OIG Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

Congressional Response Report

Disability Denials in 2009 in Buchanan, Oklahoma, and Dallas Counties

A-01-13-23072 | April 2014

OIG Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

April 25, 2014

The Honorable Carl Levin
Chairman, Permanent Subcommittee on
Investigations
Committee on Homeland Security and Government Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Levin:

In a November 5, 2012 letter, you asked for our assistance in ensuring the Social Security Administration (SSA) is not denying benefits to individuals who deserve them.

My office is committed to conducting reviews that identify areas in which SSA can improve the effectiveness and efficiency of its programs and operations. Thank you for bringing your concerns to my attention. The report highlights various facts pertaining to our review of 300 disability cases in Buchanan County, Virginia; Oklahoma County, Oklahoma; and Dallas County, Alabama. To ensure SSA is aware of the information provided to your office, we are forwarding a copy of this report to the Agency.

If you have any questions concerning this matter, please call me or have your staff contact Kristin Klima, Congressional and Intragovernmental Liaison at (202) 358-6319.

Sincerely,

Patrick P. O'Carroll, Jr.
Inspector General

Enclosure

cc:
Carolyn W. Colvin

OIG Office of the Inspector General
SOCIAL SECURITY ADMINISTRATION

April 25, 2014

The Honorable John McCain
Ranking Member, Permanent Subcommittee on
Investigations
Committee on Homeland Security and Government Affairs
United States Senate
Washington, D.C. 20510

Dear Senator McCain:

In a November 5, 2012 letter, the Permanent Subcommittee on Investigations asked for our assistance in ensuring the Social Security Administration (SSA) is not denying benefits to individuals who deserve them.

My office is committed to conducting reviews that identify areas in which SSA can improve the effectiveness and efficiency of its programs and operations. Thank you for bringing your concerns to my attention. The report highlights various facts pertaining to our review of 300 disability cases in Buchanan County, Virginia; Oklahoma County, Oklahoma; and Dallas County, Alabama. To ensure SSA is aware of the information provided to your office, we are forwarding a copy of this report to the Agency.

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SOCIAL SECURITY ADMINISTRATION

April 25, 2014

The Honorable Tom Coburn, M.D.
Member, Permanent Subcommittee on
Investigations
Committee on Homeland Security and Government Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Coburn:

In a November 5, 2012 letter, you asked for our assistance in ensuring the Social Security Administration (SSA) is not denying benefits to individuals who deserve them.

My office is committed to conducting reviews that identify areas in which SSA can improve the effectiveness and efficiency of its programs and operations. Thank you for bringing your concerns to my attention. The report highlights various facts pertaining to our review of 300 disability cases in Buchanan County, Virginia; Oklahoma County, Oklahoma; and Dallas County, Alabama. To ensure SSA is aware of the information provided to your office, we are forwarding a copy of this report to the Agency.

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Carolyn W. Colvin

Disability Denials in 2009 in Buchanan, Oklahoma, and Dallas Counties
A-01-13-23072

April 2014 **Office of Audit Report Summary**

Objective

To determine whether the Social Security Administration (SSA) followed the *Social Security Act* and its regulations, policies, and procedures when it denied claims for disability benefits in 2009 for individuals from Buchanan County, Virginia; Oklahoma County, Oklahoma; and Dallas County, Alabama.

Background

On November 5, 2012, the Senate Committee on Homeland Security and Government Affairs, Permanent Subcommittee on Investigations (PSI), requested a review of disability denials in three specific counties.

The *Social Security Act* defines disability as a medically determinable impairment(s) that prevents an adult from engaging in any substantial gainful activity and causes a child to have marked and severe functional limitations. To carry out the provisions in the Act, SSA put policies and procedures in place.

For our review, we determined whether SSA (including the disability determination services [DDS]) followed certain policies and procedures when denying disability claims.

Our Findings

In our sample of 300 cases, we found 28 in which SSA (or the DDSs) did not follow some policies and procedures. However, although SSA did not follow certain policies and procedures, it correctly denied benefits in these 28 cases based on the evidence available for our review.

Below are the policies and procedures SSA did not follow.

- Making a reasonable attempt to obtain all relevant evidence related to a claimant's condition.
- Considering medical opinions.
- Asking the treating source(s) to conduct a consultative examination or ruling the source out.
- Determining the credibility of the claimant's statements regarding his/her symptoms.
- Assessing the severity of multiple non-severe impairments in combination.
- Determining whether the claimant could do past relevant work or any other work.

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ABBREVIATIONS

AC	Appeals Council
Act	*Social Security Act*
ALJ	Administrative Law Judge
CE	Consultative Examination
C.F.R.	Code of Federal Regulations
CY	Calendar Year
DDS	Disability Determination Services
eCAT	Electronic Claims Analysis Tool
OASDI	Old-Age, Survivors and Disability Insurance
OIG	Office of the Inspector General
POMS	Program Operations Manual System
PRW	Past Relevant Work
PSI	Permanent Subcommittee on Investigations
RFC	Residual Functional Capacity
SGA	Substantial Gainful Activity
SSA	Social Security Administration
SSI	Supplemental Security Income
U.S.C.	United States Code

OBJECTIVE

Our objective was to determine whether the Social Security Administration (SSA) followed the *Social Security Act* (Act) and its regulations, policies, and procedures when it denied claims for disability benefits in 2009 for individuals from Buchanan County, Virginia; Oklahoma County, Oklahoma; and Dallas County, Alabama.

BACKGROUND

On September 13, 2012, the Senate Committee on Homeland Security and Government Affairs, Permanent Subcommittee on Investigations (PSI), issued a report on *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions*. The PSI sampled 300 disability allowances and concluded that, in more than 25 percent of the cases, SSA did not properly address insufficient, contradictory, or incomplete evidence. Based on these findings, on November 5, 2012, PSI asked us to conduct a similar review of disability denial decisions. See Appendix A for the request.

SSA provides disability benefits to eligible individuals through its Old-Age, Survivors and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs under Titles II and XVI of the Act.[1] The Act considers an adult disabled if he/she is unable to engage in any substantial gainful activity (SGA) because of a medically determinable impairment(s) that can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 months. The Act also considers a child disabled for SSI purposes if he/she has a medically determinable impairment(s) that causes marked and severe functional limitations and can be expected to result in death or, has lasted, or can be expected to last, for a continuous period of not less than 12 months.[2]

To determine whether an adult is disabled, SSA's regulations provide a five-step sequential evaluation process. This process generally considers whether the claimant

1. is performing SGA,
2. has a severe condition that meets the duration requirement,
3. has a condition that meets or medically equals a listing on SSA's Listing of Impairments,

[1] The OASDI program covers workers and their dependents or survivors, while the SSI program covers financially needy individuals. Act §§ 202 *et seq.*, 223 *et seq.*, and 1611 *et seq.*, 42 U.S.C. §§ 402 *et seq.*, 423 *et seq.*, and 1382 *et seq*.

[2] Act §§ 216(i)(1), 223(d)(1), and 1614(a)(3), 42 U.S.C. §§ 416(i)(1), 423(d)(1), and 1382c(a)(3). *See also* 20 C.F.R. §§ 404.1505, 416.905, and 416.906.

4. can perform past relevant work (PRW), and

5. can perform any other work.[3]

SSA's regulations also provide a similar three-step sequential evaluation process for evaluating disability in children.[4] For both processes, the adjudicator generally follows the steps in order. As soon as the adjudicator can make a decision at a step, he/she stops the analysis and makes a decision. (For more information about these processes, see Appendix B.)

A State disability determination services (DDS) generally makes the initial disability determination for SSA using SSA's regulations. If an individual disagrees with the initial determination, SSA's regulations give him/her the right to file an appeal within 60 days from the date of notification of the determination. In most cases, an individual may request up to four levels of appeal: (1) reconsideration by a DDS, (2) hearing by an administrative law judge (ALJ), (3) review by the Appeals Council (AC), and (4) review by a Federal Court.[5] (See Appendix C for more information about the initial disability determination and appeals processes.)

To carry out the aforementioned regulations, SSA put numerous policies and procedures in place. For our review, we determined whether SSA (including the DDSs) was following certain policies and procedures, as described below, when appropriate.

- *Determined whether the claimant was performing SGA*. SGA is the performance of significant physical/mental activities in work for pay or profit or in work of a type generally performed for pay or profit. In 2009, employees' "countable earnings" indicated SGA and self-employed individuals' "countable income" was "substantial" if the amount averaged more than $980 per month for non-blind individuals or $1,640 for blind individuals.[6]

- *Made a reasonable attempt to obtain all relevant evidence related to the claimant's condition*. This evidence may include statements from the claimant and other sources about the claimant's impairment(s), restrictions, daily activities, etc. This evidence also includes medical records for at least the 12 months before the claimant's application filing date, unless SSA needs to develop for an earlier period or the claimant alleges a disability that began less than 12 months before the filing date.[7]

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[3] 20 C.F.R. §§ 404.1520 and 416.920.

[4] 20 C.F.R. § 416.924.

[5] Act § 1869 *et seq.*, 42 U.S.C. § 1395ff *et seq*.

[6] 20 C.F.R. §§ 404.1572 and 416.972. *See also* SSA, POMS, DI 10501.001 (January 5, 2007) and DI 10501.015 B and C (November 1, 2013).

[7] SSA, POMS, DI 22505.001 (December 17, 2013) and DI 25501.210 C.3 (November 19, 2012).

- *Considered medical opinions*. Medical opinions come from the (1) claimant's physician, psychologist, or other acceptable medical sources or (2) DDS medical/psychological consultants. DDS medical/psychological consultants can be physicians, psychologists, psychiatrists, optometrists, podiatrists, or speech-language pathologists. At the initial and reconsideration levels, these consultants make findings of fact on medical issues, such as the existence and severity of an individual's impairment. At the hearing and AC levels, the ALJ and AC treat these findings of fact as opinions and must consider them when making a decision about disability.[8]

- *Resolved conflicts between records from different medical sources*. SSA may be able to resolve such conflicts by re-contacting the medical sources for additional evidence or having the claimant undergo a consultative examination (CE), which is a physical/mental examination or test paid for by SSA.[9]

- *Asked the treating source(s) to conduct a CE or ruled the source(s) out*. In addition to resolving conflict(s), SSA requests CEs when there is insufficient evidence. A treating source is ordinarily preferred to perform the CE because he/she is often in the best position to provide detailed information about the nature and severity of a condition. A treating source is a claimant's physician, psychologist, or other acceptable medical source who has provided the claimant with ongoing medical treatment or evaluation.[10]

- *Determined the credibility of a claimant's statements about his/her symptoms*. The adjudicator determines whether the claimant has an impairment that could reasonably be expected to produce the symptoms he/she alleges based on the objective medical evidence. If there is such an impairment, SSA must then assess the claimant's statements concerning the intensity, persistence, and limiting effects of his/her symptoms based on all the evidence.[11]

- *Assessed the severity of multiple non-severe impairments in combination*. The adjudicator must assess the combined impact of multiple non-severe impairments, rather than the impact of each impairment, on the ability to function.[12]

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[8] 20 C.F.R. §§ 404.1616 and 416.1016. *See also* Social Security Ruling 96-6p: *Policy Interpretation Ruling Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence*, July 2, 1996. *See also* SSA, POMS, DI 24515.002 A.5 (June 13, 2001) and DI 24515.013 (February 14, 2001).

[9] SSA, POMS, DI 22505.008 B (February 28, 2001) and DI 22510.001 A.1 (November 30, 2012).

[10] SSA, POMS, DI 22510.007 A.1 (November 26, 2012) and DI 22510.010 B.1 (December 20, 2011). *See also* SSA, *Medical/Professional Relations*, http://www.ssa.gov/disability/professionals/bluebook/general-info.htm.

[11] SSA, POMS, DI 24515.066 A (May 13, 1999).

[12] SSA, POMS, DI 22001.015 3 (March 30, 1994).

- *Made a reasonable effort to obtain relevant work history*. Relevant work history refers to information on jobs a claimant generally worked over the past 15 years before SSA adjudicated his/her claim. Such information includes job descriptions, hours worked in a week, pay, type and level of physical and mental activities, etc.[13]

- *Determined whether the claimant could do PRW*. SSA defines PRW as work that was SGA, performed during the relevant 15-year period, and performed long enough to learn it. SSA determines whether an individual can do PRW by comparing his/her residual functional capacity (RFC) to the physical and mental demands of his/her PRW.[14]

- *Determined whether the claimant could do any other work.* SSA defines other work as work that is SGA and exists in significant numbers in the national economy. SSA will determine whether a claimant can do other work if he/she can adjust to it, considering his/her RFC, age, education, and work experience.[15]

To conduct our review, we randomly selected 300 cases from the populations in Table 1. These populations are similar to those PSI identified in its review of allowance decisions.

Table 1: Populations

Number of Calendar Year 2009 Disability Denials for Individuals from Buchanan, Oklahoma, and Dallas Counties	Level of Adjudication
3,917	Initial
1,784	Reconsideration[16]
285	Hearing
105	AC
16	Federal Court

[13] SSA, POMS, DI 25001.001 B.65 (March 5, 2013) and SSA, *Adult Disability and Work History Report More Info: How We Decide Whether you Can Do Your Past Work*, http://www.socialsecurity.gov/hlp/radr/10/ent001-app-process3.htm (October 22, 2012).

[14] An individual's impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what he/she can do in a work setting. The RFC is the most the individual can still do despite these limitations. SSA assesses RFC based on all relevant evidence in the case record. 20 C.F.R. §§ 404.1545 and 416.945. *See also* SSA, POMS, DI 25001.001 B.60 (March 5, 2013) and DI 25005.001 B (September 19, 2011).

[15] SSA, POMS, DI 22001.030 (September 30, 1991) and DI 25015.001 (July 26, 2011).

[16] SSA eliminated the reconsideration step for individuals living in certain States, as part of its Disability Redesign Prototype. Dallas County is in one of these States. However, in a few of the Dallas County cases, the individuals lived in non-Prototype States when they filed their initial disability claims. Therefore, they requested reconsiderations after SSA denied their initial claims.

For each sample case, we generally reviewed information in the electronic disability folder and on the Summary Earnings Query, as appropriate.[17] Through this analysis, we identified some cases in which (a) SSA did not follow some of its policies and procedures, even though it correctly denied benefits or (b) we questioned the denial determinations, even though the Agency followed the policies and procedures we tracked. We sent these cases to SSA for review and confirmation. (For more information on our scope and methodology, see Appendix D.)

RESULTS OF REVIEW

Of the 300 sample cases, we found 28 in which SSA (or the DDSs) did not follow some policies and procedures. Despite this, the Agency correctly denied benefits to these claimants based on the evidence we reviewed. In the remaining 272 cases, we found no issues.

SSA Policies and Procedures Not Followed

In 28 cases, SSA did not follow some of its policies and procedures. Table 2 and Table 3 summarize these policies and procedures by adjudicative level and county within which the claimants lived at the time of adjudication. (See Appendix E for tables that summarize these policies and procedures by program title and denial reason.)

[17] For initial cases, we generally reviewed the initial level information in the electronic folders. For reconsideration cases, we generally reviewed the initial and reconsideration level information in the electronic folders. For hearing cases, we generally reviewed the initial, reconsideration, and hearing level information in the electronic folders. For the AC and Federal Court cases, we reviewed the same information as we did for the hearing cases since the AC does not adjudicate the issue of underlying disability, but instead whether there is a basis to grant review of the hearing decision, and SSA is not responsible for making the Federal Court decisions. 20 C.F.R. §§ 404.970 and 416.1470.

Table 2: SSA Policies and Procedures Not Followed at Each Adjudicative Level

SSA Policy and Procedure Not Followed	Initial	Reconsideration	Hearing	AC[18]	Federal Court	Total Cases
Cases that Did Not Meet One Policy and Procedure						
1. Making a Reasonable Attempt to Obtain All Relevant Evidence Related to the Claimant's Condition	0	1	3	8	0	**12**
2. Considering Medical Opinions	1	0	1	1	0	**3**
3. Asking the Treating Source(s) to Conduct a CE or Ruling the Source(s) Out	0	0	0	2	0	**2**
4. Determining the Credibility of the Claimant's Statements Regarding His/Her Symptoms	0	2	0	0	0	**2**
5. Assessing the Severity of Multiple Non-severe Impairments in Combination	2	2	0	0	0	**4**
6. Determining Whether the Claimant Can Do PRW or Any Other Work	0	0	0	1	0	**1**
Subtotal	**3**	**5**	**4**	**12**	**0**	**24**
Cases that Did Not Meet *More Than One* Policy and Procedure						
Items 4 and 5 (above)	0	1	0	0	0	**1**
Items 2 and 4 (above)	0	1	0	0	0	**1**
Items 1 and 2 (above)	0	0	1	0	0	**1**
Items 1 and 3 (above)	0	0	1	0	0	**1**
Subtotal	**0**	**2**	**2**	**0**	**0**	**4**
Total Cases	**3**	**7**	**6**	**12**	**0**	**28**

[18] Since the AC does not adjudicate the issue of underlying disability, the policies and procedures that were not followed in these cases were attributable to the hearing level.

Table 3: SSA Policies and Procedures Not Followed in Each of the Claimant's Counties

SSA Policy and Procedure Not Followed	Buchanan	Oklahoma	Dallas	Total Cases
Cases that Did Not Meet One Policy and Procedure				
1. Making a Reasonable Attempt to Obtain All Relevant Evidence Related to the Claimant's Condition	0	8	4	**12**
2. Considering Medical Opinions	1	0	2	**3**
3. Asking the Treating Source(s) to Conduct a CE or Ruling the Source(s) Out	0	0	2	**2**
4. Determining the Credibility of the Claimant's Statements Regarding His/Her Symptoms	0	2	0	**2**
5. Assessing the Severity of Multiple Non-severe Impairments in Combination	2	1	1	**4**
6. Determining Whether the Claimant Can Do PRW or Any Other Work	0	1	0	**1**
Subtotal	**3**	**12**	**9**	**24**
Cases that Did Not Meet *More Than One* Policy and Procedure				
Items 4 and 5 (above)	0	1	0	**1**
Items 2 and 4 (above)	0	1	0	**1**
Items 1 and 2 (above)	0	1	0	**1**
Items 1 and 3 (above)	0	0	1	**1**
Subtotal	**0**	**3**	**1**	**4**
Total Cases	**3**	**15**	**10**	**28**

Although SSA did not follow certain policies and procedures in 28 cases, it correctly denied benefits to the claimants based on the evidence available for our review. Examples follow.

- In July 2009, a claimant from Dallas County, Alabama, applied for disability benefits, alleging several conditions, including back problems, a learning disability, and obsessive-compulsive disorder. The DDS examiner made a reasonable effort to obtain all the medical records. In addition, the DDS examiner had the claimant undergo physical and psychological CEs. The report on the psychological CE contained an opinion from the CE provider that the claimant likely could understand, carry out, and remember instructions as well as respond appropriately to supervision, co-workers, and work pressures. In September 2009, the DDS examiner denied the claim for insufficient evidence. When making this determination, the DDS examiner did not consider the psychological CE provider's opinion. However, considering such evidence would not have changed the determination to deny benefits since the evidence supported such a determination.

- In April 2009, a claimant from Oklahoma County, Oklahoma, requested that his denied disability claim be reconsidered, alleging chest pain, low blood pressure, anemia, and depression. The DDS examiner determined these impairments were not severe and therefore denied the claim in June 2009. In determining severity, the examiner assessed the impact of each impairment separately, rather than the combined impact of the impairments, on the claimant's ability to function, as required by policy. However, had the examiner followed policy, the determination would not have changed. In July 2009 and June 2010, the claimant requested a hearing and an AC review, respectively. The ALJ issued an unfavorable decision, and the AC found no reason to review the ALJ's decision.

- In January 2007, a claimant from Oklahoma County, Oklahoma, requested a hearing after he received a denial determination on his reconsideration. He alleged various impairments, including a learning disability, bipolar disorder, and knee problems. The claimant submitted medical records from all but two of his sources, and the hearing office did not make a reasonable effort to obtain the records from these two sources. These two sources treated the claimant for his knee problem as did many of the other sources. In January 2009, the ALJ issued an unfavorable determination. Since the hearing office had some of the medical records on how the knee problem was treated, the missing medical records would not have changed the determination.

SSA Denial Determinations that OIG Questioned

In 3 of the 300 sample cases, we questioned the denial determinations, even though SSA followed the policies and procedures we tracked. SSA reviewed these cases and informed us the determinations were correct.

In one case, the claimant complained of pain in her shoulders, back, and legs. She stated that such activities as lifting, standing, and sitting were very limited because of pain. The DDS examiner determined the claimant was not disabled. However, the ALJ determined the claimant was disabled, even though he did not hold a hearing and essentially used the same evidence as

the DDS examiner. We sent this case to SSA to assist us in determining whether the initial determination was correct.

According to SSA, both determinations were correct. The adjudicators made different determinations because some of the policies and procedures followed involved a certain degree of judgment. For example, since the objective medical evidence on file showed the claimant had impairments that could reasonably be expected to produce pain, the adjudicators had to assess her statements concerning her symptoms' intensity, persistence, and limiting effects based on all the evidence in file. The DDS examiner found those statements only partially credible, while the ALJ found them generally credible. According to SSA, "This is an example where two independent adjudicators can reasonably come to different conclusions when considering all the evidence."

Cases Adjudicated Using SSA's Electronic Claims Analysis Tool

SSA's electronic claims analysis tool (eCAT) is a Web-based application designed to document a disability adjudicator's analysis and ensure the adjudicator considers all relevant Agency policies when making a disability determination. Only 51 of our cases from Buchanan County, Virginia, were adjudicated at the initial or reconsideration levels using eCAT since the Virginia DDS was the only 1 among the components responsible for our cases that had eCAT at the time of adjudication. In these 51 cases, we found the DDS followed all the policies and procedures we tracked—which is similar to what we found in a prior review.[19] Hence, among the 300 cases in our sample, cases documented using eCAT were more likely to follow SSA's policies and procedures than cases adjudicated without eCAT. Since SSA adjudicated our sample cases in 2009, the Agency had implemented eCAT in all DDSs and was developing a similar tool, known as the Electronic Bench Book, for hearing offices.[20]

Other Improvements to the Initial Disability Determination and Appeals Processes

The Agency has also made other improvements to the initial disability determination and appeals processes. These improvements include the development of hearing decision reviews that comprised the following reviews.

- Pre-effectuation reviews of randomly selected cases. These reviews measure ALJ performance and change ALJ decisions if appropriate.

- Post-effectuation focused quality reviews based on identified anomalies or randomly selected cases. For these reviews, SSA may analyze (1) the work of individual adjudicators or other participants in the hearing process (such as medical examiners or claimant representatives) or

[19] SSA OIG, *The Effects of the Electronic Claims Analysis Tool* (A-01-11-21193), July 2011.

[20] We plan to start a review of hearing offices' use of the Electronic Bench Book.

(2) specific issues (such as those involving certain impairments or hearing dismissals). Since these reviews are post-effectuation, they generally do not change the hearing decisions.[21]

The pre- and post-effectuation reviews provide feedback to adjudicators and address concerns in particular cases. Furthermore, SSA informed us these reviews support consistent, legally sufficient, and policy compliant decisionmaking by identifying recurrent decision making issues that can be addressed through training, policy clarification, procedural changes, or software.

In addition to these reviews, SSA developed the Disability Information Gateway Resource tool, which consolidates all links to disability resources and training materials into a searchable database, and the CE policy tool, which contains all CE policy related to the development and review of CE evidence. Both tools are in a central location that disability adjudicators at all levels can use for their resource and training needs.[22]

CONCLUSION

In some of our sample cases, SSA did not follow all of its policies and procedures. Despite this, the Agency correctly denied benefits to the claimants based on the information we reviewed. Since adjudicating these cases in 2009, the Agency has made improvements to the initial disability determination and appeals processes, which SSA developed to promote the consistent application of policies and procedures and enhance the accuracy of disability determinations at each adjudicative level.

[21] SSA OIG, *The Social Security Administration's Review of Administrative Law Judges' Decisions* (A-07-12-21234), March 2012 and *Identifying and Monitoring Risk Factors at Hearing Offices* (A-12-12-11289), January 2013 .

[22] SSA OIG, *Training at Offices that Make Disability Determinations* (A-01-11-21169), March 2012.

APPENDICES

Appendix A – CONGRESSIONAL REQUEST

United States Senate
COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

November 5, 2012

VIA U.S. MAIL & EMAIL (misha.kelly@ssa.gov)

The Honorable Patrick P. O'Carroll, Jr.
Inspector General
Social Security Administration
6401 Security Boulevard
Altmeyer Building, Suite 300
Baltimore, MD 21235

Dear Mr. O'Carroll:

As Ranking Member and Chairman of the U.S. Senate Permanent Subcommittee on Investigations, we write to request the assistance of your office in ensuring the Social Security Administration (SSA) is not improperly denying disability benefits to individuals who may deserve receiving them.

On September 13, 2012, the Subcommittee's Minority Staff issued an investigative report entitled: *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions*. The Subcommittee reviewed certain case files of 300 disability applicants who were awarded benefits through Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), or both, at the initial application and successive levels of appeal.

The investigation found that more than a quarter of the 300 disability case files reviewed failed to properly address insufficient, contradictory, or incomplete evidence. These findings corroborated a 2011 internal SSA review that found decisions made by Administrative Law Judges had errors or were insufficient 22 percent of the time. The case files reviewed by the Subcommittee were from counties in regions with error rates ranging from 22 to 26 percent, according to SSA findings.

We are also concerned that individuals who were denied benefits may have been subject to similar types of errors or insufficient decisions. Therefore, to protect the integrity of the disability application and appellate process, we are requesting that your office analyze a similar sample of cases that were denied at initial application and each level of appeal.

We look forward to working with you and your office on this request. If you have any questions, please contact Daniel Goshorn (Senator Levin) at 202/224-4664 or Andrew Dockham (Senator Coburn) at 202/224-2224.

Sincerely,

Tom Coburn, M.D.
Ranking Member
Permanent Subcommittee on Investigations

Carl Levin
Chairman
Permanent Subcommittee on Investigations

Appendix B – Evaluating Disability in Adults and Children

The *Social Security Act* (Act) considers an adult to be disabled if he/she is unable to engage in any substantial gainful activity (SGA)[1] because of a medically determinable physical or mental impairment (or combination of impairments) that can be expected to result in death or that has lasted, or can be expected to last, for a continuous period of not less than 12 months.[2]

The Social Security Administration (SSA) has a five-step sequential process for evaluating disability for adults that generally follows the definition of disability in the Act (see Figure B-1).[3] SSA generally follows the steps in order. As soon as SSA can make a decision at a step, the analysis stops, and SSA makes a decision.

At Step 1, SSA generally considers whether the claimant is performing SGA. If the claimant is performing SGA, SSA finds him/her not disabled, regardless of the severity of his/her impairments. If the claimant is not performing SGA, SSA generally requests all the evidence needed for consideration at Steps 2 through 5.

At Step 2, SSA determines whether the claimant's impairment—or combination of impairments—is severe.[4] If the claimant does not have a severe medically determinable impairment(s) that meets the duration requirement, SSA denies the claim. If the claimant has a severe medically determinable impairment(s) that meets the duration requirement, the Agency goes to Step 3 and looks to the Listing of Impairments. If the severity of the impairment meets or medically equals a specific listing and meets the duration requirement, SSA determines the individual to be disabled.

If the individual's impairment does not meet or medically equal a listing or does not meet the duration requirement, the Agency goes to Step 4, and, if necessary, Step 5. At Step 4, the Agency determines whether the claimant can perform any past relevant work (PRW)[5] by

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[1] SGA means the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. In 2009, "countable earnings" of employees indicated SGA and "countable income" of self-employed individuals was "substantial" if the amount averaged more than $980 per month for non-blind individuals or $1,640 for blind individuals. 20 C.F.R. §§ 404.1572 and 416.972. *See also* SSA, POMS, DI 10501.001 (January 5, 2007) and DI 10501.015 B and C (November 1, 2013).

[2] Act §§ 216(i)(1), 223(d)(1)(A), and 1614(a)(3)(A), 42 U.S.C. §§ 416(i)(1), 423(d)(1)(A), 1382c(a)(3)(A). *See also* 20 C.F.R. §§ 404.1505 and 416.905.

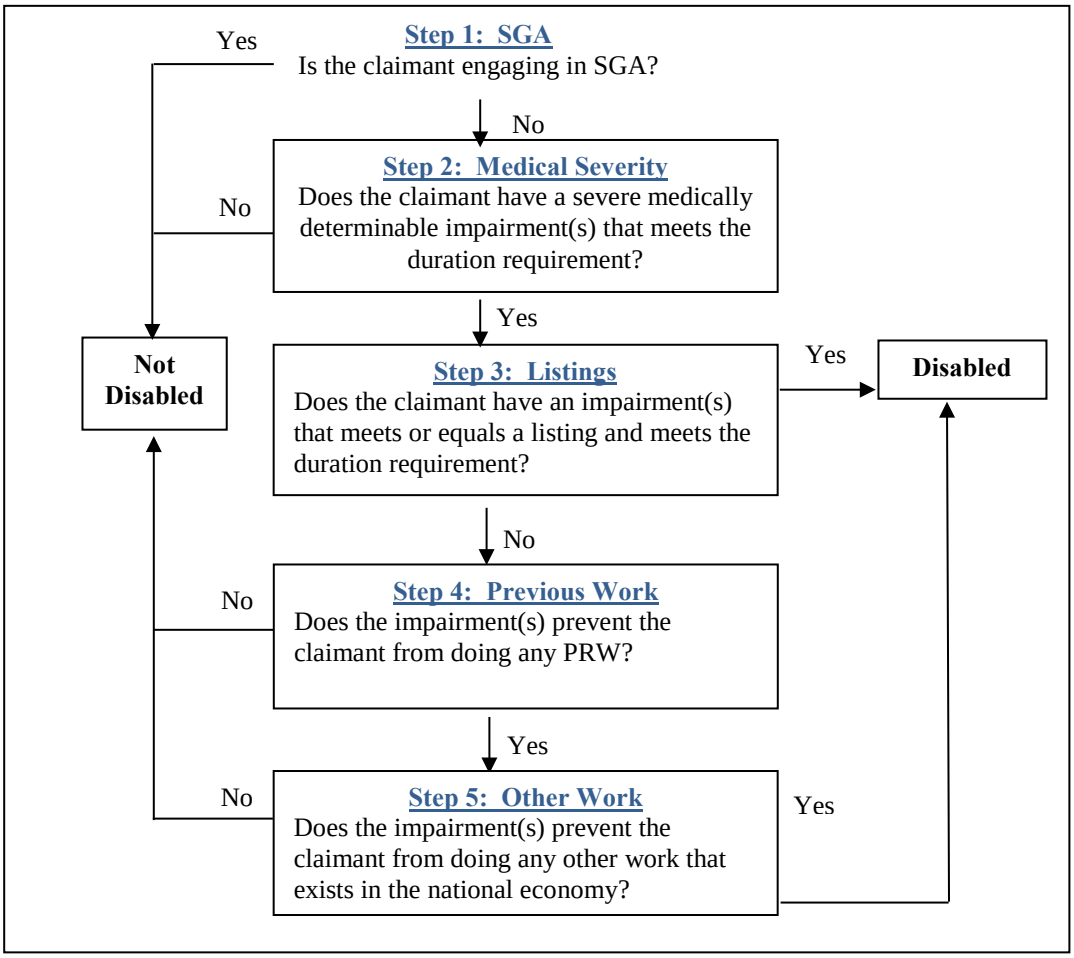
[3] 20 C.F.R. §§ 404.1520 and 416.920.

[4] 20 C.F.R. §§ 404.1520(c), 404.1521, 416.920(c) and 416.921. An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. *See also* Social Security Ruling 85-28, *Titles II and XVI: Medical Impairments that are Not Severe*.

[5] SSA defines PRW as work that was SGA, generally performed within the 15-year period before the date of adjudication, and performed long enough to learn it. 20 C.F.R. §§ 404.1560(b)(1), and 404.1565(a), 416.960(b)(1), and 416.965(a).

comparing his/her residual functional capacity (RFC)[6] to the PRW's physical and mental demands as the claimant performed it or as it is normally performed in the national economy. If the claimant can perform PRW, SSA denies the claim. If the claimant cannot perform PRW, SSA goes to Step 5 and determines whether the claimant can perform any other substantial gainful work that exists in the national economy, considering his/her RFC, age, education, and past work experience. If the claimant can perform any other work, then SSA finds him/her not disabled; if the claimant cannot perform any other work, SSA finds him/her disabled.

Figure B-1: SSA's Five-Step Sequential Evaluation Process for Determining Disability for Adults

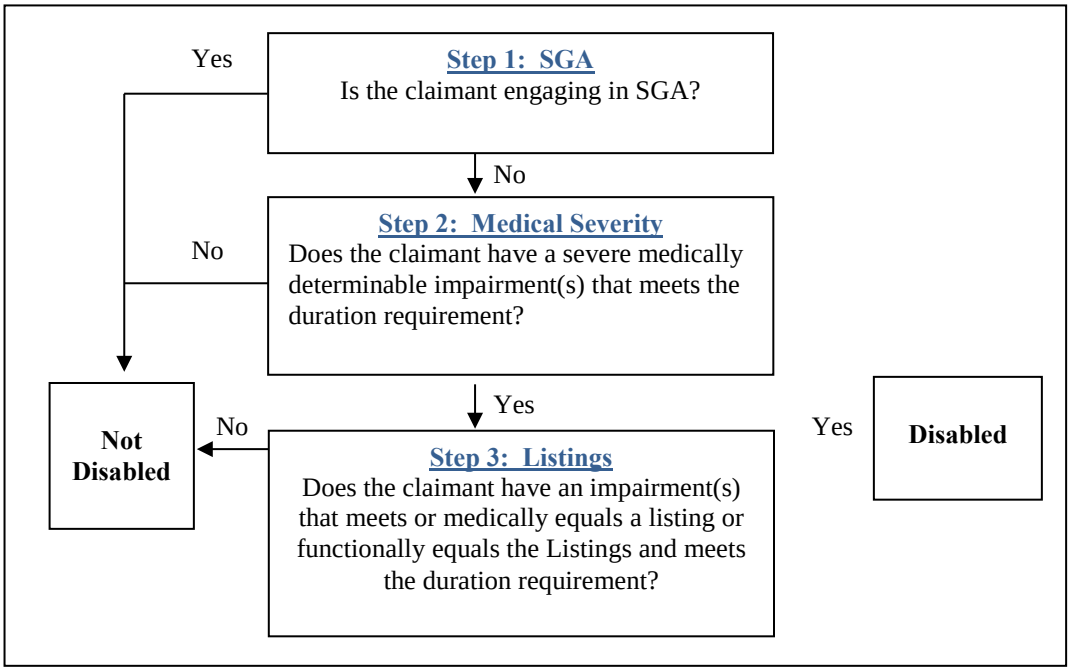


[6] An individual's impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what he/she can do in a work setting. The RFC is the most the individual can still do despite these limitations. SSA assesses RFC based on all relevant evidence in the case record. 20 C.F.R. §§ 404.1545 and 416.945.

The Act considers an individual under age 18 disabled for Supplemental Security Income (SSI) purposes if he/she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations and can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months.[7]

As shown in Figure B–2, SSA has a similar sequential process with three steps for evaluating disability in children under SSI.[8] Steps 1 and 2 are the same as for adults, with "severe" defined in terms of age-appropriate childhood functioning instead of basic work-related activities. At Step 3, SSA determines whether the impairment(s) meets or medically equals a listing or functionally equals the listings and meets the duration requirement.

Figure B–2: SSA's Three-Step Sequential Evaluation Process for Determining Disability for Children



[7] Act § 1614(a)(3)(C), 42 U.S.C. § 1382c(a)(3)(C). *See also* 20 C.F.R. § 416.906.

[8] 20 C.F.R. § 416.924.

Appendix C – Initial Disability Determination and Appeals Processes

Initial Disability Determination Process

State-run disability determination services (DDS) generally make the initial disability determinations for the Social Security Administration (SSA). SSA reimburses the States for all allowable DDS expenses and oversees the quality of the DDS' work. At most DDSs, a disability adjudicatory team comprised of an examiner and medical/psychological consultant[1] uses SSA's regulations to request the relevant medical and other evidence and evaluates the evidence to determine whether a claimant meets the definition of disability under the *Social Security Act*.

Appeals Process

If the claimant disagrees with the initial determination, he/she can file an appeal within 60 days from the date of notification of the determination. In most cases, an individual may request up to four levels of appeal: reconsideration, hearing, Appeals Council (AC) review, and Federal Court review.[2]

Reconsideration

A disability adjudicatory team that did not make the initial determination will evaluate all existing relevant evidence plus any additional evidence submitted and make a new determination.

Hearing

An administrative law judge (ALJ) generally conducts a hearing at a hearing office. Before the hearing, the claimant and his/her representative may examine the evidence used in making the determination under appeal and submit new evidence. At the hearing, the ALJ can question the claimant and any witnesses the claimant brings. The ALJ may request other witnesses, such as medical or vocational experts, to testify at the hearing. The claimant and his/her representative may also question the witnesses.

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[1] Medical/psychological consultant refers to physicians, psychologists, psychiatrists, optometrists, podiatrists, and speech-language pathologists employed by the DDS. 20 C.F.R. §§ 404.1616 and 416.1016. *See also* SSA, POMS, DI 24501.001 B 2 (January 7, 2013). At DDSs that use single decision-makers, a disability examiner can make the disability determination in many cases without approval of a medical/psychological consultant. On November 12, 2010, the Agency implemented a regulation to allow all State disability examiners to make fully favorable determinations in certain cases without the approval of a medical/psychological consultant. 20 C.F.R. §§ 404.1615(c)(3) and 416.1015(c)(3). *See also* SSA, POMS, DI 23023.001 (December 9, 2013).

[2] 20 C.F.R. §§ 404.900 through 404.985 and 416.1400 through 416.1485.

The ALJ does not determine whether the DDS' decision was correct but issues a new (de novo) decision based on the evidence. If the claimant waives the right to appear at the hearing, the ALJ makes a decision based on the evidence on file and any new evidence submitted for consideration. The ALJ may also decide on his/her own not to hold a hearing if he/she can make a fully favorable determination based on such evidence.

Under certain circumstances, an SSA attorney advisor may conduct proceedings before the hearing. As part of the prehearing proceedings, the attorney advisor, in addition to reviewing the existing record, may request additional evidence and schedule a conference with the parties. If after completing these proceedings the attorney advisor can make a fully favorable decision, an attorney advisor may issue the decision.[3]

AC Review

The AC consists of administrative appeal judges and appeal officers. A claimant who is dissatisfied with the hearing office decision can ask the AC to review that decision. The AC may deny, dismiss, or grant a request for review. If the AC denies or dismisses the request for review, the hearing office decision becomes SSA's final decision. If the AC grants the request for review, it can (1) issue its own decision affirming, modifying, or reversing the hearing office decision or (2) remand the case to the hearing office for a new decision, additional evidence, or other action. If the AC issues its own decision, that decision becomes SSA's final decision. The AC may also review a case within 60 days of the hearing office decision on its own motion; that is, without a claimant requesting the review.

Federal Court Review

If a claimant is dissatisfied with SSA's final decision, he/she may file a civil action with the U.S. District Court. The U.S. District Court has the power to dismiss, affirm, modify, or reverse SSA's final decision and may remand the case to SSA for further action, including a new decision.[4] If SSA's final decision is supported by "substantial evidence" and consistent with the *Social Security Act*, the court should affirm the decision.[5] If the U.S. District Court does not find in favor of the claimant, he/she can appeal to the U.S. Court of Appeals (Circuit Court) and ultimately to the U.S. Supreme Court.

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[3] 20 C.F.R. §§ 404.942 and 416.1442.

[4] SSA Handbook § 2014 (November 30, 2010).

[5] Act § 205(g), 42 U.S.C. § 405(g). *See also* SSA, HALLEX, I-3-3-4 (September 8, 2005).

Appendix D – Scope, Methodology, and Sample Results

To accomplish our objective, we:

- Reviewed applicable sections of the Social Security Administration's (SSA) laws, regulations, rules, and procedures.
- Reviewed prior Office of the Inspector General reports related to the disability programs.
- Reviewed the Permanent Subcommittee on Investigations (PSI) report, *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions*, September 2012.
- Analyzed files of cases containing all disability decisions made in Calendar Year (CY) 2009, which we identified in a prior review.[1] From these files and other SSA records (such as the Master Beneficiary Record, Supplemental Security Record, and Office of Hearing and Appeals Query), we obtained the disability denial cases and the ZIP codes for the claimants in most of these cases. With the ZIP codes, we identified the separate populations shown in Table D–1.

Table D–1: Populations

Number of CY 2009 Disability Denials for Individuals from Buchanan, Oklahoma, and Dallas Counties	Level of Adjudication
3,917	Initial
1,784	Reconsideration[2]
285	Hearing
105	Appeals Council (AC)
16	Federal Court

- Selected samples from these populations using the same sampling plan that PSI used in its review. The sampling plan had the following requirements.

1. Select 100 cases from each county, for a total of 300 cases.
2. For each set of 100 cases, select 20 from each level of adjudication.

[1] SSA OIG, *Overall Disability Claim Times for 2009* (A-01-10-10168), May 2011.

[2] SSA eliminated the reconsideration step for individuals living in certain States, as part of its Disability Redesign Prototype. Dallas County is in one of these States. However, in a few of the Dallas County cases, the individuals lived in non-Prototype States when they filed their initial disability claims. Therefore, they requested reconsiderations after SSA denied their initial claims.

3. For each set of 20 cases,

    - At least 15 involve adults who applied for Old-Age, Survivors and Disability Insurance (OASDI) or both OASDI and Supplemental Security Income (SSI) payments.

    - The remaining cases involve children who applied for SSI payments.

4. Also, for each set of 20 cases,

    - at least 5 have a diagnosis of Intellectual Disability,[3]

    - at least 5 have a diagnosis of Other Mental Disorders,

    - at least 5 have a diagnosis of Musculoskeletal System and Connective Tissue, and

    - the remaining cases have other diagnoses from SSA's Listings of Impairments.

Since we did not have enough cases that met all the sampling requirements, we adjusted the plan similar to the adjustments PSI made in its review. Specifically, when there were not enough cases in a particular diagnostic category and adjudicative level, we replaced these cases with

1. cases from another diagnostic category at the same adjudicative level,

2. adult SSI-only cases at the same adjudicative level, or

3. cases from a prior adjudicative level when Steps 1 and 2 were not possible or did not resolve the issue.

For each case, we reviewed information in the claimant's electronic disability folder and on his/her Summary Earnings Query, as appropriate.[4] When there was insufficient information in SSA's electronic disability folder, we replaced the case with another that had the same requirements. Sometimes, this was not possible because of the limited availability of cases within certain diagnostic categories and adjudicative levels. In this situation, we followed Steps 1 through 3 above. See Table D–2 through Table D–4 for the sample sizes we used for each county.

[3] In 2013, SSA replaced the term "mental retardation" with the term "intellectual disability."

[4] For initial cases, we generally reviewed the initial level information in the electronic folders. For reconsideration cases, we generally reviewed the initial and reconsideration level information in the electronic folders. For hearing cases, we generally reviewed the initial, reconsideration, and hearing level information in the electronic folders. For AC and Federal Court cases, we reviewed the same information as we did for the hearing cases since the AC does not adjudicate the issue of underlying disability, but instead whether there is a basis to grant review of the hearing decision, and SSA is not responsible for making the Federal Court decisions. 20 C.F.R. §§ 404.970 and 416.1470.

Table D–2: Buchanan County Sample by Level, Benefit Type, Age Group, and Diagnosis[5]

Level/Benefit Type		Diagnosis for Adults (>/= age 18)				Diagnosis for Children (< age 18)				Total
		Intellectual Disability	Other Mental	Musculo-skeletal	Other	Intellectual Disability	Other Mental	Musculo-skeletal	Other	
Initial	T2/CC[6]	1	7	5	4	0	0	0	0	20
	T16[7]	0	0	0	0	1	1	0	1	
Reconsider-ation	T2/CC	1	7	5 (+17)	4 (+20)	0	0	0	0	57
	T16	1	0	0	0	1	0	0	1	
Hearing	T2/CC	0	3	7	5	0	0	0	0	15
	T16	0	0	0	0	0	0	0	0	
AC	T2/CC	0	1	2	3	0	0	0	0	6
	T16	0	0	0	0	0	0	0	0	
Federal Court	T2/CC	0	0	2	0	0	0	0	0	2
	T16	0	0	0	0	0	0	0	0	
Total		3	18	38	36	2	1	0	2	**100**

[5] We replaced hearing, AC, and Federal Court cases with reconsideration cases in red font in parenthesis.

[6] T2 refers to OASDI benefits and CC refers to concurrent cases, which have both OASDI and SSI payments.

[7] T16 refers to SSI payments.

Table D–3: Oklahoma County Sample by Level, Benefit Type, Age Group, and Diagnosis[8]

Level/Benefit Type		Diagnosis for Adults (>/= age 18)				Diagnosis for Children (< age 18)				Total
		Intellectual Disability	Other Mental	Musculo-skeletal	Other	Intellectual Disability	Other Mental	Musculo-skeletal	Other	
Initial	T2/CC	4	4	4	4	0	0	0	0	20
	T16	0	0	0	0	1	1	1	1	
Reconsider-ation	T2/CC	4	4	4	4	0	0	0	0	20
	T16	0	0	0	0	0	2	1	1	
Hearing	T2/CC	0	10	5	5	0	0	0	0	20
	T16	0	0	0	0	0	0	0	0	
AC	T2/CC	0	10 (+2)	5 (+11)	3 (+4)	0	0	0	0	40
	T16	0	(+2)	(+1)	0	0	0	0	2	
Federal Court	T2/CC	0	0	0	0	0	0	0	0	0
	T16	0	0	0	0	0	0	0	0	
Total		8	32	30	20	1	3	2	4	**100**

[8] We replaced Federal Court cases with AC cases in red font in parenthesis.

Table D–4: Dallas County Sample by Level, Benefit Type, Age Group, and Diagnosis[9]

Level/Benefit Type		Diagnosis for Adults (>/= age 18)				Diagnosis for Children (< age 18)				Total
		Intellectual Disability	Other Mental	Musculo-skeletal	Other	Intellectual Disability	Other Mental	Musculo-skeletal	Other	
Initial	T2/CC	4	4 (+8)	4 (+4)	4 (+2)	0	0	0	0	38
	T16	0	0	0	0	1 (+1)	1 (+1)	1 (+1)	1 (+1)	
Reconsideration	T2/CC	0	0	0	2	0	0	0	0	3
	T16	0	0	0	0	0	0	0	1	
Hearing	T2/CC	0	10 (+1)	5 (+9)	5 (+11)	0	0	0	0	41
	T16	0	0	0	0	0	0	0	0	
AC	T2/CC	0	1	6	5 (+1)	0	0	0	0	18
	T16	1	1	0	0	0	0	0	3	
Federal Court	T2/CC	0	0	0	0	0	0	0	0	0
	T16	0	0	0	0	0	0	0	0	
Total		5	25	28	30	2	2	2	6	**100**

For each case, we determined whether SSA followed these policies and procedures, when appropriate.

- Determined whether the claimant was performing substantial gainful activity (SGA).[10]
- Made a reasonable attempt to obtain all relevant evidence related to the claimant's condition.
- Considered medical opinions.
- Resolved conflicts between records from different medical sources.

[9] We replaced reconsideration cases with initial cases, AC court cases with initial and hearing cases, and Federal Court cases with hearing and AC cases. All replacements are in red font in parenthesis.

[10] SGA means the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. In 2009, "countable earnings" of employees indicated SGA and "countable income" of self-employed individuals was "substantial" if the amount averaged more than $980 per month for non-blind individuals or $1,640 for blind individuals. 20 C.F.R. §§ 404.1572 and 416.972. *See also* SSA, POMS, DI 10501.001 (January 5, 2007) and DI 10501.015 B and C (November 1, 2013).

- Asked the treating source(s) to conduct a consultative examination or ruled the source(s) out.[11]
- Determined the credibility of a claimant's statements regarding his/her symptoms.
- Assessed the severity of the claimant's multiple non-severe impairments in combination.
- Made a reasonable effort to obtain a claimant's relevant work history.[12]
- Determined whether the claimant could do past relevant work or any other work.
- Notified the claimant that the ALJ may dismiss the hearing if he/she or the appointed representative does not appear at the hearing.[13]
- Attempted to establish a good reason for the claimant or appointed representative not appearing at the hearing.
- Received a written request to withdraw the claim.

Through this analysis, we identified 42 cases in which it appeared SSA (a) did not follow some of its policies and procedures, even though it correctly denied benefits or (b) incorrectly denied benefits, even though the Agency followed the policies and procedures we tracked. We sent these 42 cases to SSA for review and confirmation.

We conducted our audit from November 2012 through December 2013 in Boston, Massachusetts. The entities audited were the field offices, disability determination services, and payment service centers under the Office of the Deputy Commissioner for Operations; Disability Quality Branches under the Office of Deputy Commissioner for Budget, Finance, Quality, and Management; and ALJs and AC under the Office of the Deputy Commissioner for Disability Adjudication and Review. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We tested the data obtained for our audit and determined them to be sufficiently reliable to meet our objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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[11] A consultative examination is a physical/mental examination or test that SSA requests at its expense when there is insufficient or conflicting evidence in a case. SSA, POMS, DI 22510.001 (November 30, 2012).

[12] Relevant work history refers to information on jobs a claimant generally worked over the past 15 years before SSA adjudicated his/her claim. Such information includes job descriptions, hours worked in a week, pay, type and level of physical/mental activities, etc. SSA, POMS, DI 25001.001 B.65 (March 5, 2013) and SSA, *Adult Disability and Work History Report More Info: How We Decide Whether you Can Do Your Past Work*, http://www.socialsecurity.gov/hlp/radr/10/ent001-app-process3.htm (October 22, 2012).

[13] For the purposes of this review, we considered dismissals as a type of denial.

Appendix E – Sample Cases with Findings by Title and Denial Reason

The Social Security Administration (SSA) provides disability benefits to eligible individuals through its Old-Age, Survivors and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs under Titles II and XVI of the *Social Security Act* (Act).[1] The Act considers an adult disabled if he/she is unable to engage in any substantial gainful activity (SGA)[2] because of a medically determinable impairment(s) that can be expected to result in death or, has lasted, or can be expected to last, for a continuous period of not less than 12 months. The Act also considers a child disabled for SSI purposes if he/she has a medically determinable impairment(s) that causes marked and severe functional limitations and can be expected to result in death or, has lasted, or can be expected to last, for a continuous period of not less than 12 months.[3] To determine whether an individual is disabled, SSA is required to follow certain policies and procedures, which stem from the definitions of disability.

We sampled 300 disability denials and found that, in 28 cases, SSA did not follow some of its policies and procedures. Despite this, the Agency correctly denied benefits to the claimants based on the evidence available for our review. Table E–1 and Table E–2 summarize these cases by title and denial reason.

[1] The OASDI program covers workers and their dependents or survivors, while the SSI program covers financially needy individuals. Act §§ 202 *et seq.*, 223 *et seq.*, and 1611 *et seq.*, 42 U.S.C. §§ 402 *et seq.*, 423 *et seq*., and 1382 *et seq*.

[2] SGA means the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. In 2009, "countable earnings" of employees indicated SGA and "countable income" of the self-employed was "substantial" if the amount averaged more than $980 per month for non-blind individuals or $1,640 for blind individuals. 20 C.F.R. §§ 404.1572 and 416.972. *See also* SSA, POMS, DI 10501.001 (January 5, 2007) and DI 10501.015 B and C (November 1, 2013).

[3] Act §§ 216(i)(1), 223(d)(1), and 1614(a)(3), 42 U.S.C. §§ 416(i)(1), 423(d)(1), and 1382c(a)(3). *See also* 20 C.F.R. §§ 404.1505, 416.905, and 416.906.

Table E–1: Cases with Findings by Title[4]

SSA Policy and Procedure Not Followed	Title II	Title XVI	Concurrent	All Cases
Cases that Did Not Meet One Policy and Procedure				
1. Making a Reasonable Attempt to Obtain all Relevant Evidence Related to the Claimant's Condition	4	0	8	**12**
2. Considering Medical Opinions	0	0	3	**3**
3. Asking the Treating Source(s) to Conduct a Consultative Examination or Ruling the Source(s) Out[5]	1	0	1	**2**
4. Determining the Credibility of the Claimant's Statements Regarding His/Her Symptoms	0	0	2	**2**
5. Assessing the Severity of Multiple Non-severe Impairments in Combination	1	0	3	**4**
6. Determining Whether the Claimant Can Do Past Relevant Work (PRW) or Any Other Work	1	0	0	**1**
Subtotal	**7**	**0**	**17**	**24**
Cases that Did Not Meet *More Than One* Policy and Procedure				
Items 4 and 5 (above)	0	0	1	**1**
Items 2 and 4 (above)	0	0	1	**1**
Items 1 and 2 (above)	0	0	1	**1**
Items 1 and 3 (above)	0	0	1	**1**
Subtotal	**0**	**0**	**4**	**4**
Total	**7**	**0**	**21**	**28**

[4] Concurrent beneficiaries receive both titles II and XVI benefits simultaneously.

[5] A consultative examination is a physical/mental examination or test that SSA requests at its expense when there is insufficient or conflicting evidence in a case. SSA, POMS, DI 22510.001 (November 30, 2012).

Table E–2: Cases with Findings by Denial Reason

SSA Policy and Procedure Not Followed	Impairment Not Severe	Insufficient Evidence	Capacity for SGA - Any PRW	Capacity for SGA – Other than PRW	All Cases
Cases that Did Not Meet One Policy and Procedure					
1. Making a Reasonable Attempt to Obtain all Relevant Evidence Related to the Claimant's Condition	0	0	4	8	**12**
2. Considering Medical Opinions	0	1	0	2	**3**
3. Asking the Treating Source(s) to Conduct a Consultative Examination or Ruling the Source(s) Out	0	0	0	2	**2**
4. Determining the Credibility of the Claimant's Statements Regarding His/Her Symptoms	0	0	2	0	**2**
5. Assessing the Severity of Multiple Non-severe Impairments in Combination	4	0	0	0	**4**
6. Determining Whether the Claimant Can Do PRW or Any Other Work	0	0	0	1	**1**
Subtotal	**4**	**1**	**6**	**13**	**24**
Cases that Did Not Meet *More Than One* Policy and Procedure					
Items 4 and 5 (above)	1	0	0	0	**1**
Items 2 and 4 (above)	0	0	1	0	**1**
Items 1 and 2 (above)	0	0	1	0	**1**
Items 1 and 3 (above)	0	0	1	0	**1**
Subtotal	**1**	**0**	**3**	**0**	**4**
Total	**5**	**1**	**9**	**13**	**28**

Appendix F – Major Contributors

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