenomenon is observed, although to a lesser degree, in those cases which both the ALJ and the Appeals Council denied.

In short, although there was a fair amount of agreement as to whether a case should be allowed or denied according to the standards governing ALJs, there was significantly less agreement on the basis for reaching that decision. It seems obvious that when these kinds of variations occur in decisions on cases in which the decisionmakers agree upon the outcome, there is a considerable degree of latitude for the individual judgments of different decisionmakers to produce a different outcome on the same case. Although it may be possible by various means to lessen inconsistency in the determination process, one cannot necessarily expect that two different decisionmakers or decision-making levels operating under the same rules and procedures will uniformly produce the same decision results on the same cases.

3. Subjectivity, Organizational Trends, and Management Emphases

SSA has long recognized that determining whether an individual is capable of engaging in substantial gainful activity—the basic measure of whether or not one is disabled under the law—is a complex process. By its very nature, the process involves some degree of subjective judgment by the adjudicator, especially in cases where the claimant's condition is near the border that divides the disabled person from one who is not disabled. The data presented in the previous section concerning inconsistency in decisionmaking are, to some degree, indicative of this subjective element.

There are indicators that the subjective element in the disability determination process, in combination with other factors, may result in distinct differences and trends in disability decisions made at different organizational levels. These differences seem to reflect organizational bias and change, as opposed to random inconsistency in the application of standards by individual disability decisionmakers.

When we review the Disability Insurance program allowance and denial data for the past 10 years, we find definite trends or changes which seem to be unaccounted for by any significant changes in the standards which govern the separate adjudicative bodies, or in the characteristics of the applicant population. As shown in the preceding chapter (Charts 1 and 2), allowance rates at the various decisional levels were relatively stable during the period 1970-77. DDSs allowed about 40 percent of initial Disability Insurance claims and 33 percent of reconsideration appeals. The allowance rate for ALJs hovered in the 45 percent range, varying from a low of 42 percent in 1970 to a high of 49 percent in 1975. This picture began to change dramatically in the latter part of the 1970's, however, as the DDS allowance rate started to decline. By fiscal year 1980 the DDS allowance rate on

initial claims had dropped to 33 percent, and on reconsideration appeals to 15 percent.

The reconsideration claims volume and allowance rates are particularly worth noting, since a denial at reconsideration is the necessary precursor to an appeal for an ALJ hearing. The volume of reconsiderations in the latter part of the 1970's has been double or triple the volume in the first half of the decade, and continues to increase. At the same time, the allowance rate on reconsiderations, which was 33 percent in 1975, has steadily declined in subsequent years. It presently stands at less than half of the 1975 rate. What may very well be a reciprocal change has occurred in the ALJ allowance rates during the last few years. From an allowance rate level of 47 percent in 1977, the ALJ rate climbed to 51 percent in 1978, 55 percent in 1979, and 58 percent in 1980.

We cannot definitively establish why these trends occur or whether the trends in ALJ allowance rates were the result of changes in the DDS allowance pattern. There is no question, however, that a primary focus of the Social Security Administration in recent years has been to tighten administration of the disability program at the DDS level to attempt to minimize subjectivity and ensure that only those who were severely disabled were awarded benefits. This tightening was a reasonable and necessary response to the experience of the early and mid-1970's, when the combination of high application and allowance rates caused program costs to quadruple. Various management processes—more explicit instructions, requirements for better documentation, increased physician participation in adjudication and review, greatly strengthened quality control—were used to accomplish this change. As a result, it is likely that a more stringent application of the subjective adjudicative standards has been in evidence in the last few years.

This hypothesis cannot be conclusively proven, but the trends in disability applications and DDS allowance rates, our knowledge of recent program and administrative emphases, quality assurance data, and anecdotal information from the DDSs all lend it credence. If one accepts this hypothesis, then it seems reasonable to assume that, within a limited range, the outcome of a disability determination may be a product of the general policies under which the adjudicator is operating and the nature and extent of quality control and other management procedures applied in the organization to reduce subjectivity and promote consistent interpretations of agency policy.

Carrying the hypothesis a step further, if steps to significantly tighten administration and quality review at the DDS level result in a higher percentage of reconsideration denials, this should have some effect at the hearings level. If ALJ behavior did not change appreciably when these denials were appealed to the hearings level—i.e., if individual ALJs continued to allow the same kinds of cases they previously had allowed—the overall ALJ allowance rate would increase. This is, in fact, what the data show. This is also consistent with the observation that, in recent years, the forces at work to tighten administration at the DDS level were largely absent at the ALJ level. While considerable attention was focused on increasing the production rate of ALJs, mechanisms such as an effective own-motion review designed to reverse incorrect decisions by ALJs were essentially absent.

The essential points are that a degree of subjectivity exists in the disability determination process, and that one of its manifestations may be different decisional behavior at different organizational levels. Available evidence at least suggests that this behavior, as reflected in historic trends, is influenced by the mind set of the various SSA adjudicatory organizations, the general policy and management framework in which they are operating, and the controls over decisional quality which are applied in the organizations.

C. Other Findings

As requested by the Congress, the initial review attempted to determine the effect of in-person appearance by the claimant before the ALJ and the effect of additional evidence submitted to the ALJ after the DDS reconsideration decision.

1. Effect of In-Person Appearance

The ALJ hearing is the first time an applicant appears before the person who decides his case. The second phase of the initial review was designed to determine the effect on ALJ decisions of the claimant's in-person appearance. In this phase, a representative subsample of 1,000 cases was selected from the 3,600 cases used in the first phase. For each case, a hard copy transcript of the original ALJ hearing was made and then edited to remove all evidence related to the claimant's in-person appearance at the hearing. Testimony of expert witnesses was retained in the edited transcript.

These 1,000 edited cases were then distributed to a representative sample of 48 ALJs (selected to mirror the allowance rate patterns of the ALJs who originally decided the cases) for a complete redetermination. The resulting decisions were then compared with the original ALJ decisions. Given that only one type of information available to the original ALJ was removed, the difference between the two sets of decisions should be indicative of the effect of the claim-

ant's in-person appearance, absent any biases which might result from the study procedure itself.[1]

The original ALJ allowance rate on this subsample of cases was 63 percent. After removing the evidence relating to the claimant's in-person appearance, the ALJ allowance rate dropped to 46 percent. Thus, the in-person appearance of claimants appears to make a difference in ALJ decisions (subject to the previously noted caveats about a "study effect").

That in-person appearance might make a difference is not surprising. On a number of occasions SSA has experimented with in-person appearance at the DDS reconsideration level. While the specific results of the studies vary and there are certain reservations due to the methodology employed, they do generally show that the allowance rate increases somewhat when the decision process includes a face-to-face appearance by the claimant.

There could be a variety of reasons for this effect. Some of these may be of an objective nature: the decisionmaker can see at first hand the claimant's appearance and functional limitations. A more subjective, emotional effect—human sympathy for an individual who appears to be severely impaired—is probably also present in some cases.

Still another factor which may be of relevance in ALJ determinations is the representation of some claimants by a lawyer or other advocate at the hearing. In FY 1981, 71 percent of claimants were represented at the ALJ hearing. In those cases where representatives were present, the ALJ allowance rate was 61 percent. In contrast, in the 29 percent of cases where claimants were not represented, the allowance rate fell to 48 percent. Data from the first phase of the initial review show a similar pattern. Of those claimants who had a hearing, 68 percent were represented. The ALJ allowance rate for those cases was 64 percent, as opposed to 53 percent for claimants not represented at hearing.

2. Effect of Additional Evidence Submitted at Hearing

The third phase of the initial review was designed to determine the effect on ALJ decisions of additional evidence submitted after the DDS reconsideration decision. This phase used all of the 1,000 cases used in the second (in-person appearance) phase. Each case was revised to remove any evidence added after the DDS reconsideration decision. The case folders, stripped of all information gathered in the hearings process, were distributed to another representative group of 48 ALJs for a complete readjudication. The resulting decisions were then compared with the decisions made in the second phase, where only the information related to in-person appearance had been removed. The differences in decisions on these 1,000 cases—adjudicated both with and without post-reconsideration evidence—should be, in the aggregate, attributable to the submission of additional evidence after the reconsideration level.

Table 6 shows that additional evidence made a significant difference in ALJ allowance rates. The overall second phase allowance rate of 46 percent dropped to 31 percent when all additional evidence was removed. A statistical test showed that the difference was due solely to additional medical evidence, which was submitted in 74 percent of the cases. Additional vocational evidence had no impact on allowance rates. Specifically, neither the difference in ALJ allowance rates shown in table 6 for cases without any additional evidence, nor the difference for cases with additional vocational evidence only, was statistically significant. The effect of additional medical evidence is the same with and without additional vocational evidence.

The OA examiners and Medical Consultant Staff also reviewed this subsample of 1,000 cases with and without the additional evidence. The OA allowance rate was 15 percent when all the evidence available to the ALJ was included. It dropped to 12 percent when the additional evidence was deleted.

Table 6. Allowance Rates Distributed by Type of Additional Evidence

Type of Additional Evidence	Total Cases	ALJ Allowance Rate		OA Allowance Rate	
		Without New Evidence	With New Evidence	Without New Evidence	With New Evidence
None [1]	20%	36%	40%	10%	11%
Vocational only	6	30	25	9	9
Medical only	50	29	49	12	15
Medical and Vocational	24	30	51	16	19
Total	100	31	46	12	15

[1] In this instance, there was no difference between cases "without new evidence" and "with new evidence." As previously noted, the difference in allowance rates (4 percentage points) for the two groups of ALJ reviewers is not statistically significant. Neither is the difference in OA rates.

[1] The way the study was designed and conducted could have influenced the results. The original ALJ decision was made with the knowledge that it would affect the benefit rights of the claimant. The second-phase decision, made by the representative sample of ALJs, was made with the knowledge that the decision would not affect benefit rights or benefit amounts. As a result, this decision may have been made more liberally or conservatively than it would have been had "live" claims been involved. This difference in the adjudicative climate in which the two sets of ALJs made their decisions could have introduced a "study effect" which might, at least in part, account for differences in decisional results. SSA is currently analyzing the study data to try to determine the magnitude of this possible study effect.

Table 7 shows that of the sample cases with additional medical evidence, in almost all cases the evidence pertained to a previously alleged medical condition rather than to a new medical condition. The additional evidence concerning prior conditions may have shown a change in the prior condition or provided more extensive documentation of the condition as it existed at the reconsideration level.

Table 7. Percent of Cases Containing Medical Evidence Pertaining to Prior and/or New Condition(s)

Additional Medical Evidence Pertaining to:	Percent of Cases
New condition	1
Prior condition	88
Both new and prior condition	11

The relative importance of new evidence to the different disability decisionmakers is worth noting. As observed earlier, there are significant differences in the way ALJs and OA view the same medical evidence. These differences are reflected in the much lower OA allowance rates shown in Table 1. Thus, it is not surprising that OA, working with the Medical Consultant Staff, found that only 12 percent of the cases in this subsample should have been allowed at the reconsideration level, and that the additional evidence submitted after reconsideration should have increased the allowance rate by only 3 percentage points, to 15 percent. Nonetheless, although this increase is small in absolute terms, it does represent a 25 percent increase over the base allowance rate of 12 percent.

The ALJs who reviewed the cases from which all additional evidence had been removed—cases which contained only the information on which the reconsideration decision was based—found that 31 percent should have been allowed at that stage. The ALJ allowance rate after the new evidence was reviewed increased by 15 percentage points, or an increase of 48 percent over the base allowance level. The treatment of additional medical evidence by the ALJs is a dominant factor in this increase. This may be reflective, at least in part, of the greater weight assigned by the ALJs to conclusions drawn by treating or consulting physicians. In any event, the discrepancy between the ALJ and the OA allowance rate for these cases is probably a product of the differences in standards, the inconsistency in the application of standards, and the other causal factors previously discussed.

IV. The Ongoing Review and Other Initiatives

The initial review indicates significant differences in adjudicatory practices and results between the prehearing and the hearing levels, and to a lesser extent, inconsistencies within the hearing level. SSA is concerned about the implications of these findings and has undertaken, or will undertake, actions in a number of areas to address the identified problems. Generally, SSA initiatives address five areas of concern:

(1) The need to improve the consistency and correctness of ALJ decisions.
(2) The need to ensure that standards governing DDSs and ALJs are consistent and are applied in a consistent manner.
(3) The need to provide improved ALJ training to promote better understanding and more consistent application of agency policy.
(4) The need to ensure complete documentation and consideration of all relevant evidence in a case, and to provide a specific and detailed rationale for the decision reached at the hearing level.
(5) The need to examine and improve other aspects of the disability determination process, particulary at the reconsideration level.

A. An Ongoing Review

On October 1, 1981, SSA implemented an ongoing program of own-motion review pursuant to section 304(g) of P.L. 96-265. The purpose of the review is to identify decisions which are inconsistent with SSA policy and standards, and to take appropriate action to revise those decisions.

The review is being conducted in the Office of Hearings and Appeals by the Appeals Council, which has the delegated authority to review all ALJ decisions and dismissal actions at the request of the claimant or on its own motion. The review program concentrates primarily on ALJ disability allowances issued for Disability Insurance and concurrent DI/SSI claims. At the outset, based on results of the initial review, a sample of decisions of ALJs and hearing offices with the highest allowance rates is being selected. Cases from these ALJs and hearing offices are being forwarded directly to OHA's central office in Arlington, Virginia, where they undergo preliminary screening and review by staff of the Appeals Council. Where appropriate, referrals are made to the Appeals Council for consideration of own-motion action.

The Appeals Council will exercise its own-motion authority if any one of the following is present:

(1) There is an abuse of discretion by the ALJ;
(2) there is an error of law;
(3) the decision is not supported by substantial evidence; or
(4) there is a broad policy or procedural issue that may affect the general public interest.

Once the Appeals Council decides to review a hearing decision on its own motion, the Council may affirm, reverse, or modify the decision or remand the case to an administrative law judge for further proceedings.

The current review sample is intended to include approximately 7 1/2 percent of total ALJ allowances in DI and DI/SSI concurrent cases. Later in fiscal year 1982, as additional resources can be made available for this effort, the review will be expanded to include additional ALJs and a national random sample of hearing decisions. By the end of FY 1982, we plan to be reviewing a total of 15 percent of ALJ allowance decisions. At present, we do not plan to include ALJ denial decisions in the review, since the Appeals Council will continue to handle those cases in which the claimant requests review of an ALJ decision denying his or her application in whole or in part.

In addition to ALJ decisions selected through a targeted sampling procedure, the review will also include decisions formally referred to OHA by other SSA components. Referrals from these components will be reviewed under what is commonly referred to as the "protest" procedure. Referrals will be made when the decision as to disability is questioned on a substantive issue rather than on a solely technical nondisability issue, as has occurred under past "protest" procedures. Generally, cases previously referred under "protest" have been those which could not be effectuated because of a legal or technical impediment.

Because the ongoing review program was only recently implemented, significant data about the results are not yet available. Nonetheless, SSA believes this program will bring about more accurate and consistent decisions by all administrative law judges. In some cases, the Appeals Council will be taking corrective action itself where an ALJ's decision is determined to be erroneous, based on the record upon which the decision was made. In other instances, the Appeals Council will return the case to an administrative law judge for corrective action, which may include obtaining additional evidence and/or a new or supplemental hearing. In either event, the administrative law judge who issued the original decision will receive specific feedback about the Council's action and the basis for it. Included will be specific instructions for correcting case deficiencies, as well as citations and discussion of relevant regulatory provisions. Apart from this direct feedback to the individual ALJ whose decisions are reviewed under the ongoing program, OHA also intends to use aggregate findings as a basis for advising the entire administrative law judge corps of the areas in which improvement in decision-making and/or documentation is necessary. Information of this type will be made available to all ALJs via instructional and educational material.

B. Standards Governing Disability Adjudication

As indicated in Chapter III, a major finding of the initial review was that the standards for deciding disability claims are applied differently at the various levels of adjudication. SSA has concluded that a significant contributing factor to this difference is that administrative law judges base their decisions on their own individual interpretations of the statute, applicable regulations, and Social Security Rulings without benefit of the guidance and clarification provided in POMS, which is used by the prehearing level adjudicators. We are persuaded that all adjudicators must be provided, and required to adhere to, a consistent set of adjudicatory standards. Another major finding of the initial review was that there are a number of specific concepts and adjudicatory areas in which agency policy needs to be clarified. The primary examples, based on the study data, are impairment severity, assessment of residual functional capacity, effect of pain on residual functional capacity, and the treatment of mental disorders, both singly and in combination with physical impairments.

SSA is in the process of establishing a consistent set of adjudicatory standards which reflect and provide binding agency policy in adjudicating cases, particularly in the difficult decisional areas noted above. Heretofore, a primary vehicle for disseminating SSA policy and agency interpretations of the regulations and statute has been the POMS. Social Security Rulings, which include Program Policy Statements, have been used primarily to illustrate the application of SSA's policy or interpretation in specific cases and to enunciate the agency's position in major policy areas. The POMS has been used to provide more specific guidance and instruction to all SSA adjudicative personnel except the administrative law judges and the Appeals Council.

SSA now recognizes that the inclusion of more specific instructional material in POMS issuances, which are not binding on ALJs and the Appeals Council, has resulted in adjudicative practices by these two sets of adjudicators which differ in many respects from those followed by the targeted POMS audience, the DDSs. To overcome this problem, SSA intends to expand its use of Program Policy Statements (which become Social Security Rulings) to address policy and adjudicatory areas which we believe are the most troublesome in terms of consistent application. Moreover, appropriate POMS guidelines will be issued in a manner which will make them binding on all levels of adjudication. These guidelines will be disseminated to all levels of adjudication and will represent a single set of standards for all to follow. We expect these efforts to have three major results:

(1) The adjudicatory standards governing DDS and ALJ decisionmaking will be essentially the same.
(2) More detailed and clearer guidance will be provided to all decisionmakers.
(3) Greater consistency, both among the DDSs and among the ALJs, as well as between the several adjudicatory levels, will be achieved.

C. Training

In recent years, primarily as a result of budgetary and resource constraints, OHA's activity in the area of program training for ALJs and support staff has been quite limited. The major effort was directed toward training of new ALJs and field personnel; however, because of the pressing need to make these resources available for case processing as quickly as possible, the training courses were of relatively brief duration. Similarly, refresher training has not been regular or systematic.

In the past, much of the responsibility for training was vested in OHA's regional offices. To insure that training for field personnel is expanded and improved, OHA has established a special staff in its central office to develop new and expanded training programs for all OHA field personnel. This staff will be developing a more extensive initial training program for new ALJs, an expansion of the continuing judicial education now provided to ALJs, and integrated training packages for ALJ support staff, particularly the staff that assists in case development and decision drafting.

A major focus of the new training process will be the areas of adjudicative differences identified in the initial review. The training will also constitute an additional mechanism for providing feedback to the ALJs regarding deficiencies identified through the ongoing review. Through its training initiatives, OHA expects to promote among ALJs and their support staffs a better understanding and application of both current and revised standards and procedures, resulting in greater consistency and accuracy in decisionmaking.

D. Other Initiatives at the Hearing Level

Although SSA believes that the major initiatives discussed previously will substantially narrow the differences which exist in the adjudicative approaches used at the prehearing and hearing levels, we are also undertaking other initiatives to address these problems through examination of, and changes in, several key aspects of the hearing level process.

The first of these initiatives to improve decisional quality at the hearing level is the elimination of the short format for fully favorable decisions. Effective January 1982, OHA will begin to discontinue use of preprinted fully favorable allowance decision forms which contain no statement of the basis for the allowance. A revised format has been developed for allowance decisions to ensure not only that they will contain a specific explanation of the reasons for the favorable conclusion, including a discussion of all relevant evidence, but also that they reflect adherence to the sequential evaluation process directed by the regulations. To facilitate use of the new decision form, the format incorporates standardized language with respect to issues, citation of applicable regulations, findings, and decisional paragraphs. It also provides for individualized discussion of and rationale for the conclusion reached. SSA expects that this initiative should eliminate the implicit incentive toward favorable decisions which many critics and observers believe has resulted from use of the short format.

The second initiative directed at improved decisional quality is the planned implementation during fiscal year 1982 of an experiment under which SSA will be a party in certain hearing proceedings. For selected hearing offices, an SSA employee will have responsibility for representing SSA's position during hearings for those claimants who are represented. The purpose of the experiment is to determine whether the participation of an agency representative in hearings could contribute toward improving the quality and timeliness of hearing decisions. SSA expects that the participation of the SSA representative in prehearing development and during the hearing itself will relieve some of the burden on the ALJ corps which has resulted from the large and growing number of hearing requests in recent years. Although the ALJ will in all cases have final responsibility for conducting the hearing and for assuring that a complete record of the case is developed, as well as for the final disposition, the SSA representative will play an active role in obtaining relevant evidence and in explaining to the ALJ and the claimant the basis for the prior unfavorable determination. The experiment will last about 9 months, following which the results will be evaluated to determine whether the quality and timeliness of the hearing process has been improved. The primary concern with respect to the quality of decisions will be whether decisional inconsistency among the ALJs is reduced.

E. Initiatives to Improve DDS Performance

Both as a result of legislative mandate and of internal SSA initiatives, SSA has undertaken a number of programs and experiments designed to improve the accuracy and consistency of disability decisions made by the DDSs. Two of these activities are particularly worth noting: the program of preeffectuation review of DDS disability allowances required by the Social Security Disability Amendments of 1980 (P.L. 96-265); and the

so-called DARE experiments initiated by SSA to test ways in which the DDS reconsideration process might be improved.

The Disability Amendments of 1980 require that SSA conduct a Federal review of certain proportions of favorable Social Security disability decisions made by DDSs before benefit payments begin. This preeffectuation review, in which incorrect decisions made by the DDS are reversed prior to notification of the claimant or payment of any benefits, is intended to promote the uniformity and accuracy of favorable disability decisions. The review applies to decisions made by the DDSs on initial claims, reconsiderations, and continuing disability investigations (reviews of the disability status of individuals currently receiving disability benefits).

SSA began the program of preeffectuation review in October 1980. Reviews were targeted on those types of allowances determined from available data to be most likely to be in error. Where such data were not available, cases were selected on a random basis. Through June 30, 1981, about 17.5 percent of State agency allowances were reviewed by SSA, and about 8.5 percent of the cases reviewed were returned to State agencies, either because the finding of disability was erroneous or because the finding was inadequately documented.

As a result of the initial operation of the preeffectuation review program, it became clear that special attention needed to be devoted to reconsideration cases. Reconsideration allowances had an error rate of 9 percent, as compared to a 3.1 percent error rate on initial DDS allowances. In order to deal with this problem, SSA in fiscal year 1982 initiated preeffectuation review of 100 percent of all allowances made at the reconsideration level. This 100 percent review should improve the accuracy and consistency of DDS reconsideration decisions and, in addition, provide data for more accurately targeting error-prone cases for review in later years.

SSA is also conducting three experiments to determine whether changes in procedures at the reconsideration level would result in different outcomes when cases move on to hearings. These so-called DARE experiments are being conducted in a number of States throughout the country. The experiments test the following changes which might be made in the reconsideration process:

DARE 1—Expanded Reconsideration Process

DARE 1, being conducted by DDSs in two States, tests singly and in combination three changes in the reconsideration process. The first change requires that the DDS secure more complete medical evidence, including a consultative examination when one had not been purchased earlier. The second change requires the DDS to provide a separate statement of residual functional capacity. The third requires that the DDS prepare a lengthy formal notice of the basis for decision. Each of these changes will provide more complete documentation of the basis for the reconsideration decision, and may result in more accurate and consistent decisions.

DARE 2—Informal Remand

DARE 2 is evaluating the effect of the DARE 1 procedures on disability claims which are denied at reconsideration and are then informally remanded to the DDS for further development following the claimant's request for an ALJ hearing. The purpose of DARE 2 is to evaluate the likely effect of these procedures if they are applied only to those cases going to hearing.

DARE 3—Face-to-Face Interviews at Reconsideration

The DARE 3 experiment is evaluating the effect at the reconsideration level of face-to-face contact between the disability applicant and the DDS decisionmaker or SSA district office interviewer. The test will also evaluate the effect of when the interview is held—early or late in the reconsideration process. The experiment is being conducted in four States, and should give an indication of the value and effect upon decisional accuracy of including face-to-face contact between the claimant and the adjudicator prior to a formal ALJ hearing.

SSA believes that the preeffectuation review, in combination with any changes at the reconsideration level which may be found appropriate as a result of the experience with the DARE experiments, will result in more accurate, consistent, and better-documented decisions by the DDSs. These improvements, in turn, should assist in improving decisional accuracy at the hearings level.

In summary, SSA has undertaken a number of activities designed to respond to the problems identified through the initial review. The most significant are probably the ongoing review of ALJ decisions required by P.L. 96-265, and the initiation of changes required to ensure that all SSA disability decisionmakers are governed by the same standards. In addition to enabling SSA to correct erroneous decisions, the ongoing review will provide SSA with the ability to continuously monitor the disability adjudication process to ensure that the problems identified in the initial review are actually corrected and that any additional areas of weakness are identified and acted upon. These actions, in conjunction with the other initiatives discussed in this report, should greatly improve the accuracy and consistency of disability decisions made throughout the SSA adjudicative system.

Technical Appendix

I. Overview

As described in the text of the report, the research plan involved an intensive multi-phased review of a randomly selected sample of allowances and denials rendered by administrative law judges (ALJs) on the issue of disability in Title II Disability Insurance (DI) and Title XVI Supplemental Security Income (SSI) claims. This review involved SSA Office of Assessment (OA) examiners, Office of Hearings and Appeals (OHA) analysts, administrative law judges, the OHA Appeals Council, and the Office of Disability Programs' Medical Consultant Staff (MCS). The review was conducted in three phases, beginning in December 1980 and ending in July 1981.

Phase I was designed to determine the extent to which different standards applied by disability determination service (DDS) personnel and by ALJs affected hearing level reversal rates. It involved a basic sample of 3,600 recent cases which were reviewed independently by OA examiners, OHA analysts, the Appeals Council, and the Medical Consultant Staff.

Phase II focused on the effect upon ALJ decisions of the claimant's in-person appearance at a hearing. It required obtaining a second ALJ decision on 1,000 cases selected from the 3,600 base sample. The claimant's personal testimony was deleted from these 1,000 cases.

Phase III was designed to determine the effect of additional evidence submitted after the reconsideration determination. It involved the same 1,000 cases used in Phase II, except that all evidence added to the file after reconsideration was removed. Additional reviews of these cases were performed by a group of ALJs and OA examiners; the latter review included input from the MCS.

The sample selected for all phases of this study included only cases involving a primary applicant for disability benefits under DI and SSI. Therefore, claims involving disabled widows/widowers, disabled adult children, and health insurance or other non-disability cases were omitted. The cases were reviewed after the ALJ's original decision was effectuated; and the results of the reviews were not intended to have case-related impact. In other words, the claim was not "readjudicated."

II. Sample Design

A. Sampling Frame

The sample of ALJ decisions was drawn from lists of all allowances and denials for the months of September 1980 through January 1981 identified from OHA's management information system (MIS).

The sample included only cases involving a primary applicant for DI benefits or SSI payments. Disabled widow/widower, disabled adult child, and health insurance or other non-disability cases were not selected.

B. Stratification

Cases listed for each month were stratified by three characteristics, which were used as the basis for sample selection.

1. Type of Claim
   a. Applicants for DI benefits, including those who applied concurrently for SSI disability payments
   b. Applicants for SSI disability payments only
2. Type of ALJ Decision
   a. Denial—Affirmation of State agency decision
   b. Allowance—Reversal of State agency decision
3. Allowance Rate of the Original ALJ During the Prior 6 Months
   a. High—71-100 percent
   b. Medium—56-70 percent
   c. Low—0-55 percent

The levels of ALJ allowance rates used for those three groupings were determined from the weighted distribution of ALJ allowance rates for claims adjudicated during the 6 month period ending September 30, 1980. The weight equaled the average monthly production rate of the individual ALJ during those 6 months. Three allowance rate levels divided that distribution into approximately three equal parts.

Use of these characteristics and their manipulation in the way described, resulted in 12 groups of strata. Table 1 presents the population of dispositions by stratum and month.

C. Phase I Sample

Original plans for the Phase I sample called for 400 completed cases from each of the 12 strata (4,800 cases in all) in order to insure reasonably precise contrast of estimated stratum allowance rates. Workload pressures in the field, however, necessitated reduction of the overall sample to 3,600 cases.

In order to achieve the latter figure, the number of sample cases required in the 6 denial strata was halved. A previous study [1] had indicated that estimates of allowance rates for cases previously denied would be less variable than those for cases previously allowed.

One-third of the sample cases were allocated to the month of September (to facilitate the Phase II and III

[1] "Consistency of Initial Disability Decisions Among and Within States," SSA Publication No. 13-11869.

reviews). The rest of the sample cases were divided equally among the other 4 months. The number of sample cases drawn each month was 25 percent higher than the target sample size in anticipation that some cases would be out-of-scope for the review or not retrievable. Within each stratum for each month, simple random samples were drawn without replacement.

Although the initial selection process was designed to include only DI or SSI disability issue cases in the sampling frame, it turned out that a small proportion of "out-of-scope" cases were included in the frame and selected for the sample inadvertently. These cases generally involved non-disability issues and thus were subsequently excluded from the study and the analysis.

Also, due to the complex nature of the case handling process at the appellate level, a small proportion of the cases were irretrievable in the time period allocated for the study.

Table 2 presents by month and stratum, targeted sample sizes, sample sizes drawn, the total number of cases actually retrieved and percent of cases in-scope for the study.

D. Appeals Council Subsample

Original plans called for an Appeals Council review of the entire 3,600 case Phase I samples. However, lack of sufficient Appeals Council staff necessitated a reduction of the Appeals Council sample to about 2,000 cases.

The Appeals Council subsample included all cases where OA disagreed in Phase I with the original ALJ decisions and a random sample of one-sixth of the claims where OA agreed with the original ALJ decision. Table 3 shows the sample sizes obtained for the Appeals Council subsample.

E. Phase II/Phase III Subsample

In order to complete the field work for Phases II and III as quickly as possible, sample cases for these phases were drawn from September dispositions only. All September allowances and half of the cases from the September denial stratum were used. Of the targeted 1,000 cases for this subsample, 973 cases were completed for all of the Phase II and Phase III review processes.

III. Selection of ALJs for Phases II and III

Two separate samples of 48 ALJs were randomly selected, one for each of Phases II and III. Sample ALJs were identified from a roster of ALJs stratified by allowance rate into three equal groups based on experience for the 6-month period ending September 1, 1980. Each sample of 48 was composed of 16 ALJs from each of the high (68–100 percent), medium (55–67 percent), and low (0–54 percent) allowance rate levels. In those intances where an ALJ was unable to participate, a replacement was assigned from the same stratum.

IV. Review Procedures

A. Folder Preparation

1. Lists of sample cases were prepared indicating whether the case was a DI (including concurrent DI/SSI) or SSI claim, an allowance or denial, and giving the current location of the claim folder. Sample case folders were retrieved and associated with the cassette recording of the hearing if a hearing had been held.
2. The original hearing decision was separated from the rest of the material and placed in a sealed envelope.
3. If the case was designated for use in Phases II and III of the study, the evidence in the folder was separated into three parts:

   a. All of the evidence considered in connection with the reconsideration determination was placed in one section.
   b. All additional evidence considered by the ALJ with a date of origin before the date of the reconsideration, and received after the reconsideration determination, was placed in a second section.
   c. All of the remaining evidence received after reconsideration was placed in a third section.

B. Phase I Review Procedures

1. Office of Assessment
   The first review was done by the Medical Consultant Staff and OA examiners, using the rules governing the DDSs and without knowledge of the original ALJ decision.

   a. Medical Consultant Staff—MCS performed a front-end review of all 3,600 cases in the baseline sample. A severity rating was made on each case based upon the total evidence in file. Cassette recordings of the hearing (if held) were considered as part of the evidence. The tape was audited to determine if there was medical or vocational specialist testimony at the hearing. The tape was flagged for MCS if it contained testimony from a medical specialist. Otherwise, the tape was audited at the discretion of the reviewer.

Two additional ratings were made at the same time on cases to be included in Phase III of the study. The folders requiring additional ratings had the evidence divided into three sections as described above. Medical evaluation progressed from the first section (reconsideration evidence only) to the third (all evidence) with a separate evaluation form being filled out as each section of additional evidence was added. Reports of residual functional capacity were also prepared for cases where the individual's impairment was significant but did not meet the level shown in the Medical Listings.

b. OA Examiner Review—The OA examiner was required to review the total evidence in file, including the evaluation made by MCS, and to decide whether that evidence supported an allowance or denial using the standards of evaluaton set forth in the POMS. If the case was designated for Phase III, the examiner also made a decision of allowance or denial based on the evidence available at the time of reconsideration.

2. Appeals Council Review

A de novo decision was made by the Appeals Council for each assigned case to the Appeals Council subsample and a study questionnaire was completed by an OHA analyst for each Appeals Council decision.

C. Phase II ALJ Review Procedures

Since new hearings could not be held as part of the study, written transcripts were made from the cassettes for each of the Phase II cases. These transcripts were used as the source of the expert testimony which had been presented at the original hearing. However, any testimony by the claimant or observations about the claimant's personal appearance were edited out of the transcript by an OA examiner. The cases were distributed at random to the Phase II ALJs. A decision to allow or deny, based on the evidence in the file and the edited transcript, was made for each case.

D. Phase III ALJ Review

The folders with only that evidence which was present at the time of reconsideration were distributed at random to the Phase III ALJs. A decision to allow or deny based on this evidence was made for each case.

V. Estimation Procedures

A. Phase I Sample

As indicated previously, the study was based not on a simple random sample, but rather on a stratified random sample with unequal sampling rates. As a result, estimates for the population of claims represented by the study sample could not be derived simply by inflating the sample results. Instead, case weights were constructed for each stratum separately to account for the unequal sampling rates and the cases which were out-of-scope or which could not be retrieved. A stratified ratio estimation technique was then used to make population estimates.

Case weights were constructed using the following formula. The weight W_{hm} for the mth month and the hth stratum is given by:

$$W_{hm} = (N_{hm} \times P_{hm})/n_{hm}$$

where

N_{hm} is the population for the h stratum in the mth month.

P_{hm} is the estimated proportion of in-scope cases in the hth stratum for the mth month.

n_{hm} is the number of completed sample cases in the hth stratum for the mth month.

The estimator of the in-scope population value for a characteristic, y, from the Phase I sample takes the form:

$$y = \sum_{h=1}^{12} \sum_{m=1}^{5} \sum_{i=1}^{n_{hm}} W_{hm} Y_{hmi} \quad (1)$$

where

y_{hmi} is the value of the characteristic for the ith case in the mth month, in hth stratum.

The last column of Table 2 shows the stratum weights for the Phase I sample.

B. Appeals Council Sample

The estimator for the Appeals Council sample takes the same form as equation (1) above with an adjustment for the case weights to account for the subsampling of agreement cases previously described and to bring stratum estimates up to stratum population totals.

The Appeals Council weights were constructed as follows:

$$W_{hm}^{(AC)} = \begin{cases} \dfrac{n_{hm}}{(n_{hmd} + n_{hma})} \cdot W_{hm} \text{ for disagreements} \\ \dfrac{n_{hm}}{(n_{hmd} + 6\, n_{hma})} \cdot W_{hm} \cdot 6 \text{ for agreements} \end{cases}$$

where

n_{hm} and W_{hm} are defined as above.

n_{hmd} and n_{hma} represent the number of sample disagreements and agreements between OA and the original decision.

C. Phases II and III Sample

The estimator for this sample takes the same form as equation (1) above except that the weight W_{hm} is doubled for the denial strata (h = 1,..., 6).

VI. Estimation of Sampling Variances and Covariances

The variance estimator was derived by dividing each stratum into 10 random groups using the terminal digit of the case Social Security number. Variances and covariances were derived using the standard stratified random group estimator.

Standard error information is given in Table 4. Two words of caution are in order. First, the estimates of standard error for the Appeals Council sample are overestimated (that is conservative).[2] Second, when making contrasts of percentages between decisionmakers on the same sample or between phases for the same decisionmaker, there are large positive sampling covariances between the estimates. Thus, the square root of the sum of the squares of the standard error for the two estimates would overestimate the standard error of the difference of the estimates.

[2] A generalized attribute curve did not fit well to the individual rel- variances for the Appeals Council subsample.

TABLE 1.—Population totals—stratum by month

Stratum				Month				
Original decision	Type of claim	ALJ allowance rate	Total	Sept.	Oct.	Nov.	Dec.	Jan.
Total			80,783	17,502	17,268	16,265	14,966	14,782
1. Denial	DI	Low	10,527	2,349	2,313	2,062	1,809	1,994
2. Denial	DI	Medium	8,559	1,790	1,800	1,655	1,629	1,685
3. Denial	DI	High	3,131	658	700	624	591	558
4. Denial	SSI	Low	3,502	742	766	728	651	615
5. Denial	SSI	Medium	2,798	563	571	549	502	613
6. Denial	SSI	High	3,843	208	227	211	198	201
7. Allowance	DI	Low	10,661	2,331	2,291	2,191	1,944	1,904
8. Allowance	DI	Medium	16,514	3,470	3,467	3,298	3,097	3,182
9. Allowance	DI	High	13,993	3,212	3,000	2,847	2,680	2,254
10. Allowance	SSI	Low	2,776	576	595	581	517	507
11. Allowance	SSI	Medium	4,000	827	814	834	777	748
12. Allowance	SSI	High	3,331	776	724	685	571	575

TABLE 2.—Completion rates for the phase 1 sample

Strata	Month	Target	Number of sample cases	Phase 1 sample: Number of cases retrieved: Total	Phase 1 sample: Number of cases retrieved: Percent inscope	Phase 1 sample: Phase 1 inscope case weights
1	Total	200	252			
	September		83	76	90	31
	October		42	37	95	61
	November		42	34	91	61
	December		42	38	92	48
	January		42	37	89	54
2	Total	200	252			
	September		83	77	94	23
	October		42	35	97	51
	November		42	35	94	47
	December		42	39	95	42
	January		42	39	95	43
3	Total	200	252			
	September		83	77	87	8
	October		42	35	94	20
	November		42	38	95	16
	December		42	38	90	16
	January		42	37	95	16
4	Total	200	252			
	September		83	79	87	10
	October		42	35	86	22
	November		42	37	73	20
	December		42	38	90	17
	January		42	39	80	16
5	Total	200	252			
	September		83	80	88	7
	October		42	34	82	17
	November		42	38	82	14
	December		42	38	71	13
	January		42	39	92	16
6	Total	200	252			
	September		83	82	79	3
	October		42	32	84	7
	November		42	32	66	7
	December		42	37	78	5
	January		42	39	85	5
7	Total	400	499			
	September		167	151	97	15
	October		83	76	99	31
	November		83	76	97	29
	December		83	76	100	26
	January		83	75	99	25
8	Total	400	499			
	September		167	145	98	24
	October		83	80	100	43
	November		83	71	99	46
	December		83	72	100	43
	January		83	73	100	44
9	Total	400	499			
	September		167	155	98	21
	October		83	74	97	40
	November		83	63	95	39
	December		83	73	99	36
	January		83	74	99	30
10	Total	400	499			
	September		167	131	80	4
	October		83	67	94	9
	November		83	57	84	10
	December		83	70	89	7
	January		83	71	90	7
11	Total	400	499			
	September		167	148	87	6
	October		83	69	83	12
	November		83	64	91	13
	December		83	70	81	11
	January		83	76	86	10

TABLE 2.—Completion rates for the phase 1 sample—continued

Strata	Month	Target	Number of sample cases	Phase 1 sample: Number of cases retrieved: Total	Phase 1 sample: Number of cases retrieved: Percent inscope	Phase 1 sample: Phase 1 inscope case weights
12	Total	400	499			
	September		167	135	83	6
	October		83	68	91	11
	November		83	59	92	12
	December		83	75	84	8
	January		83	74	80	8

TABLE 3.—Appeals council subsample counts

	Total	Appeals council decision obtained	Appeals council decision not obtained
Total	3,558	2,183	1,375
OA agreed	1,579	255	1,324
OA disagreed	1,979	1,928	51

TABLE 4.—Standard error tables

A. Phase I sample

Base of percent	Standard error on estimated percent: 5 or 95	10 or 90	15 or 85	20 or 80	30 or 70	40 or 60	50
2,500	2.2	3.1	3.7	4.2	4.8	5.2	5.3
5,000	1.6	2.2	2.7	3.0	3.5	3.7	3.8
7,500	1.3	1.8	2.2	2.5	2.9	3.1	3.2
10,000	1.1	1.6	1.9	2.2	2.5	2.7	2.8
25,000	.7	1.0	1.3	1.4	1.7	1.8	1.8
50,000	.5	.8	.9	1.0	1.2	1.3	1.4
75,000	.5	.6	.8	.9	1.0	1.1	1.2

B.—Appeals Council subsample

2,500	3.0	4.6	5.7	6.7	8.1	8.9	9.4
5,000	2.4	3.7	4.6	5.4	6.6	7.3	7.6
7,500	2.1	3.3	4.1	4.8	5.8	6.5	6.8
10,000	1.9	3.0	3.8	4.4	5.4	6.0	6.3
25,000	1.5	2.3	2.9	3.4	4.2	4.7	4.9
50,000 and over	1.2	1.9	2.4	2.8	3.5	3.9	4.1

C.—Phase II/phase III subsample

2,500	1.9	2.7	3.2	3.7	4.3	4.6	4.8
5,000	1.4	2.0	2.4	2.7	3.2	3.4	3.6
7,500	1.2	1.7	2.0	2.3	2.7	2.9	3.0
10,000 and over	1.0	1.5	1.8	2.0	2.4	2.6	2.7