

Preventing Wasteful and Inequitable Consultative Examinations in Social Security Disability Claims

A Position Paper



Mental
Health
Project



Overview

At the heart of a Social Security disability claim is the assessment of whether a claimant's limitations prevent him or her from meeting the mental or physical demands of work. An individual seeking disability benefits from the Social Security Administration (SSA) first files an application at a local SSA office. SSA then refers the application to a state agency to assess the medical information. The state agency frequently sends the applicant for an examination by its own doctors, a consultative examination, who then offer medical opinions about the individual's ability to function in a work setting. This medical opinion becomes part of what the state agency reviews to make a finding of disabled or not disabled on the application. SSA too easily relies on these purchased one-time examinations rather than use resources to obtain existing medical records or functional assessments from the applicant's current treating doctors. SSA spends considerable dollars on this structure by funding the state agency work yet exercises very little oversight into its activities. And, SSA policy treats these one-time examinations as equally persuasive as treating provider reports. This lack of oversight results in wasteful practices and uneven quality in medical opinions, leading to improper denials that necessitate time-consuming appeals or cause people to give up their claims altogether.

I. Introduction to Disability Advocacy Programs

Urban Justice Center's (UJC) Mental Health Project's mission is to end the cycles of homelessness, hospitalization and incarceration experienced by New York City's low-income persons with mental health concerns. New York Legal Assistance Group (NYLAG) works to combat economic, racial, and social injustice by advocating for people experiencing poverty or in crisis. Both UJC and NYLAG are funded by the New York State Disability Advocacy Program to provide high quality direct representation to individuals who have been denied disability benefits by the Social Security Administration and to work to improve the disability process. Community Legal Services of Philadelphia (CLS) provides free civil legal assistance to more than one million low-income Philadelphians. The SSI Unit at CLS provides direct representation to people applying for SSI benefits, as well as to people appealing denials before an administrative law judge and advocates for systemic reform. Together, these organizations have considerable experience with SSA's adjudicative process and the barriers to efficient processing of disability claims.

II. Overview of the Social Security Administration's Disability Process

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits provide modest but vital income support to people with disabilities, many of whom are struggling just to make ends meet.

When people with disabilities apply for SSI or SSDI, extensive medical records are necessary to prove the severity of their symptoms. SSA contracts in each state with a state agency, typically called disability determination services (DDS), to perform the initial disability review and the review for the first level of administrative appeal for disability cases. An analyst in the state agency must request the necessary records from the claimant's treating providers (including doctors and other medical and behavioral health providers). However, if the treating

providers do not respond in a very short period of time or if the request is not properly made, then the state agency sends the claimant to a consultative examination (CE) to solicit a medical opinion.¹ SSA pays for these examinations, and each state has a contract with a medical agency or agencies to provide them. In some states, like New York and Pennsylvania, a private company, Industrial Medicine Associates (IMA), has an exclusive contract to perform CEs.

III. The Role of Consultative Examinations

Consultative examinations are helpful in some circumstances, but CEs should be used only as a last resort. CEs, by regulation, should be used only when SSA cannot obtain the information it needs from treating sources.² CE examinations are not designed to be comprehensive: the evaluators are brand new to the patients, are typically not specialists in the impairments the person presents, and rarely have (or review) sufficient medical records to have context of the claimant's medical history. Instead, CEs rely mostly on a questionnaire completed by the claimant and a brief in-person examination to render their findings. The examination is short: the new doctors spend less than 30 minutes per customer, including time to go over the questionnaire, do the examination, and write up notes for the assessment. Finally, SSA does not adequately supervise the CE program, causing the quality of these examinations and the examination reports to be inconsistent.

Unsurprisingly, the CEs often get the case wrong: they sometimes fail to document or ask about key impairments; they misdiagnose impairments due to limited information; they often fail to document or adequately appreciate functional limitations; and the final medical opinions over-estimate a person's ability to work. Here are two examples:

In one case, a claimant reported to the examiner her abnormal findings on a recent echocardiogram and stress test that her treating provider performed to evaluate her shortness of breath.³ The claimant told the examiner the results showed her "valves were not functioning properly" and she had not been cleared to have bariatric surgery due to these findings. While the examiner listened to her heart with a stethoscope, he did not send her for any other cardiac tests. In his final assessment, the examiner failed to include any cardiac or pulmonary diagnoses, even though he noted that she "complains of shortness of breath which with etiology includes cardiac and pulmonary ailment" and her "cardiac risk factor is compounded by uncontrolled diabetes and hypercholesterolemia which each providers [sic] a number one risk factor for myocardial infarction."

In another example, a psychiatric evaluator overlooked the claimant's longstanding Schizophrenia. The evaluator diagnosed Bipolar Disorder, a diagnosis not identified by any treating source, and then assessed limitations based on an incorrect diagnosis.

In another case, the examiner failed to note in his opinion that the claimant shook during the five-minute interview, that the claimant could not complete a questionnaire on his own, that he was accompanied to the examination, that he could not name what day it was, could not recall which year it was, could not name the current President, could not perform simple math

*without using his fingers, and could not recall anything for the memory and concentration testing. As a result, the examiner's opinion captured only moderate limitations.*⁴

SSA regulations recognize that CEs are supposed to serve only as a backstop in cases where evidence is missing, usually because a claimant has been unable to seek treatment or the agency was unable to secure direct medical evidence from a treating provider.⁵ However, state agencies routinely seek CE assessments even where the claimant has treating providers who could supply medical records and opinions about functioning. Medical records from treating sources already record findings about examinations, rendering a new CE examination duplicative. State agencies over-refer to CEs because it is easier to assign a claimant to a CE than to secure the treating provider records. As a result, CEs are overused and SSA wastes millions of dollars on these cursory and often inadequate examinations. This problem, overreliance on CEs, blossomed into a crisis a few years ago when SSA passed new rules regarding how to treat evidence. In the past, SSA had a policy, coined the “treating physician rule,” that directed that treating provider evidence should be considered more persuasive than evidence from non-treating providers, like CEs. The prioritization of treating-source evidence was consistent with SSA’s guidance directing that CEs should be only used as a last resort. However, in 2017, SSA changed the rules to now allow adjudicators to consider the perfunctory CE examinations as equally persuasive evidence to treating doctors’ reports.⁶ Not only has this new rule created internal inconsistency, but it creates a system where people are subject to unfair denials because a single examination, often by a medical provider who does not specialize in the presenting problems, can dictate the outcome of a claim.

The consequences of these denials are severe. Claimants too frequently abandon their claims after denials—in fiscal year 2020, 721,603 claims were abandoned after the initial and reconsideration denials.⁷ Even if a claim is appealed, the wait may be well more than a year for a final decision to issue.⁸ A long waiting period for crucial benefits exacerbates hardships; a disproportionate number of claimants who appeal die awaiting a final decision compared to the death rate of the general population.⁹ And, frustratingly, we know that many new decisions issued by ALJs are based on a more extensive record than what SSA possessed earlier.¹⁰ This pattern flourishes because SSA rarely if ever oversees the state agency practices or evaluates if the practices comport with its own policies. By allowing state agencies to rely excessively on the CE opinions, SSA endorses a process that prevents countless individuals with disabilities from accessing vital income support.

IV. Poorly Designed Medical Records Development Procedures Increase the Likelihood for a CE

State agency adjudicators are directed to seek out CEs if they do not get sufficient treating provider evidence. The problem is the DDSs struggle to obtain complete medical records¹¹ because medical development procedures are poorly designed to solicit treating provider evidence, and adjudicators are not provided sufficient time to receive it. As a result, state agencies fill in the gap with CEs in cases where comprehensive treating provider evidence is or could be available.

a. State agency medical records development procedures increase the likelihood for a CE.

SSA regulations and internal operating rules dictate how state agencies must collect evidence.¹² These rules, however, are not well calculated to build up medical records for a claim. For example, the internal rules require the state agency to mail or fax requests for medical records to a claimant's treating providers and, if no reply, to follow up after 10-20 days.¹³ This is not an adequate timeframe: Other federal laws provide 30 days for medical providers to respond to medical records requests.¹⁴ As a practical matter, most treating providers operate from large medical facilities with specialized departments that respond to requests for copies of records. A typical response to record requests by NYLAG and UJC in New York City is 40-60 days. CLS sees similar record response times in Philadelphia. Many facilities also subcontract with copier services which can lead to even more delays in the receipt of records as the request makes its way through various layers of processing. Here, SSA does not give treating providers sufficient time to send copies of records.

SSA requirements to follow up on records requests also in inadequate. SSA has tasked state agencies with making "every reasonable effort" to obtain records from treating sources. SSA states "every reasonable effort means that we will make an initial request for evidence from your medical source or entity that maintains your medical source's evidence, and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one follow-up request to obtain the medical evidence necessary to make a determination. The medical source or entity that maintains your medical source's evidence will have a minimum of 10 calendar days from the date of our follow-up request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case."¹⁵

SSA has defined "every reasonable effort" here in a manner that is not reasonably calculated to result in actual receipt of treating source evidence. Advocates nationally report that it often takes 1-3 months to obtain records from health records departments, and advocate best practices include routine follow-up calls and faxes as required, often more than once. In our experience, it is not uncommon for a follow up contact to reveal that the records department did not receive the records request.

If SSA revised its rules to allow appropriate time for requested medical records to come in, then state agencies would be more likely to have treating provider materials to work from and not need to farm out medical development to CEs. We know that adequate time to secure records makes a difference to what is collected because, according to an Office of the Inspector General study in 2014, over 200,000 cases reviewed contained medical evidence at the later hearing level on appeal that the state agency staff could have obtained at the initial decision level but did not.¹⁶ Had SSA policies been well calculated to allow DDSs to get that treating-source evidence at the initial level, it is more likely DDS could have promptly made an accurate disability decision, saving claimants from years of hardship while wading through preventable appeals.¹⁷

b. State agencies fail to secure medical source statements from sources who know the claimant's longitudinal medical history.

SSA considers medical opinions to be a valued part of a medical record.¹⁸ Medical source statements (meaning, opinions from medical sources about someone's ability to complete work tasks with their limitations) are crucial to disability cases because they ask medical professionals tailored questions to elicit opinions about whether someone's disabilities would keep them from working, the key issue in these claims.

Despite the value of this opinion evidence, SSA almost never succeeds in its efforts to have treating doctors send in these valuable opinions. Two reasons for this failure stand out. First, state agencies differ widely in how they ask for an opinion. One state agency includes a checkbox on its medical records request asking if the treating doctor will perform a consultative examination, while another state sends the full medical statement form but to the records department and not directly to the doctor. Records departments will process the request for a copy of medical files, but they cannot "produce" a copy of an opinion that does not exist yet in the record. Further, the records department does not have a process to forward this request directly to the doctor. In other words, the treating doctor very rarely sees the request for a medical opinion.

Second, SSA's internal rules do not specify that these medical opinions must be secured; rather, the internal rules speak to the need to get medical records generally.¹⁹ Further, SSA policy does not require that state agencies do any follow up to solicit these important medical opinions: on the contrary, SSA's operations manual directs state agencies that "you are not required to follow up with a medical source solely to obtain a medical opinion."²⁰ SSA creates a gap in the medical records by failing to take appropriate measures to obtain an opinion from a treating source and then fills the gap with an unnecessary, albeit easier to obtain, CE assessment. It is unsurprising then that SSA, through state agencies, rarely secures valuable medical opinions from treating doctors and instead will rely on CEs to get this important information to adjudicate claims. This problem is well known to the agency. In New York, advocates asked the state agency to 1) send a request for a statement directly to the treating provider and not to the medical facility records department and 2) provide a copy of the request to the claimant so that the claimant can assist with reaching the doctor. The New York agency refused to take these steps. Advocates from other states also report that DDSs generally do not call a doctor's office to request an opinion statement. Notably, advocates nationally report treating sources are generally willing and able to complete assessments. Advocates are concerned that SSA's approach has an inequitable impact. Under-resourced disability claimants, who are less likely to be represented, are far less likely to take steps to try to secure this valuable treating source evidence themselves than represented claimants.

c. State agencies send approximately 34% of claimants to a CE (paid by SSA) to examine a claimant for the first time and then provide case determinative information about the claimant.

State agencies fall back on the option to pay for CEs in an average of 34% of cases.²¹ This varies state to state, with the highest percent of cases in New York (51.9%), New Mexico (45.5%), and

Puerto Rico (66.1%).²² SSA does not track how many of these cases have records from treating providers added later, which would mean that the CE was unnecessary. Advocates nationally report that essentially all of their cases with a CE report also have treating provider records added at some point.

A 2014 OIG report evaluated the completeness of disability claims files and found many cases had medical evidence at the hearing level that did not appear in the file at the DDS level, even though it existed at the time.²³ It costs SSA less money to approve a case at the state agency level than it does if the case must go to the hearing level. The report notes that “if 5 percent of the cases that were not fully developed at the state agency level did not need a hearing, SSA could save about \$23 million.”²⁴ That savings would be in addition to the savings of avoiding unnecessary CEs. In some areas, like New York, the state agency sends fully half of claimants to a CE, costing over \$25 million a year in New York alone.²⁵ The total cost for consultative examinations nationally in 2019 was \$345,269,112.²⁶

V. SSA Inadequately Supervises CE Evidence Development

SSA engages in very limited oversight of CE examinations. SSA asks state agencies to report the number and type of complaints made (i.e. egregious versus non-egregious) and the number of on-site visits the state agency conducted at the CE providers. These reports are not detailed, and there are no guidelines for what an on-site visit entails. SSA offers a “Suggested Protocol for DDS Onsite Reviews of CE Providers.”²⁷ This is simply a list of broad topics such as “cleanliness” of the facility, with no guideline to measure if a provider meets a satisfactory standard.²⁸ This protocol is recommended, rather than mandatory. Therefore, even though New York and Pennsylvania accurately reported that they completed all necessary on-site visits in 2017, SSA has limited insight into the policies and practices of each consultative examination office.²⁹

Consumers are hard-pressed to find an avenue to make SSA aware of bad practices at exam sites. There is no public guidance about how and when concerned claimants should make a complaint, or about what is required when a state agency investigates a complaint. Each state creates its own procedure for following up with complaints and must report that procedure to SSA, but there is no guidance as to what is considered an adequate procedure.³⁰ SSA suggests that DDSs “should consider surveying claimants’ evaluation of CE providers on a routine basis” but this is not mandatory.³¹

SSA also does not require CEs to produce uniform evaluations and assessments.³² There is no uniform format or required information for reports, and at least one provider does not include a medical opinion at all.³³ CEs tend to rely on templated forms that are not tailored to the individual claimant’s conditions. SSA does little to monitor or audit quality control, and it fails to track the number of medical appointments handled per day or the time the provider spends on each case, leading to examinations that are even shorter than the already short mandatory exam period. In a 2021 roundtable hosted by the Social Security Advisory Board about evidence collection for applications, one participant noted that the shift to one centralized CE provider in a state tended to produce less detailed, more templated and highly repetitive reports and the time in each consultation has decreased to between 7 to 12

minutes.³⁴ Another participant likened the single centralized provider to an assembly-line model. Similarly, a study of CE examinations for mental disorders noted they “generally consisted of nonstandardized diagnostic interviews and mental status exams, with little to no standardized psychological testing other than intelligence testing.”³⁵

a. IMA

IMA has contracts to perform Social Security Disability Examinations in 30 states.³⁶ In New York and Pennsylvania, IMA is the sole agency contracted by the state to perform consultative examinations. In other states, many different providers are contracted to perform them. In NY, claimants were referred for consultative examinations in 51.7% of cases in 2019.³⁷ In PA, CE referrals occurred in 35.8% of cases.³⁸

NYLAG analyzed 988 quality review surveys completed by claimants following IMA consultative examinations in 2017 and 2018.³⁹ The reviews were collected by New York State’s Office of Temporary and Disability Assistance (OTDA), which oversees the state agency and its operations. Of the claimants that responded to the query about length of time spent with the doctor, only 139 of 988 appointments (14%) met or exceeded 60 minutes. In fact, almost half of the appointments (454 of 988 appointments) were estimated to be 20 minutes or less and, of those, 279 (28%) were estimated to be 15 minutes or less. OTDA’s requirements for consultative examinations require the shortest comprehensive examination to be 30 minutes with 20 minutes of actual time spent with a physician.⁴⁰ Similarly, psychological examinations must be at least 60 minutes with a minimum of 45 minutes spent with the psychologist.⁴¹ These surveys indicate that basic requirements are not met in a significant number of cases. One anonymous consultative examiner says, “*For mental status exams, bringing them in, sitting them down, going through the interview, getting out of the office and then dictating—that is a half hour.*” This is well below the time required for psychological exams and calls into question the reliability of the information put into the report. These consistently truncated exams are especially disturbing because the CE report is often the determinative factor in whether a claimant is granted disability benefits.

Rushed exams conflict with SSA’s regulations that require “sufficient time . . . to permit the medical source to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (i.e., time set aside for the individual, not the actual duration of the consultative examination) should be used. (1) Comprehensive general medical examination—at least 30 minutes; (2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes; (3) Comprehensive psychiatric examination—at least 40 minutes; (4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and (5) All others—at least 30 minutes, or in accordance with accepted medical practices.”⁴²

Anecdotally, we have reports that IMA doctors and psychologists are pressured by internal reviewers from IMA to change their reports to reflect a higher level of functioning by reducing the severity of symptoms noted in initial drafts.

One anonymous consultative examiner says, *“Sometimes they will say . . . based off of your report, we think this should be moderate. I was trying to ask, ‘How do you really mark these? Depending on what you see?’ He [said] that the Office of Disability [are] already sticklers to not give people disability for whatever reason—[looking to just save money—[sic] basically, if they get a lot of reports from us that say marked or severe it diminishes the quality of our rankings. We reserve our markings for only the most severe. Sometimes we get back edits from the processing office, not that they disagree but they will circle it and say please confirm that this is accurate; and maybe [they] highlight a lesser column like mild and say, is this more appropriate?”*

This practice of downplaying a person’s functional limitations appears to be the result of a desire to limit the number of evaluations that assess severe limitations, a marker likely to yield an approved claim.

VI. SSA Policy Changes Allow Perfunctory CE Reports Too Much Weight, Causing a Crisis in Disability Adjudications

It has become more important that the CE program be thoughtfully and carefully managed, because SSA changed its rules in 2017 to allow for CE opinions to take greater prominence in a claim. Prior to March 2017, a longstanding rule applied in any disability determination that almost uniformly resulted in greater weight assigned to an opinion by a treating provider than to other opinions such as a CE opinion. SSA rules gave priority to the treating physician’s opinion because he or she was most able to provide a detailed, longitudinal picture of the claimant’s medical conditions and “may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.”⁴³

The rule changed in March 2017 to eliminate this legal preference for a treating provider opinion, placing that kind of opinion as no more persuasive than that of a CE’s report after a single brief examination. In other words, the CE opinion now has a much larger role in the determination process than it did previously. Thus, a state agency can rely on a CE to deny a case even when there is a treating physician’s opinion or longitudinal medical evidence in the record that supports a finding of more significant limitations than those witnessed in the CE.

At the same time, overall management of the CE program and its practices remains lax. Where the CE program initially was meant to provide examiners as a last resort to assess claimants who did not have treating providers, it is now widely overused where claimants do have a treating provider. The overreliance on CEs was particularly prevalent during the pandemic—where SSA relied on CE reports to process claims when treating records were harder to secure. Many people are, therefore, denied disability benefits even in cases where the evidence supports a finding that they cannot work, which can take years and multiple appeals to correct if the people have not abandoned their claims.

VII. Opportunities for Change

1. Require meaningful efforts to secure medical records.

SSA must revise program rules to meet its own policy, by allowing state agencies enough time to receive requested information from a claimant's treating medical sources, which are the preferred source of medical evidence. Treating-provider evidence always provides more detailed and comprehensive information than perfunctory CE examination reports.

In addition to changing the time frame for securing medical records, SSA must also revise its standard for follow up on records requests and redefine "every reasonable effort" to obtain records from treating sources.

Providing more time to receive treating provider evidence would be a win-win: more comprehensive medical information could be obtained, and taxpayer-funded fees for CEs avoided. This would require a regulatory change from SSA that would then be implemented by the state agencies.

2. Require state agencies to develop more effective ways to seek evaluations from treating providers.

Sometimes claimants are referred to CEs because the analyst wants a specific assessment of the claimant's ability to lift and carry, sit and stand, and to perform other work activities over the course of an 8-hour workday. Instead of paying for a CE to complete a form extrapolating the claimant's abilities in those areas from a 20-minute exam, the state agency should be required to solicit the evaluation directly from the claimant's treating provider in a manner likely to generate a response. A treating provider, who has been working with the claimant over many months or years, is better able to extrapolate the claimant's ability to perform work activities.

Sending requests for evaluation forms to medical records departments is not well calculated to get treating providers to complete them. Evaluation forms need to be sent directly to the doctor's office and to each claimant so that the claimant can assist in obtaining the evaluation form. Only if the treating provider refuses to complete an evaluation form should the claimant be referred to a CE.

Each DDS is responsible for structuring a quality assurance process, one that must monitor CE requests as well as contacts and follow up with treating sources.⁴⁴

3. Increase outreach to treating providers.

SSA's regulations indicate a preference for SSA to request the claimant's treating provider perform a specialized examination for the disability claim, like a CE. Despite this, the state agencies do little in the way of outreach and training of treating providers to increase the number of treating providers performing CE exams for their patients. SSA should do pilot programs or fund initiatives to grow the connection between state agencies and medical providers. For example, SSA could also pilot a program to partner with larger medical providers so that salaried doctors on staff at larger facilities would be eligible to provide CE

exams and accept payment for them. Also, SSA could pilot a program to partner with rural or smaller town providers to make such examinations more accessible as centralized CE providers tend to offer a limited number of locations for examinations, which may require some claimants to travel for hours to the locations which may be expensive to them or challenging depending on their disabilities.

4. Assess outlier state agencies.

Some state agencies are relying on CEs at much higher rates than others. SSA should take steps to audit those agencies whose rate of referring claimants to CEs varies widely from the national average.

5. Require uniform CE evaluation forms and require more persuasive findings.

SSA should set minimum requirements for CE assessment forms and require forms more tailored to specific body systems and impairments. Doing so will help protect claimants from being subject to inconsistent evaluation reports across the country. Moreover, SSA should introduce requirements that CEs support or explain any findings they have with clinical observations.

6. Tighten oversight.

SSA should increase its oversight of state agencies' use (and overuse) of CE reports by increasing supervision. SSA should published clear guidelines on how claimants can make a complaint and then require transparency about the kinds of complaints, the scope of audits, and any investigations and penalties. SSA should require quality reviews to look into these examinations, with an eye towards addressing bias based on race, gender, and ability. One participant at the Social Security Advisory Board roundtable noted that quality review processes do not provide feedback on the actual quality of the examinations nor on the necessity for each examination.⁴⁵ A sensible change is to evaluate the quality review process and criteria for feedback. Currently, SSA merely requires each DDS to have a quality assurance process, but SSA does not require a uniform structure or scope for these reviews.⁴⁶ A recent GAO study of SSA oversight of a related arm at state DDS offices identified deficiencies by SSA in oversight and training at DDS offices,⁴⁷ and SSA's efforts to address the concerns should include oversight of CE usage and reports. SSA assigns to its regional offices the task of serving as a resource for DDS offices, and the regional offices could set up complaint processes about DDS operations.

7. Restore the Treating Physician Rule.

SSA should restore the pre-March 2017 treating-physician rule which created a legal preference for treating source opinions over non-treating CE opinions. This preference is appropriate because treating provider evidence is almost always more comprehensive and thorough than perfunctory CEs. By restoring this legal preference, SSA policy would more appropriately relegate CE evidence to be evidence of last resort consistent with its other policy statements.⁴⁸

8. Address the impact of structural inequality in SSA’s policies regarding when and how DDSs use CEs.

SSA does not track race and ethnicity data, so it’s impossible to rule out an inequitable use of CEs across communities. SSA should analyze and report on the ways in which Black communities and non-Black communities of color are disproportionately impacted by racism in the systems that SSA relies upon for evidence, and audit the use of CEs through a race-equity lens. Meaningful oversight over and transparency within consultative examinations would enable SSA to more effectively address bias, particularly against claimants of color or LGBTQI claimants who disproportionately face bias and discrimination in healthcare systems.

VIII. Conclusion

SSA policy recognizes the limited value of CEs by directing that CE reports should only be requested if a state agency “cannot get the information we need from your medical sources” or there are inconsistencies in the record.⁴⁹ Yet, non-treating CE reports are routinely ordered in cases where they are not necessary. This practice wastes SSA resources and harms claimants. The harm increased after SSA changed its policy to allow adjudicators to weigh perfunctory opinions by non-treating CEs, often with medical specialties poorly matched to the claimants’ presenting problems, as equal to or even more persuasive than evidence from the claimants’ treating doctors. Although SSA does not track race data, SSA’s CE policies may perpetuate racial inequity in SSA’s disability process.

SSA must revise program rules to require state agencies have enough time to acquire requested information, either underlying medical records or a medical opinion, from a claimant’s treating medical providers, which are the preferred source of medical evidence. The slight delay in decision-making caused by changing the process will be well worth it to secure the relevant evidence at the earliest possible step. Fully half of SSA hearing judges recently surveyed cited poor development at the DDS level as a hurdle to meeting internal productivity goals.⁵⁰ Treating-provider evidence always provides more detailed and comprehensive evidence than perfunctory CE reports. More effective rules for evidence collection would yield the preferred evidence more often and far sooner in the process, reducing the need to pay for CEs and for higher level appeals.

SSA’s change in the weight assigned to treating providers does not mean the agency no longer has responsibility to obtain treating provider opinions, nor should SSA’s inattention to the CE program allow it to become the easy substitute for gaining outcome determinative medical opinions. Moreover, SSA could obtain considerable cost savings by reducing the number of CEs ordered and by reducing the number of ALJ hearings held.

At the same time, SSA needs to increase oversight of these programs and revise quality review to monitor if CEs are ordered appropriately, meet minimum time requirements, and if CE evaluation reports are appropriately tailored to individual conditions.

In addition to improving oversight to obtain CEs that accurately reflect the functioning of disabled claimants, SSA must also revise its regulations and return to its longstanding treating

physician rule. Any concerns SSA has about the length of treatment necessary to give a provider the label of “treating physician” can be addressed in the new regulations.

¹ Consultative examinations are physical or mental examinations, or sometimes testing, purchased by the Social Security Administration. 20 C.F.R. §§ 404.1519 and 416.919. Although SSA can purchase a CE from a treating source if the treating source is an approved provider, this rarely happens. Very few practicing medical professionals are on the list of approved providers. See, for example, a small sample of CEs assessed by Mathematica Policy Research based on data provided by SSA indicated that none of the CEs were treating sources. David Wittenberg et al., *An Assessment of Consultative Examination Processes, Content and Quality: Findings from the CE Review Data*, MATHEMATICA POL’Y RES., Nov. 2012, at xv, 25-26.

² See 20 C.F.R. §§ 404.1519a and 416.919a.

³ This example is from a NYLAG client.

⁴ This example is from a UJC client.

⁵ See, e.g., 20 C.F.R. § 404.1519a; see also POMS DI 22505.008(C) (3)(a)

<https://secure.ssa.gov/poms.NSF/LNX/0422505008> (providing guidance on when to purchase a consultative exam).

⁶ 20 C.F.R. §§ 404.1520c and 416.920c; but see 20 C.F.R. §§ 404.1527 and 416.927 (detailing the treating physician rule, which applied to claims filed prior to March 27, 2017).

⁷ OFF. OF PERS. MGMT., LIMITATION ON ADMIN. EXPENSES, FY 2022 CONG. JUSTIFICATION, at 165 (2021),

<https://www.ssa.gov/budget/FY22Files/2022LAE.pdf>. In fiscal year 2020, SSA processed 1,967,753 initial claims but only processed 403,106 claims at the administrative law judge appeals level, suggesting large levels of abandoned claims. *Id.*

⁸ U.S. GOV’T ACCOUNTABILITY OFF., GAO 20-614E, SOC. SEC. DISABILITY: INFO. ON WAIT TIMES, BANKRUPTCIES, AND DEATHS AMONG APPLICANTS WHO APPEALED BENEFIT DENIALS, at 1 (2020), <https://www.gao.gov/assets/710/708794.pdf>.

⁹ *Id.*

¹⁰ OFF. OF THE INSPECTOR GEN., A-01-13-23082, COMPLETENESS OF THE SOC. SEC. ADMINISTRATION’S DISABILITY CLAIMS FILES, at 7 (July 29, 2014) https://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-13-23082_0.pdf.

¹¹ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-09-149, SOCIAL SECURITY DISABILITY: COLLECTION OF MEDICAL EVIDENCE COULD BE IMPROVED WITH EVALUATIONS TO IDENTIFY PROMISING COLLECTION PRACTICES, 2 (2008)

¹² See 20 C.F.R. §§ 416.921 and 404.1512 and SSA’s Program Operating Manual (POMs). The POMs is a primary internal rule book used by Social Security employees to process claims for Social Security Benefits. Although the POMs is intended for SSA employees, a publicly available version is posted online. See SSA’s Program Operations Manual System, <https://secure.ssa.gov/apps10/>.

¹³ POMS DI 22505.006; POMS DI 22505.035.

¹⁴ 20 C.F.R. § 164.524(b)(2)(i).

¹⁵ 20 C.F.R. §§ 404.1512 and 416.912.

¹⁶ OFFICE OF THE INSPECTOR GEN., *supra* note 11.

¹⁷ GAO-09-140 at 6, *supra* note 12.

¹⁸ 20 C.F.R. §§ 404.1513 and 416.913.

¹⁹ POMS DI 22501.002.

²⁰ POMS DI 22505.035(A)(2) (emphasis added).

²¹ OFFICE OF PERS. MGMT., LIMITATION ON ADMINISTRATIVE EXPENSES, FY 2021 CONGRESSIONAL JUSTIFICATION, at 123 (2021), <https://www.ssa.gov/budget/FY21Files/2021LAE.pdf>.

²² *Id.*

²³ OFF. OF THE INSPECTOR GEN., *supra* note 11.

²⁴ *Id.*

²⁵ OFF. OF PERS. MGMT., *supra* note 21 at 123.

²⁶ *Id.*

²⁷ POMS DI 39545.500.

²⁸ See POMS DI 39545.525 Exhibit 1.

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- ²⁹ See SOC. SEC. ADMIN., DDS CE OVERSIGHT REPORT (2017), <https://www.ssa.gov/foia/resources/proactivedisclosure/2020/FY%202017%20State%20DDS%20CE%20Oversight%20Reports.pdf>.
- ³⁰ See POMS DI 39545.375.
- ³¹ POMS DI 39545.350.
- ³² See, e.g., Wittenberg et al., *supra* at note 1, at 42.
- ³³ In one small study of CE reports, only 19% of CE reports for initial claims included a medical source statement. *Id.*
- ³⁴ SOC. SEC. ADVISORY BD., ROUNDTABLE ON EVIDENCE COLLECTION – THE CORNERSTONE OF SOCIAL SECURITY DISABILITY DETERMINATION (July 29, 2021) <https://www.ssab.gov/research/roundtable-medical-evidence-collection-the-cornerstone-of-social-security-disability-determination/>.
- ³⁵ INST. OF MED. OF THE NAT’L ACADEMIES, PSYCHOLOGICAL TESTING IN THE SERVICE OF DISABILITY DETERMINATION 56 (2015), <https://www.ncbi.nlm.nih.gov/books/NBK305232/> (“In practice, CEs for mental disorders generally consist of nonstandardized diagnostic interviews and mental status exams, with little to no standardized psychological testing other than intelligence testing.”); see also Wittenberg et al., *supra* at note 1, at 38 (“At least 85% of mental CE reports contained the necessary elements to a mental health examination, except that insight and judgment appeared in only 79% of the reports.”).
- ³⁶ *The IMA Group Announces Acquisition of MedPlus Disability Evaluations*, BUSINESSWIRE (Aug. 7, 2021, 7:03AM), <https://www.businesswire.com/news/home/20210817005166/en/The-IMA-Group-Announces-Acquisition-of-MedPlus-Disability-Evaluations>
- ³⁷ OFF. OF PERS. MGMT., *supra* note 21, at 123.
- ³⁸ *Id.*
- ³⁹ In 2019, the New York State Office of Temporary and Disability Assistance provided documents in response to FOIL requests submitted by NYLAG. Included were questionnaires from 2017 and 2018 completed by individuals following consultative examinations conducted by IMA in New York State.
- ⁴⁰ N.Y. STATE OFF. OF TEMP. & DISABILITY ASSISTANCE, CONDITIONS GOVERNING REFERRALS FOR CONSULTATIVE EXAMINATIONS O-5 <http://www.bidnet.com/bneattachments?/418990513.doc> (last visited June 7, 2021).
- ⁴¹ *Id.*
- ⁴² 20 C.F.R. §§ 404.1519n and 416.919n.
- ⁴³ 20 C.F.R. §§ 404.1527 and 416.927.
- ⁴⁴ POMS DI 30001.200(b)(2).
- ⁴⁵ SOC. SEC. ADVISORY BD., *supra* note 34.
- ⁴⁶ U.S. GOV’T ACCOUNTABILITY OFF., GAO 22-103815, SOC. SEC. ADMIN. ACTIONS NEEDED BY SSA TO ENSURE DISABILITY MEDICAL CONSULTANTS ARE PROPERLY SCREENED AND TRAINED, at 12-13 (2021), <https://www.gao.gov/assets/gao-22-103815.pdf>.
- ⁴⁷ *Id.*
- ⁴⁸ See, e.g., 20 C.F.R. § 404.1519a; see also POMS DI 22505.008(C)(3)(a) <https://secure.ssa.gov/poms.NSF/LNX/0422505008> (providing guidance on when to purchase a consultative exam).
- ⁴⁹ 20 C.F.R. §§ 404.1519a and 416.919a (2021).
- ⁵⁰ U.S. GOV’T ACCOUNTABILITY OFF., GAO 21-341, SOC. SEC. DISABILITY: PROCESS NEEDED TO REVIEW PRODUCTIVITY EXPECTATIONS FOR ADMIN. LAW JUDGES, at 35-36 (2021), <https://www.gao.gov/products/gao-21-341>.