Administrative Conference of the United States

The Use of Medical Personnel in Social Security Disability Determinations

Frank S. Bloch
Professor of Law
Vanderbilt University School of Law

Conference Consultant

(1989)

ABOUT THE ADMINISTRATIVE CONFERENCE

The Administrative Conference of the United States is a permanent, independent federal agency established by the Administrative Conference Act of 1964 (5 U.S.C. §§ 571-576). The purpose of the Administrative Conference is to improve the procedures of federal agencies so that the agencies may fairly and expeditiously carry out their responsibilities to protect private rights and the public interest while administering regulatory, benefit, and other government programs. The Conference provides a forum in which agency officials, private lawyers, university professors, and other experts in administrative law and government can combine their experience and judgment in cooperative efforts to study procedural problems and explore solutions.

Administrative Conference of the United States
2120 L Street, N.W., Suite 500
Washington, D.C. 20037

TABLE OF CONTENTS

I. INTRODUCTION

Millions of Social Security claims are processed every year in which a wide range of issues must be resolved, from technical calculations of income and resources to paternity determinations. Of all these issues, disability stands out as the most difficult issue to adjudicate initially and as the issue most often contested by claimants on appeal.[1] Moreover, the absolute numbers for the disability programs are staggering: more than 2,000,000 applications for Disability Insurance Benefits and Supplemental Security Income based on disability in 1988 and, for the same year, over 250,000 disability hearings and over 50,000 Appeals Council agency reviews of disability hearing decisions.[2]

Although the determination of disability itself includes many different types of issues, the contested matters in most disability claims center around the claimant's alleged medical condition and the extent to which it affects the claimant's ability to work.[3] It would seem to follow, therefore, that doctors or other medically trained staff are uniquely qualified to make, or at least participate in, disability determinations. The purpose of this study is to test this assumption and to measure it against an evaluation of current practice at the Social Security Administration and selected other federal agencies that administer disability programs. On the basis of this material, recommendations are then made toward improving the use of medical personnel in the Social Security disability programs.

Many different types of medically trained personnel are and should be used in the disability determination process. Thus, in addition to doctors, who can be on staff full- or part-time or hired as independent consultants, there are nurses and, for claims based on mental impairments, psychologists. The term "medical personnel" as used in this report is intended to include all of these professionals. More limited terms, such as "medical staff" and "medical decisionmakers," are used as needed. Also, it should be noted that the specific focus in this report on the development and evaluation of medical evidence follows from its focus on the use of medical personnel. The development and evaluation of nonmedical evidence, relating, for example, to vocational issues, can be very important in disability cases; however, these matters are outside the scope of this report.

A study of the need for medical personnel in disability adjudications must begin with an examination of the applicable disability standards. Disability decisions are based on more than an assessment of the claimant's medical condition; they are, after all, made for the purpose of awarding a benefit conferred by Congress in order to further a public social and economic agenda. The mixed social/economic/medical/legal dimension of disability adjudications can caution away from direct reliance on the medical profession for two reasons. First of all, medical questions are presented often in other than a pure medical form, thereby calling for expertise different from that held by most doctors. As a medical consultant involved in Social Security disability adjudications testified recently to the Disability Advisory Council:

---

1. In the Social Security Old Age, Survivors and Disability Insurance Program, for example, disability awards account for less than 20 percent of all awards. Social Security Administration, Social Security Bulletin, Annual Statistical Supplement 119 (1987). By contrast, of the approximately 200,000 hearings requested for claims in that program in 1988, more than 95 percent were by disability claimants. Social Security Administration, 1989 Annual Report to the Congress 33 (1989).

2. *Id.*, at 29, 31, 33.

3. The various disability standards used in the Social Security and other federal disability programs are discussed in Part IIA of this report.

> Medical expertise alone is not an adequate qualification for effective performance as an agency consultant. Disability decisions differ significantly from clinical practice. This is a complicated process with significant administrative, legal and technical nuance which must be learned and mastered. Those favoring pure medical specialists in the program somehow lose sight of this. Some of the most astute medical resources never become successful disability medical consultants.[4]

Second, doctors may be frustrated in applying their expertise outside of their accustomed professional role as healers.[5] They are accustomed to evaluating a patient's total circumstances leading to disability, including self-reported assessments of work capacity, rather than focusing directly on the existence or non-existence of particular impairments.[6] More fundamentally, some doctors are simply uncomfortable with statutory entitlements based on "disability"; they can be committed to the belief that a particular condition, defined as a disability under applicable statutes and regulation, does not have, in fact, disabling effects.[7]

Despite these concerns, medical staff are included in the disability adjudication process for every federal disability program. Each program utilizes them differently, however; the only common feature is that in all programs participation by medical staff is concentrated at the agency-level initial decision and reconsideration stages, as opposed to administrative appeals. One approach, used by the Social Security Administration and the Veterans Administration, is to include a doctor directly in making disability decisions. In other programs, doctors can participate at various stages in the administrative process as advisors, sometimes with significant authority.[8] This lack of uniformity and consistency in the use of medical personnel in federal disability programs results in part from the differences in disability standards being applied, but also demonstrates an ambivalence about the role they should play.

There are, of course, cost considerations that must be taken into account. The Social Security Administration spent more than $1.5 billion in Fiscal Year 1988 to process Disability Insurance Benefits claims and Supplemental Security Income claims based on blindness or disability from the initial decision level through the Appeals Council. Of these costs, the percentage spent at each level of adjudication was as

---

4. Statement of Albert F. Vickers, Chief State Agency Medical Consultant, Texas Disability Determination Service, to Disability Advisory Council (March 20, 1987), at 1. Noting that disability medicine is itself a speciality, Dr. Vickers decried the absence of formal training or certification in the field. *Id.*

5. *See, e.g.*, Hadler, *Medical Ramifications of the Federal Regulation of the Social Security Disability Insurance Program*, 96 Annals of Internal Medicine 665, 668 (1982) ("An unfortunate ramification of [the Social Security disability program] is that 'disability' has become a legal, rather than clinical construct. The physician's role in disability determination has become a discontinuous function; it is to suggest eligibility to the patient"). Although speaking from the perspective of doctors providing medical evidence, similar professional ambivalence is seen in doctors serving as decisionmakers. Interview with J. Gary Hickman, Assistant Director for Policy, and Robert M. White, Chief, Regulations Staff, Compensation and Pension Service, Veterans Administration (July 19, 1988) [hereinafter VA interview]. Interview with Kenneth E. Eaton, Chairman, Roger K. Bauer, Vice Chairman, and Stephen A. Jones, Executive Assistant to the Chairman, Board of Veterans Appeals, Veterans Administration (July 20, 1988), and interview with Holly E. Moehlman, Chief Member, Harold H. Sterling, M.D., Medical Member, and Lawrence M. Sullivan, Law Member, Section 19, Board of Veterans Appeals, Veterans Administration (July 20, 1988) [hereinafter BVA interviews].

6. *See, e.g.*, statement of Norton M. Hadler, M.D., before the Disability Advisory Council, Minutes of the Disability Advisory Council (June 19, 1987), at 13.

7. This happens with some frequency in the Black Lung program, where doctors' opinions can be discounted because their views on pneumoconiosis are "hostile" to the purposes of the Black Lung Act. *See* text accompanying notes 609-610, *infra*.

8. There is some participation by doctors in appeals at the Social Security Administration, and doctors are included as members of the Board of Veterans Appeals; however, in both of these programs there is still a greater role for doctors in initial decisionmaking. *See generally* text accompanying notes 142-72, 229-41, 256-66, *infra*.

follows: 67% for initial decisions, 12% for reconsiderations, 18% for administrative hearings, and 3% at the Appeals Council.[9] These figures include costs incurred at various Social Security Administration offices and the state Disability Determination Services.[10] Because the Disability Determination Services are responsible for most of the medical evidence development in disability claims, their costs are particularly relevant. In Fiscal Year 1988, the Disability Determination Services spent $236,811,909 on medical consultants, consultative examinations and compiling other medical evidence for the record. This amount represents 15% of the total cost of adjudicating disability claims that year, and can be broken down as follows: $124,750,298 for consultative examinations, $64,727,572 for medical consultants, and $47,334,039 for compiling other medical evidence for record, including reports (other than consultative examinations) by treating physicians.[11]

Although it would be impossible to project accurately the cost of implementing the recommendations accompanying this report, these figures provide at least some basis for estimating the range of additional costs that may be incurred. One approach is to assume that costs of improved development at a single initial decision stage would be approximately the same as the present cost of processing a claim through both initial decision and reconsideration. The cost of reconsideration probably includes the additional medical consultant time needed to implement the recommendations, and efficiencies gained by developing medical evidence in a single process could result in spending no more money to obtain the required complete medical record. Under this approach, the additional cost of evaluating all claims at a single, improved initial decision stage would be the additional cost of reconsidering all claims that do not proceed to reconsideration. In Fiscal Year 1988, approximately 970,000 disability claims were denied at the initial decision level; of these denials, approximately 436,500 were appealed to the reconsideration level and approximately 533,500 were not appealed.[12] The average cost for a reconsideration decision was $296.21.[13] Therefore, the additional cost in Fiscal year 1988 would have been approximately $158,028,035 (533,500 x $296.21), or an increase of approximately 10% over actual expenditures that year.

Another approach is to focus on the direct costs of developing and evaluating medical evidence. It would seem that an increase in spending of from 25% to 50% for medical consultants, consultative examinations and compiling other medical evidence for the record would be sufficient to implement the recommendations. Increasing the Fiscal Year 1988 amount spent for these purposes by 25% would have cost approximately $59 million, or less than 4% over actual expenditures that year; an increase of 50% would have cost approximately $118 million, or less than 8% over actual expenditures that year.

It should be noted that there are possible cost savings over present practice that could result from the recommendations, such as obtaining more and better information from claimants and treating medical sources thereby reducing the need for consultative examinations. Moreover, it is quite likely that many claims presently denied but not appealed to the reconsideration stage would require little or no additional medical evidence, as the initial decision was based on non-medical factors or was clearly correct

---

9. Source: figures provided to Frank S. Bloch by the Social Security Administration, Office of Budget, by letter from George H. Kullgren dated October 31, 1989.

10. The administrative process used for disability determinations at the Social Security Administration is discussed at text accompanying notes 135-172, *infra*.

11. *See* note 9, *supra*.

12. Source: Social Security Administration, Report of the Disability Advisory Committee (July 25, 1989), at Tab D, p. 2. This figure was calculated by multiplying the total number of initial claims (1,516,373) by the percentage denied (64%) and the percentage appealed (45%) or not appealed (55%) to the reconsideration level.

13. *See* note 9, *supra*.

and based on clear medical evidence. Also, better decision could result in fewer hearings and appeals to the Appeals Council. For example, administrative hearings and Appeals Council review cost $324,679,064 in Fiscal Year 1988;[14] reducing appeals by only 20% would have resulted in savings of almost $65 million. Moreover, the cost of each appeal would be reduced because less additional development of medical evidence would be needed at the appellate level. As a result, the net additional cost of the recommendations could be considerably less than projected.

In the next part of this report, an overview is presented of the disability standards and administrative procedures used to determine disability in five federal disability programs: Social Security, Railroad Retirement, Veterans, Civil Service and Black Lung. The Social Security standards and procedures are discussed in some detail, followed by comparative discussions of similarities and differences found in the other programs. Selected aspects of the disability standards are examined again in Part III, with a focus on identifying categories of medical decisions and types of medical issues presented in disability adjudications. The use of doctors in assessing these issues and reaching these decisions is explored as well. In Part IV, three models for the use of medically-trained decisionmakers, distilled in part from current practice, are presented. Finally, in Part V, a number of specific recommendations are made, drawn from these models.

---

[14]. *See* note 9, *supra*.

II. BACKGROUND

The question of the appropriate use for medically trained decisionmakers in Social Security disability programs must be considered in the context of the substantive standards for disability benefits used to determine eligibility. Current administrative procedures used to determine disability, which themselves are formed to a certain degree by applicable substantive standards, must be considered as well. Accordingly, this section presents an overview of the general Social Security disability standards and the administrative procedures used by the Social Security Administration to implement those standards. These standards and procedures are also compared to those used in four other federal disability programs in order to put current Social Security practice in context and to provide a frame of reference for the models and recommendations which follow in later sections of the report.

A. Disability Standards

At the heart of any disability program is a statutory definition of disability which is used as the basis for determining eligibility for benefits.[15] These statutory standards vary in substance from program to program, depending on the group of beneficiaries involved and the social and economic purposes for providing that group disability benefits. Thus, the general standard for Black Lung benefits, intended to address a particular need arising out of the coal mine industry, is altogether different from the more broadly-intended Social Security standard.[16] For this reason, a finding of disability by one agency is usually of little relevance to another.[17]

The statutory standards also vary in terms of specificity, depending on how much control Congress wants to exercise over the implementation of the standard in the particular program. For most programs, however, specific implementation has been left to the appropriate agencies, which in turn have promulgated detailed, and often voluminous, regulations, rulings and various other forms of substantive guidelines for disability adjudications. In some programs, the resulting criteria for disability determinations remain relatively broad. In others, the combined statutory and regulatory criteria are extremely detailed, focusing on specific impairments and prescribed levels of functional loss. The Social Security Administration's Listing of Impairments is a good example of detailed definition of a statutory standard by regulation.[18]

---

15. Every program also has eligibility requirements unrelated to disability which fall into two broad categories: status, such as employment or service history for the Social Security, Railroad Retirement, Veterans Compensation, Civil Service and Black Lung programs; and income and resource limitations for the Supplemental Security Income and Veteran's Pension programs. *See generally*, F. Bloch, FEDERAL DISABILITY LAW AND PRACTICE (1984, Supp. 1986) §§ 2.3-.5, 3.5-.10, 3.17-.18, (Social Security and SSI); 5.4-.13 (Veterans Compensation and Pension); 7.4-.5 (Civil Service Disability Retirement); 9.4-.7 (Black Lung Disability Benefits). Generally these requirements will not be considered in this report except to the extent that they relate to the process for determining disability.

16. In practice, however, there can be circumstances where a Black Lung claimant can establish disability according to criteria essentially the same as those used for Social Security benefits. *See* text accompanying notes 126-32, *infra*.

17. The correct measure of importance, of course, should depend on the closeness of the standards involved. See, e.g., Floyd v. Bowen, 833 F.2d 529, 534 (5th Cir. 1987) ("disability determination by another agency is entitled to great weight . . . [but is] not binding on the . . . [Social Security Administration if] the criteria applied by the two agencies vary"). Flood v. Schweiker, 643 F.2d 1138, 1139 (5th Cir. 1981) (100% disability rating by the Veterans Administration should be given at least some weight in a Social Security case).

18. The Listing is used for most benefits only as criteria for one method of proving disability; however, for some beneficiaries the Listing amounts to the exclusive definition of the statutory standard. *See* text

The statutory disability standard and key substantive regulations for the Social Security disability programs will be discussed in this section, followed by a comparative discussion of the disability standards for other federal disability programs. Regulations which deal with methods of evaluation can also refine the substantive disability standard, and therefore such regulations will be discussed in this section rather than in the next section covering administrative procedures.

1. Social Security Act Programs

There are five separate disability benefit programs included in the Social Security Act: Disability Insurance Benefits, Childhood Disability Benefits, Supplemental Security Income for low-income disabled adults, spouse's disability benefits for disabled surviving spouses of insured wage earners and child's Supplemental Security Income for low-income disabled children. Disability decisions for the Disability Insurance Benefits and Supplemental Security Income programs are made according to the same disability standard; there are separate, more restrictive disability standards for the spouse's disability benefits and child's Supplemental Security Income programs. The general standard for Disability Insurance Benefits, Childhood Disability Benefits, and adult Supplemental Security Income will be discussed first. Then, the standards for surviving spouse's disability benefits and child's Supplemental Security Income will be discussed together and related to the general standard.

a. Disability Insurance Benefits, Childhood Disability Benefits, and Adult Supplemental Security Income

The general disability standard for Disability Insurance Benefits and Childhood Disability Benefits is defined in the Social Security Act as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[19] The disability standard for Supplemental Security Income is virtually the same,[20] and the two standards are interpreted consistently as being identical.[21] The general standard includes three separate components, each of which must be established to prove disability: a severity requirement, defined as the "inability to engage in any substantial gainful activity"; a medical origin requirement, in that the disability must be based on a "medically determinable physical or mental impairment"; and a duration requirement, which limits eligibility to cases where the disability "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." As a result, a short-term disability, no matter how severe, is not sufficient to establish eligibility; nor is a long-term inability to work due to social or vocational factors alone.

---

accompanying notes 60-76, *infra*. Another example is the Veteran Administration's Schedule for Rating Disabilities.

19. 42 U.S.C. §§ 416(i), 423(d)(l)(A) (1982). Childhood Disability Benefits are authorized at *id.* § 402(d). They are available to disabled children of Social Security Old Age or Disability Insurance beneficiaries or insured wage earners who have died, who are disabled due to a disability which began before they reached the age of 22. *See generally* 20 C.F.R. § 404.350.

20. The only difference in language is that the standard is phrased in terms of an individual who is "unable to engage in substantial gainful activity..." *id.* § 1382c(a)(3)(A).

21. *See e.g.*, Davis v. Heckler, 759 F.2d 432, 435 n. 1 (5th Cir. 1985) ("[t]he relevant law and regulations governing the determination of disability under a claim for disability insurance benefits are identical to those governing the determination under a claim for supplemental security income"); Hankerson v. Harris, 636 F.2d 893, 895 n. 2 (2d Cir. 1980).

The severity and medical origin requirements are defined further in the Act: an individual is eligible for Disability Insurance Benefits, Childhood Disability Benefits or Supplemental Security Income "only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy."[22] This means that benefits are not awarded based on an inability to perform work one has done in the past, so long as there is any other work in the national economy the claimant can do considering his or her age, education and prior work experience.[23] Also, benefits cannot be awarded due to an inability to obtain employment so long as there is employment in the national economy of a type that the claimant can perform.[24]

The Social Security Administration has broken down the general disability standard into a series of five steps known as the "sequential evaluation process" for determining disability.[25] The sequential evaluation process, which is commonly expressed in the form of questions addressing a claimant's medical condition and vocational circumstances, is designed to test evidence of disability from different perspectives by focusing on different factual and legal issues. Each of the steps of the process is tied to an aspect of the general disability standard. The process operates on a flow chart model: the steps are considered in a set order until a decision is reached, so that at some steps a decision is made to deny benefits or to move further along the evaluation, while at others a decision is made to grant benefits or to move further along the process. When followed fairly and correctly the sequential evaluation process leads to disability decisions based on the ultimate question raised by the general disability standard: whether the claimant is unable to engage in substantial gainful activity.[26] Nonetheless, the Social Security disability standard is, from an administrative point of view, inherently difficult; Administration officials estimate that up to 25 percent of fully developed and properly evaluated claims could be decided legitimately one way or the other.[27]

---

22. 42 U.S.C. §§ 423(d)(2)(A), 1382c(a)(3)(B).

23. The phrase "work which exists in the national economy" is defined further as "work which exists in significant numbers either in the region where [the claimant] lives or in several regions of the country." This language was added following a series of court decisions which had interpreted the definition of disability to allow benefits when there were no employment opportunities for a claimant. The leading case was Kerner v. Flemming, 283 F.2d 916 (2d Cir. 1960). *See also* Baker v. Gardner, 362 F.2d 864 (3d Cir. 1966); Torres v. Celebrezze, 349 F.2d 342 (1st Cir. 1965). These cases are discussed in Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 Harv. L. Rev. 833, 850-55 (1976).

24. As stated in the Act, the ability to perform substantial gainful activity is to be determined "regardless of whether such work exists in the immediate area in which [the claimant] lives, or whether a specific job vacancy exists . . ., or whether [the claimant] would be hired." 42 U.S.C. §§ 423(d)(2)(A), 1382c(a)(3)(B).

25. 20 C.F.R. §§ 404.1520, 416.920 (1988). *See also* S.S.R. No. 86-8 (Cum. Ed. 1986). The term "sequential evaluation process" comes from earlier versions of these regulations, *e.g.*, 20 C.F.R. § 404.1503 (1980), and is still widely used.

26. The sequential evaluation process has been accepted by courts as a proper method for adjudicating Social Security disability claims. *See* Bowen v. Yuckert, 482 U.S. 137, 158 (1987); Tolany v. Heckler, 756 F.2d 268, 270 (2d Cir. 1985) ("use of the [sequential evaluation process] is not discretionary; it is a regulatory requirement"). *See also* McCoy v. Schweiker, 683 F.2d 1138, 1141-1146 (8th Cir. 1982); Berry v. Schweiker, 675 F.2d 464, 467 (2d Cir. 1982).

27. Interview with David A. Rust, Assistant Commissioner for Disability, John C. Ritter, Executive Program and Policy Officer, John Mather, M.D., Chief Medical Officer, Hugh Meade, Division Director, Division of Medical and Vocational Policy, and Lenore Carlson, Division Director, Division of Field Disability Operations, Office of Disability, Social Security Administration (July 21, 1988) [hereinafter SSA interview]. *See also* J. Mashaw, BUREAUCRATIC JUSTICE 206 (1983).

The first question posed in the sequential evaluation process is whether the claimant currently is performing substantial gainful activity. If so, that activity itself demonstrates that the claimant is not disabled, regardless of his or her medical condition.[28] If the claimant is not performing substantial gainful activity, a second question is asked: whether the claimant has a "severe" impairment, that is, an impairment or combination of impairments which significantly limits his or her ability to perform work. If not, again the claimant is considered not disabled.[29] The purpose of these first two steps is to make early determinations of nondisability in cases where the evaluation is relatively simple. Thus, a determination that a claimant is engaging in substantial gainful activity involves relatively simple vocational issues including the actual amount of money earned at the job.[30] The question whether a claimant suffers from a severe impairment is a purely medical determination made without consideration of the claimant's age, education, and work experience.[31] Administration policy is to continue with the evaluation if there is any doubt on the issue of severity.[32]

Just what is meant by a "severe" impairment, or more importantly, what is a sufficiently "nonsevere" impairment to justify denial of benefits at the second step of the sequential evaluation process, has been the subject of a great deal of controversy. In the mid-1980s, a number of courts either struck down the severity requirement on the ground that it failed to take into account vocational factors,[33] or simply reinterpreted the requirement so that a finding of nonseverity would be limited to cases clearly outside the statutory definition.[34] In 1987, the Supreme Court upheld the severity requirement as both efficient and reliable, since it allows the Administration to identify "at an early stage those claimants whose medical impairments are so slight that it is unlikely they would be found to be disabled even if their age, education, and experience were taken into account."[35] In a concurring opinion that was perhaps more on point, Justice O'Connor found, in essence, that the Social Security Administration never intended to require more than a "de minimis" impairment to pass through the second step of the

---

28. 20 C.F.R. §§ 404.1520(b), 416.920(b). The reason for this step is self evident. Because disability is defined as an inability to engage in substantial gainful activity, it follows that an individual who actually engages in substantial gainful activity cannot be disabled.

29. *Id.* §§ 404.1520(c), 416.920(c).

30. Work activity is ordinarily substantial and gainful if the earnings exceed certain amounts listed in the regulations, and not substantial and gainful if the earnings are below certain amounts; if the earnings fall between those amounts a case-by-case evaluation is made. *See id.* §§ 404.1574(b), 416.974(b). Vocational evaluations focus on the claimant's "experience, skills, supervision and responsibilities," and whether his or her work "contribute[s] substantially to the operation of a business." *Id.* §§ 404.1573(a), 416.973(a). *See also* S.S.R. 83-33, 83-35, 84-24, 84-25 (Cum. Ed. 1981-85).

31. 20 C.F.R. §§ 404.1520(c), 416.920(c).

32. Interview with William C. Taylor, Member, Appeals Council, James R. Rucker, Chief Administrative Law Judge, Joann Anderson, Director, Field Policy and Analysis Staff, Office of Chief Administrative Law Judge, and Barry Elgen, Policy Analyst, Division of Legislation Policy Analysis and Coordination, Office of Policy and Procedures, Office of Hearings and Appeals, Social Security Administration (August 23, 1988) [hereinafter OHA interview]. *See also* S.S.R. 85-28 (Cum. Ed. 1981-85); POMS DI 24505.005A.

33. *See, e.g.*, Yuckert v. Heckler, 774 F.2d 1365, 1370 (9th Cir. 1985), *rev'd sub nom.* Bowen v. Yuckert, 482 U.S. 137, (1987); Johnson v. Heckler, 769 F.2d 1202, 1212 (7th Cir. 1985) *vacated and remanded*, 482 U.S. 922 (1988),; Baeder v. Heckler, 768 F.2d 547, 551 (3d Cir. 1985) *vacated*, 482 U.S. 156.

34. *See e.g.*, Estran v. Heckler, 745 F.2d 340, 341 (5th Cir. 1984); Evans v. Heckler, 734 F.2d 1012, 1014 (4th Cir. 1984); Brady v. Heckler, 724 F.2d 914, 917-20 (11th Cir. 1984).

35. Bowen v. Yuckert, 482 U.S. at ____, 107 S.Ct. at 2297.

sequential evaluation process.[36] The percentage of claims denied on the basis of nonseverity has declined steadily in the past few years.[37]

The third step of the sequential evaluation process, reached when a claimant is not engaging in substantial gainful activity but does suffer from a severe impairment, utilizes the Social Security Administration's Listing of Impairments.[38] The question asked is whether the claimant has a medical condition or combination of conditions that meets or equals the requirements of an impairment included in the Listing; if so, the claimant is considered disabled.[39] If not, then the sequential evaluation process continues. The Listing of Impairments is designed to increase efficiency in cases of claimants with obviously severe, readily identifiable impairments, on the theory that an impairment that meets the strict criteria in the Listing can be recognized and evaluated early in the disability determination process.[40]

Disability can be found at the third step of the sequential evaluation process also if the claimant's impairment or combination of impairments is the "medical equivalent" of one of the listed impairments.[41] A comparison is made between the symptoms, signs and laboratory findings relative to the claimant's impairment or impairments, and the medical criteria of a particular listing.[42] As with determinations of disability based on an impairment that meets a listing, determinations involving the medical equivalence of a listing are based on medical evidence only.[43] Although tied to the Listing of Impairments, this is perhaps the most unclear and difficult evaluation in the process.[44]

The second and third steps of the sequential evaluation process may be viewed as screening devices which allow the Administration to dispose of the most straightforward cases quickly and efficiently on medical grounds. At the second step, claimants with "not severe" impairments are denied without considering their age, education or work experience because they cannot conceivably be found disabled as a result of their

---

36. 482 U.S. at ____, 107 S.Ct. at 2298 (citing S.S.R. 85-28 (Cum. Ed. 1981-85)).

37. *See* Staff of House Comm. on Ways and Means, 101st Cong., 1st Sess., Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, 46 (Comm. Print 1989) (from 34.3 to 43.2 in 1981-84; 23.3 in 1985; 20.1 in 1986; 18.3 in 1987; 20.4 in 1988.)

38. 20 C.F.R. § 404, Subpart P, Appendix 1. Since the Supplemental Security Income standard is identical to the standard for Disability Insurance Benefits, the Listing in Part 404 of the regulations, which covers Disability Insurance Benefits, is incorporated by reference in the Supplemental Security Income regulations. *See id.*, § 416.925. The Listing is discussed at text accompanying notes 314-25, *infra.*

39. 20 C.F.R. §§ 404.1520(d), 416.920(d).

40. The Administration is required to evaluate a claimant's impairment against the Listing in every case that reaches the third step of the sequential evaluation process. 20 C.F.R. §§ 404.1520(a), (d), 416.920(a), (d). *Cf.* Hutchison v. Bowen, 787 F.2d 1461, 1463 (11th Cir. 1986) (although administrative law judge "did not explicitly state that the [claimant's] impairments were not contained in the listings, such a determination was implicit in the . . . decision" and thus did not fail to follow sequential analysis). *See also* Livingston v. Califano, 614 F.2d 342, 345 (3d Cir. 1980). Even though a claim can be resolved later in the sequential evaluation process, failure to decide whether a claimant meets or equals the requirements of the Listing is cause for remand. *See* Hutchinson v. Schweiker, 535 F.Supp. 962, 969 (S.D. Ohio, 1982). *See also* Todd v. Heckler, 736 F.2d 641, 642 (11th Cir. 1984) (remand necessary so that administrative law judge could fulfill "duty to develop the facts [concerning relationship of claimant's impairment to listing] fully and fairly"). Thus, when a claim may be based on a listing, "the [Administration] should set forth a sufficient rationale in support of [its] decision to find or not to find a listed impairment." Berry v. Schweiker, 675 F.2d 464, 469 (2d Cir. 1981). *See also* Streissel v. Schweiker, 717 F.2d 1231, 1233 (8th Cir. 1983).

41. 20 C.F.R. §§ 404.1520(d), .1526; 416.920(d), .926. Medical equivalence is defined further as requiring "medical findings...at least equal in severity and duration to the listed findings." *Id.* §§ 404.1526(a), 416.926(a).

42. *Id.* The listing used will be the listing for the particular impairment; if that impairment is not listed, the listing of the impairment most like the claimant's impairment included in the listing will be used. *Id.*

43. *Id.* §§ 404.1526(b), 416.926(b). *See also* S.S.R. 83-19 (Cum. Ed. 1981-85).

44. Medical equivalence determinations are discussed further at text accompanying notes 357-78, *infra.*

slight impairments. The third step is the converse to the second: claimants are found disabled on the basis of medical evidence which demonstrates that their impairments are so severe that consideration of age, education or work experience is unnecessary.

The last two steps of the sequential evaluation process combine the effects of a claimant's age, education and prior work experience with functional limitations caused by the claimant's physical or mental impairments, in order to address directly the ultimate eligibility issue of whether the claimant can perform any substantial gainful activity which exists in the national economy. The fourth step asks whether the claimant can perform any jobs he or she performed in the past; if so, and assuming that the work was performed in the not too distant past and amounted to substantial gainful activity, the claimant is not disabled.[45] If the claimant cannot perform past relevant work, then the process moves to the final step at which the question is whether the claimant can perform any other work existing in the national economy.[46]

Some of the issues raised in these last two steps of the sequential evaluation process are purely vocational: the specific work requirements of a particular job, whether work a claimant performed for only a short period of time should be considered as relevant past work, whether the claimant acquired transferable skills during past work, and whether a job exists in sufficient numbers in the national economy to be considered.[47] More often, however, the important issues relate to the claimant's ability to function, which involves two different types of assessments. The issue can be whether the claimant has a general capacity to perform work-related tasks at a certain level, known as the claimant's "residual functional capacity" for work. This requires an assessment of the claimant's medically-based functional limitations. On the other hand, the issue can be whether the claimant has the physical or mental capacity to perform any particular aspect of a job identified as vocationally relevant. This requires an assessment of the claimant's medical-vocational functional limitations.

If a claim is resolved at the fourth step of the sequential evaluation process on the basis of a finding that the claimant can perform past relevant work, the contested medical-vocational issues are usually relatively simple: does the claimant have the ability to carry out the tasks required at a job he or she has performed in the past. If a case progresses to the fifth step of the process, the burden shifts to the Social Security Administration to prove that the claimant can perform other work available in significant numbers in the national economy.[48] There are two methods available to the Administration for meeting this burden. The preferred option is to use its Medical-Vocational Guidelines, which includes a set of three tables designed to identify whether significant numbers of jobs exist in the national economy for claimants with specified levels of residual functional capacity, age, education, and prior work experience.[49] The medical issue is the claimant's residual functional capacity, that is, whether the claimant

---

45. *See* 20 C.F.R. §§ 404.1520(e), 416.920(e).

46. *Id.* §§ 404.1520(f), 416.920(f).

47. *See generally* F. Bloch, *supra* note 15, at §§ 2.31, 2.33, 2.39.

48. Neither the act nor regulations allocate the burden relative to the question whether a claimant can perform available alternative work; however, this shifting of burden is clearly established by case law. *See e.g.*, Rodriguez v. Bowen, 876 F.2d 759, 761 (9th Cir. 1989); Ray v. Bowen, 865 F.2d 222, 224 (10th Cir. 1989); Tennant v. Schweiker, 682 F.2d 707, 710 (8th Cir. 1982. An administrative law judge will be reversed if he or she fails to shift the burden of proof. *See* Fowler v. Bowen, 866 F.2d 249, 251 (8th Cir. 1989); Trundle v. Bowen, 830 F.2d 807, 810 (8th Cir. 1989) (administrative law judge must "explicitly" shift burden of proof).

49. 20 C.F.R. § 404, Subpart P, Appendix 2. The Guidelines have been incorporated into the Supplemental Security Income regulations at Part 416. *Id.*, § 416.969. *See generally* note 38, *supra*.

is limited to sedentary work, light work, or medium work.[50] There is a table, or "grid," for each of these three levels of residual functional capacity; each table has a set of "rules" with entries in three columns accounting for a claimant's age, education, and previous work experience, and a final entry in a fourth column which directs a decision of disabled or not disabled. The appropriate grid is chosen based on the claimant's residual functional capacity; then, a particular rule is chosen based on the claimant's age, education, and previous work experience, which directs a conclusion that the claimant is or is not disabled.[51]

The Medical-Vocational Guidelines can be used to find that a claimant is not disabled only when all of the criteria involved in choosing an applicable rule in the grids are met. Thus, the Guidelines are not applicable "where their evidentiary underpinnings do not coincide exactly with the evidence of disability appearing on the record."[52] Because the Guidelines take into account only exertional impairments in determining residual functional capacity, they cannot be used to prove nondisability when a claimant suffers from a nonexertional impairment.[53] The determination whether the Guidelines apply can involve significant medical questions with respect to the existence of nonexertional impairments such as mental, sensory, or skin impairments, and postural, manipulative, or environmental restrictions.[54] Other types of nonexertional impairments include alcoholism,[55] pain,[56] and mental or psychological impairments.[57] In order to

---

50. *See id.* § 404, Subpart P, Appendix 2, at 201.00, 202.00, 203.00. Residual Functional Capacity is discussed at text accompanying notes 381-91, *infra*. There is no table for individuals still able to perform heavy or very heavy work; the medical-vocational guidelines provide, in effect, that sufficient jobs exist in the national economy for such individuals regardless of their age, education or work experience. 20 C.F.R. § 404, Subpart P, Appendix 2, at 204.00. On the other hand, if it is found that an individual is unable to perform work at even a sedentary level, he or she will assume to be disabled, absent specific evidence to the contrary. 43 Fed. Reg. 55,353 (1978).

51. The grids were developed by the Social Security Administration by taking notice of various types of vocational data supported by major government publications, such as the U.S. Department of Labor's Dictionary of Occupational Titles and Occupational Outlook Handbook. *See* 20 C.F.R. § 404, Subpart P, Appendix 2 at 200.00(b). The Supreme Court has upheld the guidelines as a valid exercise of the Secretary's rule-making authority. Heckler v. Campbell, 461 U.S. 458 (1983). There is still some controversy with respect to the application of the age criteria of the grids. *See* Broz v. Schweiker, 711 F.2d 957, 959 (11th Cir. 1983), *reh'g denied*, 721 F.2d 1297 (11th Cir. 1983).

52. Thomas v. Schweiker, 666 F.2d 999, 1004 (5th Cir. 1982). *See also Heckler*, 461 U.S. at 462 n. 5; 20 C.F.R. § 404 Subpart P, Appendix 2, at 200.00(a) ("where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled").

53. *See* S.S.R. 85-15 (Cum. Ed. 1985). The grids may be used, however, as a guideline once a nonexertional impairment is found. *See* 20 C.F.R. § 404, Subpart P, App. 2 Rule 200.00(e)(2); Eggleston v. Bowen, 851 F.2d 1244, 1247 (10th Cir. 1988) ("[U]se of the Grids is only precluded to the extent that nonexertional impairments further limit the claimant's ability to perform work at the applicable exertional level").

54. *See* 20 C.F.R. § 404, Subpart P, Appendix 2, at 200.00(e); 43 Fed. Reg. 55,358 (1978). See generally SSR No. 83-13 (1983). Environmental limitations include exposure to dust, fumes, and heat. See Thomas v. Schweiker, 666 F.2d 999, 1004 (5th Cir. 1982).

55. *See* Neal v. Bowen, 829 F.2d 528, 531 (1987); Cannon v. Harris, 651 F.2d 513, 518 (7th Cir. 1981).

56. *See* Green v. Schweiker, 749 F.2d 1066, 1072 (3d Cir. 1984); Nelson v. Heckler, 712 F.2d 346, 348 (8th Cir. 1983); Dellolio v. Heckler, 705 F.2d 123, 127 (5th Cir. 1983). However, the Sixth Circuit rejected pain as a non-exertional impairment for these purposes because pain is not included in a list of non-exertional impairments in the Guidelines, which includes mental, sensory and environmental limitations. Cole v. Secretary, 820 F.2d 768, 772 n.1 (6th Cir. 1987) (refusing to follow *Green*, that had characterized chest pains and dizziness as nonexertional). The dissent in Cole, however, found that the regulations mention the list only as an example and "do not dictate that other limitations which affect more than physical exertional may not be considered nonexertional". The dissent's approach is used by the majority of the Circuits. *See, e.g.*, Bolton v. Bowen, 814 F.2d 536 (8th Cir. 1987) (pain and dizziness).

57. *See* Webber v. Secretary, 784 F.2d 293, 299 (8th Cir. 1986) (hypochondriasis); Grant v. Schweiker, 699 F.2d 189, 192 (4th Cir. 1983) (low intelligence and impaired dexterity).

preclude the use of the Guidelines, the nonexertional impairment must have a significant effect on the claimant's ability to perform a full range of work activity at the designated residual functional capacity level.[58]

When the Guidelines cannot be used to meet the Administration's burden of showing that suitable alternative employment exists, particular proof as to the availability of jobs for the individual claimant must be presented. In claims reaching this stage of the process, the vocational issues are the most complicated.[59] The medical questions, which can also be difficult, are similar to those involved in determining whether a claimant can perform past relevant work: can the claimant perform the tasks required in the jobs identified by the vocational expert.

b. Surviving Spouse's Disability Benefits and Child's Supplemental Security Income

There are two types of Social Security disability benefits for which claimants must establish eligibilty on the basis of a substantially different disability standard from that used for Disability Insurance Benefits, Childhood Disability Benefits, and adult Supplemental Security Income: Survivor Insurance Benefits for surviving spouses of insured workers seeking disability benefits under the Old Age, Survivors and Disability Insurance Program, and child's Supplemental Security Income for children seeking benefits on the basis of their own disability. In both cases, the disability standard is more strict than the standard used for the majority of beneficiaries in those programs, disabled insured wage earners and disabled adult children of insured wage earners under the Old Age, Survivors and Disability Insurance Program and adults under the Supplemental Security Income program.[60] These stricter disability requirements, discussed separately below, limit eligibility for surviving spouse's disability benefits and child's Supplemental Security Income to claimants with impairments that meet or equal the criteria in the Social Security Administration's Listing of Impairments.[61]

There are two differences in the disability standard for surviving spouse's disability benefits that result in a stricter set of requirements for those benefits as compared to Disability Insurance Benefits for insured wage earners. The first difference goes to the severity of the disabling impairments or impairments. A disabled spouse must suffer from an impairment at "a level of severity which under regulations prescribed by the [Social Security Administration] is deemed to be sufficient to preclude an individual

---

58. *See e.g.*, Thompson v. Bowen, 850 F.2d 346, 350 (8th Cir. 1988); Kirk v. Secretary, 667 F.2d 524, 537 (6th Cir. 1981), *cert denied*, 461 U.S. 957 (1983). *Cf.* Roberts v. Schweiker, 667 F.2d 1143, 1145 (4th Cir. 1981) (once a claimant's nonexertional limitations were recognized "recourse must be had to other evidence than the [guidelines] alone to conclude whether the claimant is capable of performing alternative work").

59. Particular jobs must be identified which can be performed by the claimant given his or her age, education and prior work experience. Often expert vocational testimony is needed to identify such jobs. *See* 20 C.F.R. §§ 404.1566(e), 416.966(e); Spencer v. Bowen, 798 F.2d 275, 277 n.2 (8th Cir. 1986); Ferguson v. Schweiker, 641 F.2d 243, 247-48 (5th Cir. 1981); Cowart v. Schweiker, 662 F.2d 731, 736 (11th Cir. 1981). However, failure by an administrative law judge to call a vocational expert does not constitute reversible error as long as substantial evidence supports the conclusion. Tucker v. Bowen, 776 F.2d 793, 796 (8th Cir. 1985). *See also* Dawson v. Bowen, 815 F.2d 1222 (8th Cir. 1987) ("[Administration] must produce expert vocational testimony or other evidence that jobs are available").

60. In addition to the usual non-disability requirements surviving spouses must satisfy certain additional requirements, including a minimum age requirement of 50 years. Benefits are available only until age 60, after which time survivors old age benefits can be awarded. 42 U.S.C. §§ 402(e)(1)(B)(ii), f(1)(B)(ii) (Supp. IV 1986). *See generally*, Bloch, *supra* note 15, at §§ 3.17 - .18.

61. *See generally* text accompanying notes 38-44, *supra*. This restrictive reading of these standards has been challenged. *See* text accompanying notes 67-70, *infra*.

from engaging in any gainful activity."[62] The standard itself differs from the standard for Disability Insurance Benefits in two respects: first, a stricter concept of "any gainful activity" is used in place of the more liberal "any substantial gainful activity"; and second, the Social Security Administration is expressly authorized to define what is meant by "any gainful activity" through regulation. The second major difference is that the disability standard for surviving spouses specifically removes from consideration nonmedical vocational factors, such as a claimant's age, education and prior work experience.[63]

The promulgation of a more restrictive disability standard for surviving disabled spouses was deliberate. Congress intended, when it amended the Social Security Act in 1967 to include spouse's disability benefits, that this new area of disability entitlement be open to a relatively narrow group of beneficiaries.[64] The Social Security Administration has implemented the surviving spouse's disability standard by requiring an impairment or combination of impairments that meet or equal an impairment found in the Administration's Listing of Impairments.[65] In other words, a claimant's condition is considered sufficiently severe to preclude engaging in any gainful activity only if the requirements of the Listing of Impairments, or the equivalent, are met. As a result, surviving spouse's disability claims are evaluated by means of only the first three steps of the sequential evaluation process.[66] The real difference is that an evaluation according to the Listing of Impairments becomes the dispositive evaluation in spouse's disability benefit cases, as opposed to an optional finding of presumptive disability before vocational factors are taken into account, as is done in Disability Insurance Benefits claims.

Attempts to challenge the more restricted disability standard for spouses have been, by and large, unsuccessful.[67] Typically, courts have found that limiting eligibility to persons whose impairments meet or equal a listed impairment is a reasonable policy consistent with congressional intent, since Congress specifically charged the Administration with promulgating regulations defining the spouse's disability standard.[68] More recently, some courts have questioned whether the "any gainful activity" standard has been implemented properly through the Social Security Administration regulations.[69] Thus, there seems to be some room to argue that disability can be established in a Surviving Spouse's Insurance Benefits case by proving that the claimant cannot engage in "any gainful activity" because of factors other than those included in the Listing, such as greatly diminished residual functional capacity, or, in the alternative, that there should

---

62. 42 U.S.C. § 423(d)(2)(B). There is an independent requirement that the spouse be at least 50 years of age. *See* note 60, *supra*.

63. *See id.* § 423(d)(2)(A).

64. *See* S. Rep. No. 744, 90th Cong., 1st Sess. 49 (1967); 113 Cong. Record 23,049 (1967) ("we wrote this provision of the Bill very narrowly...because it represents a step into an unexplored area where cost potentials are an important consideration") (statement of Chairman, House Committee on Ways and Means).

65. 20 C.F.R. § 404.1578(a)(1). *See also id.* § 404.1525(a) (defining level of severity in Listing as precluding engaging in any gainful activity).

66. The regulations mention only the first and third steps; however, all three are logically applicable. *See id.* § 404.1578. *See generally* text accompanying notes 25-44, *supra*.

67. Constitutional challenges have failed consistently. *See e.g.*, Willeford v. Secretary, 824 F.2d 771, 773 (9th Cir. 1987); Wokojance v. Weinberger, 513 F.2d 210, 213 (6th Cir.), *cert. denied*, 423 U.S. 856 (1975); Sullivan v. Weinberger, 493 F.2d 855, 862-63 (5th Cir. 1974), *cert. denied*, 421 U.S. 967 (1975).

68. *See e.g.*, Willeford, 824 F.2d at 773-74; Sullivan v. Weinberger, 493 F.2d at 862; Gillock v. Richardson, 322 F.Supp. 354, 357 (D. Kan. 1970).

69. For a recent, strong decision invalidating the Administration's regulation, *see* Marcus v. Bowen, 696 F.Supp. 364 (N.D. Ill. 1988).

be some broader notion of medical equivalence in Surviving Spouse's Insurance Benefits cases.[70]

Children applying for disability benefits under the Supplemental Security Income program are also required to establish eligibility through the Listing of Impairments. The statutory standard does not provide for special regulations or even a specific, more limited standard. Instead, it says simply that as compared to the general disability standards for adults in the Supplemental Security Income program, "in the case of a child under the age of 18, [the child is disabled] if he suffers from any medically determinable physical or mental impairment of comparable severity."[71] Regulations provide, however, that a child must either meet or equal the criteria in the Listing, supplemented by special provisions in Part B of the Listing applicable only to children under the age of 18.[72] The Social Security Administration has reasoned, in essence, that vocational factors are not relevant for children because they do not function in a work setting.[73]

The Social Security Administration's regulation limiting proof of disability for a child's Supplemental Security Income claim to the Listing of Impairments had been upheld consistently.[74] More recently, however, some courts have taken a fresh look at the issue and have supported the view that a broader set of criteria should be considered in these cases. Thus, in a recent decision, the Third Circuit held that restricting child's Supplemental Security Income disability claims to proof under the Listing was inconsistent with the broader language in the Act.[75] The court found that the Listing "has not been shown to provide an exhaustive catalog of medical findings which could, singly or in combination, describe, 'any' impairment which might satisfy the statutory standard of 'comparable severity.'"[76]

2. Other Disability Programs

The disability standards used for other federal disability programs all share with the general Social Security disability standard a primary focus on the effect of an impairment on the claimant's ability to work. Beyond this, however, most other programs depart from the Social Security standard in one or more major respects. The one exception is the Railroad Retirement program which, for most claimants, applies a standard essentially identical to the Social Security standard. It is not surprising, therefore, that the entire Railroad Retirmeent program is administered in much the same

---

70. *See e.g.*, Tolany v. Heckler, 756 F.2d 268, 270-71 (2d Cir. 1985); Hamby v. Heckler, 607 F.Supp. 331, 334 (W.D.N.C. 1985). Thus, in Taggart v. Heckler, 576 F.Supp. 624, 627 (W.D. Ark. 1984), the Court stated that "[t]he true standard of the medical equivalence test is whether a claimant is capable of doing any gainful activity." Medical equivalence is discussed at text accompanying notes 357-77, *infra*.

71. 42 U.S.C. § 1382c(3)(A) (1982).

72. *See* 20 C.F.R. § 416.924(b). The Listing of Impairments, including part B, is discussed at text accompanying notes 314-25, *infra*.

73. As explained when the Part B listings were promulgated in 1977, since "children are not expected to engage in work activity, disability in children has been defined in terms of a child's activity, growth and development. Thus, the child's theoretical capacity to engage in work activity is not considered in determining disability under the [Listing of Impairments]." 42 Fed. Reg. 14,705, 14,706 (1977). *See also* 45 Fed. Reg. 55,566, 55,570 (1980) ("[T]he use of vocational factors is not appropriate since the activities of children under 18 are extremely difficult to measure in vocational terms. In view of this, it is more equitable to evaluate childhood claims on medical terms--i.e. the impairment must meet or equal the Listing of Impairments").

74. *See e.g.*, Hinckley v. Secretary, 742 F.2d 19, 23 (1st Cir. 1984); Powell v. Schweiker, 688 F.2d 1357 (11th Cir. 1982).

75. Zebley v. Bowen, 855 F.2d 67 (3d Cir. 1988). The Supreme Court has granted *certiorari* in *Zebley*, ____ U.S. ____ (1989). *See also* Marcus v. Bowen, 696 F.Supp. 364, 376-377 (N.D. Ill. 1988).

76. *Zebley*, 855 F.2d at 69.

way as is the Social Security program. The Civil Service disability retirement standard is also quite similar to the Social Security standard, except that it incorporates a very different vocational frame of reference in assessing a claimant's ability to work.

Two other programs use markedly different disability standards. Both Veterans and Black Lung disability benefits are awarded only for impairments relating to activity -- military service and coal mine employment -- which led to the promulgation of the applicable laws.[77] As a result, the standards in these programs focus more closely on the origin and, in the Black Lung program, the specific diagnosis of the impairment. Also, the Veterans program includes payment for partial disability to some beneficiaries.

a. Railroad Retirement Programs

A railroad employee may qualify for a disability annuity under the Railroad Retirement Act[78] in two ways: the employee can be disabled with respect to his or her regular railroad occupation,[79] or with respect to any regular employment.[80] The nondisability requirements for occupational disability based on the inability to engage in the employee's regular railroad occupation are relatively restrictive; accordingly, most railroad employees apply for benefits on the basis of total disability.[81] Both occupational and total disability must be based on a "permanent" physical or mental condition, defined as an impairment that has lasted or can be expected to last for a continuous period of not less than twelve months.[82]

i. Occupational Disability

Occupational disability can be established when the employee's condition precludes performance of his or her regular railroad-related occupation.[83] This disability evaluation is made in accordance with occupational standards established by the Railroad Retirement Board in cooperation with the railroad industry. Occupational disability standards are set out by occupation; when applying them the Board looks to the individual's regular occupation or to a "reasonably comparable occupation."[84] The occupational disability standards resemble the Social Security Administration's Listing of Impairments, and are applied in much the same way.[85]

---

77. There are also veterans disability pension benefits which are not based on service-connected impairments. However, most disability benefits awarded in the veterans program are for service-connected impairments.

78. 45 U.S.C § 231-231u (1982 & Supp. V 1987).

79. *Id.* § 231a(a)(1)(iv).

80. *Id.* § 231a(a)(1)(v).

81. In order to qualify for occupational disability the employee must have a current connection with railroad industry and must be either sixty years of age or have completed twenty years of railroad employment. *Id.* § 231a(a)(1)(iv). Employees who have completed ten years of railroad service can apply for benefits based on total disability. *Id.* § 231a(a)(1)(v).

82. 20 C.F.R. § 208.10(a) (1988).

83. A regular railroad occupation is either the railroad occupation the claimant performed for more months than any other occupation in the past five years, or the railroad occupation performed for at least half of the months the claimant had been working in the past fifteen years. *Id.* § 208.9.

84. *Id.* § 208.11(a); 45 U.S.C. § 231a(a)(2).

85. *See* Crenshaw v. United States of America Railroad Retirement Board, 815 F.2d 1066, 1067 (6th Cir. 1987) ("[t]he Social Security Act regulations on disability . . . are sufficiently analagous to those of the Railroad Retirement Act to be applicable to railroad retirement cases"); Welsh v. Railroad Retirement Board, 665 F.2d 224, 225 (8th Cir. 1981). The Listing of Impairments is discussed at text accompanying notes 314-25, *supra*.

ii. Total Disability

In order to establish total disability, or the inability to engage in any regular occupation, a claimant must be "unable to perform regularly in the usual and customary manner, the substantial and material duties of any regular and gainful employment which is substantial and not trifling with any employer, whether or not subject to the [Railroad Retirement Act]."[86] One option is for the claimant to prove that he or she suffers from one of seven presumptively disabling conditions.[87] In most situations, however, total disability is evaluated according to the same criteria used by the Social Security Administration for Disability Insurance Benefits and Supplemental Security Income. Although the disability standards set forth in the two Acts are not identical, courts have found it illogical to predicate a different result in a disability claim based on the use of the words "any regular employment" as opposed to "any substantial gainful activity."[88]

Railroad Retirement disability claims are evaluated in most instances not only according to the same standards used to determine disability in Social Security cases, but also through the use of the same sequential evaluation process.[89] Although most differences between the Railroad Retirement and Social Security disability programs have been eliminated, if there is a direct conflict between the two Acts, the Board is bound by the Railroad Retirement Act.[90] This technical distinction between the two Acts is most likely to result in differences where there is lack of certainty in the Social Security disability program.[91]

b. Civil Service Disability Retirement Benefits

Federal employees are eligible for disability benefits as part of the Civil Service Retirement Program.[92] The general disability standard for the Civil Service disability

---

86. 45 U.S.C. § 231a(1(v); 20 C.F.R. § 208.17(a).

87. The requirements for presumptive disability are discussed at text accompanying notes 306-07, *infra*.

88. *See* Duncan v. Railroad Retirement Board, 375 F.2d 915, 917 (4th Cir. 1967) ("no reason suggests itself for adopting a different standard under the Railroad Retirement Act from that which the decisions have elaborated under the Social Security Act"). *See also*, Estes v. Railroad Retirement Board, 776 F.2d 1436, 1438 (9th Cir. 1985); Goodson v. Railroad Retirement Board, 595 F.2d 881, 882 n.2 (D.C. Cir. 1979).

89. *See* Arp v. Railroad Retirement Board, 850 F.2d 466, 467 (8th Cir. 1988); Burleson v. Railroad Retirement Board, 711 F.2d 861, 862 (8th Circuit 1983). The sequential evaluation process is discussed at text accompanying notes 25-69, *supra*.

90. *See, e.g.*, Costello v. Railroad Retirement Board, 780 F.2d 1352, 1354-55 (8th Cir. 1985) (Railroad Retirement Board not bound by amendments to Social Security Act where there is not a corresponding amendment to the Railroad Retirement Act); Calderon v. Railroad Retirement Board, 780 F.2d 812, 814 (9th Cir. 1986) (Trial work authorized under Social Security Act conflicts with Railroad Retirement Act).

91. Thus, some doubt about the application of the age criteria in the Social Security Administration's Medical-Vocational Guidelines to Railroad Retirement cases has been expressed, based on similar concerns about the applicability of the Guidelines in Social Security cases. *See* Boggs v. Railroad Retirement Board, 725 F.2d 620 (11th Cir. 1984), citing Broz v. Heckler, 721 F.2d 1297 (11th Cir. 1983). *See generally* note 51, *supra*, and accompanying text.

92. Until January 1, 1984, federal employees were exempt from participation in the Old Age, Survivors, and Disability Insurance program of the Social Security Act; all federal employees who began their employment before January 1, 1984, remain covered by the Civil Service disability program rather than the Social Security disability program. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 101, 97 Stat. 67-70 (1983). In 1986, Congress established the Federal Employees Retirement System, which serves as a supplemental program for federal employees covered by the Social Security program. *See* Federal Employees Retirement System Act, Pub. L. No. 99-335, § 100A, 100 Stat. 516 (1986). As a result, federal employees hired after January 1, 1984, are automatically covered by both the Social Security Act and the Federal Employees Retirement System; in addition, federal employees hired before January 1, 1984, and therefore still covered by the Civil Service Retirement System,

program is much more lenient than the standard used in the Social Security Disability Insurance Benefits program, in which benefits are available only to persons unable to perform any job that exists in significant numbers in the national economy consistent with their vocational abilities and a minimum standard of economic gain. By contrast, a federal employee can be retired on the basis of disability "if the employee is . . . unable, because of disease or injury, to render useful and efficient service in the employee's position and is not qualified for reassignment . . . to a vacant position which is in the agency at the same grade or level and in which the employee would be able to render useful and efficient service."[93] The evaluation of a claimant's ability to perform "useful and efficient service" involves a medical-vocational determination of the claimant's ability to perform the tasks required at his or her last position in federal employment.[94]

c. Veterans Disability Program

There are two fundamentally different types of disability benefits available to veterans of the military forces of the United States: compensation benefits paid to compensate a veteran for service-connected injury or disease, and pension benefits paid to relieve veterans of financial hardship caused by disabilities unrelated to service activity.[95] The pension program is in many respects quite similar to the Supplemental Security Income program. The compensation program, on the other hand, is totally different from any disability program governed by the Social Security Act. This results mostly from the service connection requirement which, although not precisely part of the disability standard, involves substantial medical-legal issues.

Both compensation and pension benefits are awarded on the basis of disability standards designed to measure the effect of the veteran's disease or injury on his or her earning capacity. The underlying statutory provisions relating to the disability requirements for the two types of benefits differ, however, in two major respects. First, there is no statutory disability standard for compensation benefits. Instead, the Veterans Administration is directed to "adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries . . . [which] shall be based as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations."[96] By contrast, pension benefits are governed by a two-part disability standard that includes a relatively specific definition of disability together with a broad grant of discretionary authority to the Administration for cases

---

were given an option to transfer to the new system. *See generally* Kearns, *Federal Employees Retirement System Act of 1986*, 49 Social Security Bulletin 5 (1986).

93. 5 U.S.C. § 8337(a) (Supp. V 1987). The same standard is used for the Federal Employees Retirement System. 5 U.S.C. § 8451(a)(1)(B) (Supp. IV 1986). The legislative history of the supplemental program reveals no indication that Congress considered restricting the disability standards for the Federal Employees Retirement System disability program. *See generally, Civil Service Pension Reform Act of 1985: Hearings on S.1527 Before the Senate Comm. on Governmental Affairs*, 99th Cong., 1st Sess. (1985); H.R. Rep. No. 606, 99th Cong., 2d Sess. (1986). A claimant must also have completed a minimum number of years of service. The minimum period for Civil Service benefits is five years; the minimum period is only eighteen months under the Federal Employees Retirement System. *See* 5 U.S.C. §§ 8331(1)(i), (ii)(x) (1982); *id.* § 8337(a)(1)(A).

94. This standard is discussed in more detail at text accompanying notes 409-24, *infra*.

95. *See* 38 U.S.C. §§ 301-362, 501-562 (1982 & Supp. V 1987). There are a number of nondisability requirements for both disability compensation and disability pension benefits. *Id.* §§ 310, 331, 521. Thus, claimants for both compensation and pension benefits must have participated in active military service. *See generally*, 38 U.S.C. § 101(24); 38 C.F.R. § 3.6 (1988). In addition, a veteran must have been discharged or released (from active military service) "under conditions other than dishonorable," 38 U.S.C. §§ 101(2), 310, 331, and the disability cannot be the result of the veteran's "willful misconduct." *See, id.* §§ 310, 331, 521(a); 38 C.F.R. § 3.1(n). The Veterans pension program includes income and resources requirements. 38 U.S.C. §§ 521, 522, 541, 543.

96. 38 U.S.C. § 355.

that fall outside of that definition.[97] The second difference is that the disability standard for compensation benefits allows findings of partial or total disability, with benefits awarded on the basis of established degrees of disability, while pension benefits are awarded only if the veteran is "permanently and totally disabled."[98]

i. Compensation Benefits

Disability determinations for compensation benefits are made whenever possible by specific references to the Veterans Administration's Schedule for Rating Disabilities, a listing of various disabilities with different assigned ratings which represent the percentage by which a veteran's earning capacity in a civil occupation is considered to be impaired by the particular disability.[99] A percentage rating or a group of ratings, scaled according to degree of severity from 10 to 100 percent, is listed for each disease or injury "represent[ing] as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations."[100] Except for the use of percentages, which is consistent with the compensation orientation of the program, the Schedule is similar in concept and approach to the Social Security Administration's Listing of Impairments. When the veteran's impairments do not fit precisely within the Schedule, other methods for determining an appropriate percentage by analogy to the Schedule are available.[101] Benefits can also be awarded for total disability upon proof of "unemployability."[102]

The service connection requirement can present extremely difficult questions of proof which are linked directly to the disability determination process. Even though a veteran's injury or disease is not in dispute, there can be serious questions relating to both the timing of the onset and etiology. There are a number of presumptions which assist in resolving the timing issue for proof of service connection, including a presumption that every veteran entered military service in "sound condition,"[103] and various general and specific presumptions dealing with the onset of certain chronic and tropical diseases.[104] The most troubling cases with respect to etiology are claims based on exposure to Agent Orange and radiation.[105]

ii. Pension Benefits

The disability standard for pension benefits provides for two alternative bases for eligibility. The first is tied to the permanent inability to work: "any disability which is sufficient to render it impossible for the average person to follow a substantially gainful occupation, but only if it is reasonably certain that such disability will continue

---

97. *Id.* § 502(a).

98. *Compare id.* §§ 314, 334 with *id.* § 521(a).

99. The Schedule is discussed at text accompanying notes 326-41, *infra*. *See generally* 38 C.F.R. §§ 4.1-.150.

100. *Id.* § 4.1.

101. *See id.* § 4.20 ("[w]hen an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous").

102. *See* text accompanying notes 425-34, *infra*.

103. 38 U.S.C. §§ 311, 332; 38 C.F.R. §§ 3.304(b), .305(b).

104. *See generally*, 38 U.S.C. §§ 312, 333; 38 C.F.R. §§ 3.308, .309. Some of these presumptions are rebuttable. *See* 38 U.S.C. § 313.

105. *See* text accompanying notes 336-41, *infra*.

throughout the life of the disabled person."[106] The second is set out more broadly: "Any disease or disorder determined by the administrator to be of such a nature or extent as to justify a determination that persons suffering therefrom are permanently and totally disabled."[107]

In practice, the same Schedule for Rating Disabilities used to establish 100% disability for compensation benefits is used to establish total disability for pension purposes, except that to receive pension benefits the disability must be rated not only at 100 percent but must also be "permanent."[108] As with compensation benefits, pension benefits can be awarded upon a showing of "unemployability."[109] In practice, the unemployability criterion amounts to a variation on the "inability to engage in substantial gainful activity" found in the Social Security disability standard.

d. Black Lung Disability Benefits

Disability benefits are available under the Black Lung Benefits Act[110] to coal mine workers who have become totally disabled by inhaling coal dust.[111] The basic disability standard for Black Lung benefits under the Act consists of two parts: the miner must be totally disabled; and the disability must be due to black lung disease, or pneumoconiosis.[112] In addition, there is a requirement that the disability arose from coal mine employment.[113]

These eligibility criteria include elements of both a traditional worker's compensation program (the disability must arise as a result of coal mine employment and therefore must be work-related) and a disability program (benefits are paid only for total disability). The coal mine employment requirement is thus comparable to the service connection requirement of the veterans compensation program. The total disability requirement, on the other hand, brings aspects of the Black Lung program closer to the Social Security disability program. There is a third, unique limitation on Black Lung eligibility: the disability must be caused by a particular disease, pneumoconiosis. Thus, a coal miner can contract Black Lung disease from work in a mine yet collect no compensation until the effects of the disease are totally disabling; in addition, benefits are not available to all miners totally disabled from coal mine employment, but only if the total disability resulted from pneumoconiosis.[114]

---

106. 38 U.S.C. § 502(a)(1).

107. *Id.* § 502(a)(2).

108. *See* text accompanying note 98, *supra*. *See also* 38 C.F.R. § 3.340(b) (Impairments are considered permanent when they are "reasonably certain to continue throughout the life of the disabled person").

109. *See* text accompanying notes 425-44, *infra*.

110. 30 U.S.C. §§ 901-945 (1982 & Supp. V 1987).

111. Benefits are also paid under certain circumstances to survivors of miners who died as a result of coal dust exposure or were totally disabled at the time of death due to such exposure. *See generally id.* § 922(a).

112. *Id.* § 901(a).

113. *Id.* *See also* 20 C.F.R. §§ 410.416 (a) (1988), 718.203 (a) (1988). This can be proved with the assistance of a presumption. *See* 30 U.S.C. § 921(c)(1) (1982) ("if a miner who is suffering or suffered from pneumoconiosis is employed for 10 years or more in one or more coal mines there shall be a rebuttable presumption that his pneumoconiosis arose out of such employment"). *See* also 20 C.F.R. §§ 410.416(a), 718.203(b) (1988).

114. A miner may become eligible for benefits through the interim presumption without establishing total disability due to pneumoconiosis. 20 C.F.R. § 727.203. Although the interim presumption can be invoked with or without proof of causality, rebuttal under 20 C.F.R. § 727.203(b)(2) (ability to do usual coal mine work or comparable and gainful work) does not address the causality requirement. *See, e.g.*, Roberts v. Benefits Review Board, 822 F.2d 636, 638 (6th Cir. 1987). Rebuttal under § 727.203(b)(3), on the other hand, requires a finding that total disability did not arise in whole or part from coal mine employment. The Supreme Court seemed to

Notwithstanding this relatively limited scope of the Black Lung Benefits Act, congressional concern over the hardships of coal miners and their families caused by pneumoconiosis is evident in the statutory and regulatory scheme which, until recently, was structured primarily with the intention of resolving the numerous medical questions about Black Lung disease and its causal relationship to disability in the claimants' favor.[115]

Logically, a claimant must first establish that he or she has pneumoconiosis; then, in addition, total disability due to pneumoconiosis must be shown. In order to prove the existence of both pneumoconiosis and total disability, a claimant can use either actual medical evidence of the disease or disability, or medical evidence combined with statutory or regulatory presumptions. The Act and regulations contain such important and detailed presumptions that for most cases the basic disability standard and the presumptions cannot be separated meaningfully. As one court has stated, the Act and regulations "spell out modifying presumptions which serve to endow the term 'pneumoconiosis' with a broad definition, one that effectively allows for the compensation of miners from a variety of respiratory problems that may bear a relationship to their employment in the coal mines."[116]

There are three important presumptions used to evaluate Black Lung disability claims: the irrebuttable presumption, the interim presumption, and the 15-year presumption. The interim presumption is the most liberal method for establishing eligibility, and therefore it is preferred when it can be used; however, it cannot be used in adjudicating claims filed on or after March 31, 1980. Nonetheless, many interim presumption cases are still being adjudicated. Moreover, the Supreme Court held recently that the 10-year requirement for invoking the interim presumption is invalid for certain claimants.[117] Accordingly, a group of Black Lung claimants whose claims were denied because the miner had not worked 10 years are entitled to have their claims reevaluated on the basis of a similar presumption contained in Social Security Administration regulations.[118]

---

recognize that the methods for invocation are broader than those available for rebuttal. *See* Mullins Coal Co. of Virginia, Inc. v. Director, ____ U.S. ____, 108 S.Ct. 427, 431 (1987) *reh'g denied*, ____ U.S. ____, 108 S.Ct. 787 (1988). ("It is noteworthy that only the first of the four alternative methods of invoking the presumption requires proof that the claimant's disease is in fact pneumoconiosis"). See generally text accompanying notes 342-56, *infra*.

115. *See* Rose v. Clinchfield Coal Co., 614 F.2d 936, 939 (4th Cir. 1980) (citation omitted) ("The creation of certain presumptions favoring claimants and the corresponding imposition of certain burdens on those imposing claims under the [Black Lung Benefits] Act reflect the purpose of the statute. Congress intended that the Act should receive a liberal construction in favor of the miner and his dependents"). *See generally* Staff of House Comm. on Education and Labor, *Legislative History of the Coal Mine Health and Safety Act*, 91st Cong., 2d Sess., (Comm. Print 1970); Staff of Senate Comm. on Education and Labor, *Black Lung Benefits Reform Act and Black Lung Benefits Revenue Act of 1977*, 95th Cong., 1st Sess., (Comm. Print 1977). The Act was amended in 1981, cutting back for the first time on the availability of presumptions and special evidentiary rules. *See* Black Lung Benefits Amendments of 1981, Pub. L. No. 97-119, § 202 95 Stat. 1643 (1981).

116. *Rose*, 614 F.2d at 938. In order to facilitate the broad compensatory purposes of 2d Sess., (Comm. Print 1970); Staff of Senate Comm. on Education and Labor, Black Lung Benefits Reform Act and Black Lung Benefits Revenue Act of 1977, 95th Cong., 1st Sess., (Comm. Print 1977). The Act was amended in 1981, cutting back for the first time on the availability of presumptions and special evidentiary rules. See Black Lung Benefits Amendments of 1981, Pub. L. No. 97-119, § 202 95 Stat. 1643 (1981(?).

(?).

. Rose, 614 F.2d at 938. In order t14 (1988).

118. *See* text accompanying notes 126-27, *infra*; 20 C.F.R. §§ 410.490(b)(1)(i), (b)(2). The interim presumption is discussed at text accompanying notes 342-56, *infra*.

The irrebuttable presumption of total disability due to pneumoconiosis is invoked upon the diagnosis of complicated pneumoconiosis.[119] The diagnosis can be made by chest x-ray, biopsy, or by other generally accepted methods of medical diagnosis.[120] In order to establish complicated pneumoconiosis by x-ray, there must be at least one opacity measuring more than one centimeter in diameter.[121] Biopsy evidence must show "massive lesions in the lung."[122] A diagnosis of complicated pneumoconiosis made by other means must establish that an x-ray or biopsy would have produced the required evidence.[123] The interim presumption provides a number of options for invoking a presumption of total disability due to pneumoconiosis, as well as a number of methods for rebutting the presumption when invoked.[124] The 15-year presumption was removed in the 1981 amendments, and therefore is not available for claims filed on or after January 1, 1982.[125]

In cases where presumptions cannot be used, eligibility must be established by direct proof according to criteria in one of two sets of regulations: Social Security regulations for claims filed before March 31, 1980, and Department of Labor regulations for claims filed on or after that date.[126] With respect to proof of pneumoconiosis, the Social Security Administration regulations require essentially the same type of evidence used to invoke the interim presumption. The criteria in the Department of Labor's permanent regulations are similar to those contained in the Social Security Administration regulations, except that stricter quality standards apply and, for claims filed after January 1, 1982, the procedures for weighing and evaluating x-ray evidence are somewhat less favorable for claimants.[127] Permanent regulations also provide for proof of pneumoconiosis through medical reports of a physician "exercising sound medical judgment."[128]

Social Security Administration regulations covering proof of total disability include three categories of impairments which can be established based on medical evidence alone,[129] or through medical vocational proof that the claimant "is . . . not only unable to do his previous coal mine work, but also cannot . . ., considering his age, his education, and work experience, engage in any other kind of comparable and gainful work

---

119. 30 U.S.C. § 921(c)(3); 20 C.F.R. §§ 410.418, 718.304. The irrebuttable presumption was upheld by the Supreme Court as a rational method of determining eligibility for benefits compensating miners with advanced stages of pneumoconiosis. Usery v. Turner Elkhorn Mining Company, 428 U.S. 1 (1976).

120. 20 C.F.R. §§ 410.418(a), (b), (c), 718.304(a), (b), (c). Complicated pneumoconiosis can also be diagnosed by autopsy for purposes of survivor's benefits. *Id.*

121. 20 C.F.R. §§ 410.418(a), 718.304(a). The measurement must show an opacity greater than, not just equal to, one centimeter. Gaudiano v. United States Steel Corp., 1 BLR 1-949, 1-951 (1978).

122. 20 C.F.R. §§ 410.418(b), 718.304(b).

123. *Id.* §§ 410.418(c), 718.304(c). *See* F. Clite's v. Jones and Laughlin Steel Company, 663 F.2d 14, 16 (3d Cir. 1982) (autopsy evidence in survivor's benefits case finding complicated pneumoconiosis based on opinion that nodules would have appeared on x-ray at between one and one and one-half centimeters sufficient).

124. The interim presumption is discussed in detail at text accompanying notes 342-56, *infra*.

125. 30 U.S.C. § 921(c)(4).

126. The Sixth Circuit has held that the operative date is the date of adjudication, rather than filing. *See* Knuckles v. Director, 869 F.2d 996, 999 (6th Cir. 1989); Saginaw Mining Co. v. Ferda, 879 F.2d 198, 204-05 (6th Cir. 1989). Social Security regulations are used because the Social Security Administration administered the program until the Department of Labor took over.

127. *See* 20 C.F.R. §§ 718.102 (proof by x-ray); 718.106 (proof by biopsy and autopsy). Quality standards and rules for weighing and evaluating medical evidence in Black Lung cases are discussed at text accompanying notes 606-10, *infra*.

128. 20 C.F.R. § 718.202(a)(4).

129. *See* 20 C.F.R. § 410.424(a), Subpart D, Appendix (the claimant can also prove that the impairment is the "medical equivalent" of the listed impairment). *Id.*

available to him in the immediate area of his residence."[130] Both of these methods parallel methods of proof used by the Social Security Administration for Social Security Disability Insurance Benefits and Supplemental Security Income: the first is in effect a limited version of the Administration's Listing of Impairments and the second is similar to the general medical-vocational standard used when a claimant does not meet the requirements of the Listing.[131] The criteria for determining total disability under the permanent regulations are also similar to those contained in the Social Security Administration regulations. The medical bases for establishing total disability include proof through pulmonary function tests, blood gas studies, the existence of cor pulmonale with right-sided congestive heart failure, and a physician's reasoned medical judgment.[132] As with proof of pneumoconiosis, there are generally stricter quality standards.

B. Administrative Procedures

Each major federal disability program is administered by a different agency.[133] The decisions of each agency are subject in turn to review by different administrative appellate bodies. These various agencies and appellate bodies operate not only at different locations and with different personnel, but also under different -- often quite different -- rules and procedures. There are, of course, many similarities due to the fact that in each instance the administrative procedures used are designed to process disability claims. Each agency, for example, has a system for identifying medical issues, compiling medical records and evaluating medical evidence for an initial decision; appeal procedures for each program take into account the need to review medical-legal issues related to disability. At the same time, many of the differences in administration result from differences in the applicable disability standard. Still other differences result from historical accident or political design.[134]

The background material on administrative procedures included in this section is intended to provide an overview of current disability adjudication practice. The overview includes a general outline of initial claims processing and administrative appeals, with more particular descriptions of those aspects relating directly to the evaluation of medical and medical-legal issues. A full discussion of the more important uses of medically-trained personnel in the disability determination process is reserved for Parts III and IV. As in the preceding section on disability standards, Social Security

---

130. *Id.* § 410.426(a).

131. *See generally* text accompanying notes 25-46, *supra*. Total disability is evaluated under these regulations by means of a process similar to the sequential evaluation process used in social security cases. *See* Bentley v. Director, 7 BLR 1-612, 1-613 (1984); Broughton v. Director, 6 BLR 1-10, 1-13 (1983); Fletcher v. Central Appalachian Coal Company, 1 BLR 1-980, 1-987 (1978).

132. *See generally* 20 C.F.R. § 718.204(c). The pulmonary function tests and blood gas studies must meet the values set forth in tables in the regulations. The tables are published in Appendix B (pulmonary function) and Appendix C (blood gas) to Part 718; *see also* § 718.204(c)(1).

133. Some of the programs in this study include more than one type of benefit. Thus, the Social Security disability program includes Disability Insurance Benefits, Childhood Disability Benefits, Supplemental Security Income and Surviving Spouse's Insurance Benefits; the Veterans program includes compensation and pension benefits. The different types of benefits are administered by the same agency with essentially the same administrative procedures.

134. The Railroad Retirement Board administers what has become essentially a parallel Social Security program for railroad employees for no apparent reason other than the fact that the railroad industry has always been regulated separately. Veterans disability benefits are administered as part of a broad range of activities and responsibilities of the Department of Veterans Affairs that make the procedures of that department and its Veterans Benefits Administration very different from, for example, the Social Security Administration or the Office of Personnel Management.

Administration procedures are presented first, followed by a comparative discussion of administrative procedures used for other programs.

1. Social Security Benefits

Social Security disability claims are evaluated up to four times through three levels of administrative review before a final decision is made to deny benefits.[135] The first two evaluations -- the initial decision and reconsideration of that decision -- are made at the district office level by the Social Security Administration, based on determinations of disability provided by state agencies known generally as Disability Determination Services. The last two evaluations -- an administrative hearing before an administrative law judge and final administrative review by the Appeals Council -- are made under the authority of the Social Security Administration's Office of Hearings and Appeals. Approval rates vary at both the initial decision and administrative hearing levels, which has raised concerns that different standards may be applied depending not only on the personnel involved but also the level of adjudication.[136]

The procedures followed in initial and reconsideration decisions are essentially the same, so they will be discussed together. The administrative law judge and Appeals Council reviews are very different from each other, and therefore will be discussed separately.

a. Initial Determinations and Reconsideration: Disability Determination Services

Applications for Social Security benefits, including Disability Insurance Benefits, Childhood Disability Benefits, Surviving Spouse's Insurance Benefits and Supplemental Security Income are filed with local offices of the Social Security Administration.[137] Most applications are filed in person by the claimant, who is interviewed by a receptionist or a service representative in order to determine for which program the claimant should apply.[138] Recently, the Administration has been encouraging preliminary interviews by telephone.

Early evaluation of the application is done by a claims representative, and is directed primarily at determining non-disability issues such as the claimant's insured status, income and resources and past work activity; a very preliminary assessment is made concerning the nature of the alleged disability, the date of onset and whether the claimant had worked at any time after the onset date. If the claimant had worked during the period covered by the application, a preliminary vocational evaluation is made pursuant to the first step of the sequential evaluation process to determine whether the work was "substantial gainful activity"; if so, the application will be denied at the

---

135. Hence the title of the recent Administrative Conference's study of the final administrative appeal: C. Koch & D. Koplow, The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council (Administrative Conference of the U.S. 1987).

136. Report of the Disability Advisory Council 82 (1988).

137. 20 C.F.R. §§ 404.610, 416.310 (1988).

138. Options include applying for Disability Insurance Benefits, for Supplemental Security Income benefits, or for both. The disability standard for the two programs is identical; this decision is based on other factors, such as work history, income and resources. *See* note 15, *supra*. Or, in appropriate cases, an application for surviving spouse's disability benefits will be submitted. This decision is also based primarily on nondisability factors, even though the standard for these benefits is more strict.

local office.[139] In all other cases, the claim is forwarded to the Disability Determination Services.[140]

The formal application for disability benefits includes a separate form known as the disability report, which is the primary form used by the Disability Determination Services in gathering information for its disability determination.[141] The form includes space for the claimant to state exactly what is wrong, and how the claimant's impairments affect his or her ability to perform work and to participate in daily activities. It also includes a request for information about the claimant's medical records and sources of medical treatment. There is also a section where the claims representative can describe personal observations of the claimant, including any difficulty noted in the claimant's ability to communicate, understand, breathe, sit, see, use hands, etc. These observations are used as lay evidence by the Disability Determination Services in making its determination.

Once the claim is received by the Disability Determination Services, it is assigned to a disability examiner who works together with a member of the Section's medical staff, known as a medical or psychological consultant. Disability examiners typically are college graduates, without any medical background. The Social Security Administration does provide examiners some training in medical issues, which is supplemented by the state agency.[142] A medical consultant must be a physician; a psychological consultant must meet certain professional qualifications.[143] According to Administration policy, the responsibility for making the disability decision, including whether or not the claimant is disabled, the day the disability began and, in termination cases, the day the disability ended, is shared by the disability examiner and the medical consultant.[144] In practice, however, the disability examiner usually takes primary responsibility and then the medical consultant decides whether to concur in the examiner's decision.[145]

The examiner's first responsibility is to review the file and to decide from which medical sources a request will be made for the claimant's medical records. The disability examiner usually decides whether to contact a particular medical source; however, examiners are encouraged to consult with the medical consultant on development -- including ordering a consultative examination -- if the case is at all unusual.[146] Once the disability examiner has obtained all necessary information, an evaluation of the claimant's medical records is made through the use of the Social Security Administration's "sequential evalution process" for determining disability.[147] As part of this process, a medical consultant must make a specific determination with respect to

---

139. *See* text accompanying notes 28-30, *supra*. However, if the claimant engaged in substantial gainful activity for only part of the period in question, the process will continue for the period during which the claimant did not work.

140. *See* 20 C.F.R. §§ 404.1503(c), 416.903(c).

141. There is also a separate work history form used when vocational factors are considered in the evaluation.

142. *See* 20 C.F.R. §§ 404.1622, 416.1022; POMS DI 39518.010B.3. The training responsibility is taken more seriously by some states than others. SSA interview, *supra* note 27.

143. *See* 20 C.F.R. §§ 404.1616, 416.1016. The term "medical consultant" will be used in this report for both medical and psychological consultants.

144. *See* POMS DI 24501.001-.010, DI 39518.010B.

145. SSA Interview, *supra* note 27; DDS interviews, *infra* notes 322, 368, 389.

146. Administration policy states that purchase of consultative examinations should be with "active . . . medical consultant participation." POMS DI 22510.001. The roles of the examiner and the consultant are discussed in more detail in Part IV of this report.

147. *See* text accompanying notes 25-59, *supra*. As noted earlier, the district office makes the determination whether the claimant is engaging in substantial gainful activity, the first step of the sequence. *See* text accompanying note 139, *supra*.

certain key medical-legal issues in the sequential evaluation process: whether the claimant suffers from a condition or combination of conditions that meets or equals the requirements of an impairment included in the Listing of Impairments and the claimant's residual functional capacity.[148] In cases involving a mental impairment, "every reasonable effort" must be made to have a psychiatrist or qualified psychologist complete the medical portions of the review and assess residual functional capacity before a determination is made that a claimant is not disabled.[149]

The examiner uses all of the medical information in the file, including a residual functional capacity assessment and any other medical findings made by the medical consultant, to complete the sequential evaluation process. In practice, it is most likely that the consultant will have made a residual functional capacity assessment or evaluated medical equivalence; often special findings on meeting the Listings are not made.[150] Thus, an examiner may have to decide without early participation by the consultant whether the claimant has a severe impairment or meets the requirements of the Listing of Impairments, in addition to whether the claimant can perform other substantial gainful activity.[151] Throughout this process, the nature and extent of interaction between the examiner and the consultant varies considerably, depending on the experience of the examiner, the quality and availability of the consultant, and the difficulty of the medical issues involved.[152]

Once a disability determination has been made by the Disability Determination Service, a notice of the determination is forwarded to the Social Security Administration for formal action on the application. The Administration then sends a written decision to the claimant, including a statement of the medical evidence considered and the reasons for the decision.[153] If the claimant is dissatisfied with the decision, a request for reconsideration can be filed.[154] Reconsideration evaluations are processed with essentially the same procedures as those used for the initial decision, except that the process begins with a more complete file and different examiners and consultants are used. Also, a face-to-face hearing is provided at reconsideration for beneficiaries found no longer disabled due to medical reasons.[155]

b. Administrative Hearing

---

148. *See generally* POMS DI 24501.010. The processes for deciding residual functional capacity and the medical equivalence of a listed impairment are discussed in detail at text accompanying notes 381-91, 357-74, *infra*.

149. This is a statutory requirement. 42 U.S.C. §§ 421(h), 1382c(a)(3)(G). *See generally* text accompanying notes 456-69, *infra*. *See also* 20 C.F.R. §§ 404.1503(e), 416.903(e); POMS DI 24501.010.

150. DDS interviews, *infra* notes 322, 368, 389.

151. In some cases, the determination whether a claimant can perform other substantial gainful activity can be done by applying the Administration's Medical-Vocational Guidelines, which direct disability decisions based on a claimant's residual functional capacity, age, education, and prior work experience. In other cases, vocational consultants are used to designate specific jobs in the national economy the claimant can perform. *See generally* text accompanying notes 48-59, *supra*.

152. The roles of the examiner and the consultant in reaching a final determination of disability are discussed in more detail at text accompanying notes 630-62, *infra*.

153. The notice must include the reasons for the decision. *See* 20 C.F.R. §§ 404.904, 416.1404. *See also* 42 U.S.C. § 405(b) (requiring detailed notice in unfavorable cases).

154. *See* 20 C.F.R. §§ 404.907-.913, 416.1407-.1413.

155. *See id.* §§ 404.914-.918, 416.1414-.1418.

A claimant can request a *de novo* hearing before an administrative law judge after receipt of an adverse reconsideration decision.[156] In some offices, the administrative law judge, or, more commonly, his or her hearing assistant, will review the file to determine whether additional factual development is necessary; in others, this decision is made by a special development unit. Development can include obtaining existing medical reports from treating sources or hospitals, or new evidence in the form of specially ordered examinations. Consulting physicians are chosen from a panel by the Disability Determination Services. The decision whether to order the examination, however, is left to the administrative law judge.[157]

Once the claimant's file has been completed, including the selection of relevant existing material from the initial processing of the case and new material submitted by the claimant and obtained by the administrative law judge, the case is reviewed and set for hearing.[158] At this point, the judge decides whether to make use of a medical advisor. This practice varies widely, with some judges using medical advisors regularly to interpret and explain medical information and other judges never using them at all.[159] At

the hearing itself, claimants, on their own or through their representatives, can present any testimony and additional documentary evidence they wish. The judges usually take an active role in questioning. They are responsible for assuring that a full and proper record is developed with respect to all apparent impairments, as well as any non-medical issues presented, particularly when the claimant is unrepresented.[160]

After the hearing record is closed, a proposed decision is prepared by a staff attorney or paralegal under the guidance of the administrative law judge. Medical evidence, together with all other evidence in the record, is weighed and evaluated according to applicable law, regulations and rulings. The administrative law judge must not only decide the case based on the record, but must also write a decision which includes findings of fact and the reasons for the decision.[161] The judge is expected to give a clear statement of the medical evidence involved and the basis for reaching key findings of medical facts.[162]

---

156. 20 C.F.R. §§ 404.930(a), 933(b), 416.1430(a), .1433(b).

157. Interview with Francis J. O'Byrne, Hearing Office Chief Administrative Law Judge, Downtown Chicago Office, Office of Hearings and Appeals, Social Security Administration (June 17, 1988) and interview with Donald C. Niersbach, Administrative Law Judge, Downtown Chicago Office, Office of Hearings and Appeals, Social Security Administration (June 9, 1988) [hereinafter Chicago OHA interviews]. Social Security consultative examinations are discussed in greater detail at text accompanying notes 571-86, *infra*.

158. The administrative law judge has the option to issue a favorable decision without a hearing or to remand for further evaluation at the agency level. *See* 20 C.F.R. §§ 404.948, 416.1448; OHA Handbook §§ 1-343, 1-343-11.

159. SSA interview, *supra* note 27. In the downtown Chicago OHA office, for example, medical advisors are called by some judges in up to ten percent of their cases; in the Nashville OHA office, by contrast, there are judges who have never used a medical advisor. Chicago OHA interviews, *supra* note 157; Interview with Peter C. Edison, Hearing Office Chief Administrative Law Judge, and Harry J. Nichol, Jr., Administrative Law Judge, Nashville Office, Office of Hearings and Appeals, Social Security Administration (August 29, 1988) [hereinafter Nashville OHA interview]. The role of medical advisors at hearings is discussed at text accompanying notes 538-41, *infra*.

160. *See, e.g.*, Mimms v. Heckler, 750 F.2d 180, 185 (2d Cir. 1984) (administrative law judge should have asked about a prior disability and any relationship between the prior disability and the pending claim). *See also* Gold v. Secretary, 463 F.2d 38, 43 (2d Cir. 1972). *See generally* Bloch, *Representation and Advocacy at Non-adversary Hearings: The Need for Non-adversary Representatives at Social Security Disability Hearings*, 59 Wash. U.L.Q. 349 (1981). *See also* Smith v. Bowen, 687 F.Supp. 902, 906 (S.D.N.Y. 1988) ("The administrative law judge's duty to develop the comprehensive record . . . is greatest when claimant is unrepresented; but the duty still exists when the plaintiff is represented").

161. 20 C.F.R. §§ 404.953(a), 416.1453(a).

162. This responsibility exists generally, with respect to all relevant evidence, findings and conclusions. *See, e.g.*, Burnett v. Bowen, 830 F.2d 731, 736 (7th Cir. 1987) (the administrative law judge's "failure to comment on

c. Appeals Council

The Appeals Council is the last opportunity for administrative review of a Social Security disability decision. A claimant can request the Appeals Council to review the decision of an administrative law judge, and the Appeals Council may itself initiate a review.[163] An Appeals Council decision, or the denial of a request for review, is a prerequisite to judicial review.[164] In practice, the Appeals Council rarely grants review.

The file is reviewed first by an analyst, who prepares a summary report and recommends a proposed decision.[165] New evidence can be submitted to the Council, unless it relates only to a period after the date of the administrative hearing decision; however, even with respect to arguably post-hearing period evidence, the Council has been quite lenient in considering new medical evidence submitted by claimants. If it appears that additional evidence is needed, the Council may remand the claim for further factual development.

There is a medical support staff available to members and analysts for consultation, both on development and substantive medical questions. The staff is used in less than 10 percent of the cases, usually those involving new evidence or particularly difficult medical issues.[168] In most cases, the important medical issues have already been identified and evaluated at least once or twice below, and therefore additional medical consultation is not needed.[169]

A member of the Appeals Council approves a decision not to review; when a review is undertaken, two members of the Council participate. Virtually all cases are decided on the basis of the written record, including cases accepted for review.[170] A written decision is sent to the claimant, which is the final administrative decision in the

---

the appellant's evidence leaves this court with a record insufficient for a meaningful appellate review . . . [To] ensure meaningful review at least a minimum level of articulation of the [administrative law judge's] assessment of the evidence is required"); Stewart v. Secretary, 714 F.2d 287, 290 (3d Cir. 1983). *Cf.* Berry v. Schweiker, 675 F.2d 464, 469 (2d Cir. 1982). (although court could determine why claimant's argument based on the Listing of Impairments was rejected, in future cases there should be a "a sufficient rationale in support of [the Administration's] decision to find or not to find a listed impairment").

163. *See* 20 C.F.R. §§ 404.967, .969, 416.1467, .1469.

164. *Id.* §§ 404.981, 416.1481. *See also* Schweiker v. Chilicky, ____ U.S. ____, 108 S.Ct. 2460, 2468 (1988); Bloodsworth v. Heckler, 703 F.2d 1233, 1238 (11th Cir. 1983). There are exceptions in certain cases raising constitutional and other collateral issues. *See* Bowen v. City of New York, 476 U.S. 467, 482 (1986); Matthews v. Eldridge, 424 U.S. 319, 330 (1976). However, denials of requests to reopen are precluded from judicial review. *Califano v. Sanders*, 430 U.S. 99, 108 (1977).

165. *See* Koch & Koplow, *supra* note 135, at 115-17.

166. The rule on post-hearing period evidence is relaxed by regulation for Supplemental Security Income cases involving cessation of disability findings and termination of benefits. *See* 20 C.F.R. §§ 404.970(b), .976(b); *id.* §§ 416.1470(B), .1476(b). *See generally* Koch & Koplow, *supra* note 135, at 108-10.

167. *See* 20 C.F.R. §§ 404.977, 416.1477.

168. OHA interview, *supra* note 32. These consultations are supposed to be in writing and included in the record. *Id.*

169. *Id.* If it is needed, the Council may choose to remand the claim. *See* note 167, *supra* and accompanying text.

170. *See* Koch & Koplow, *supra* note 135, at 120-25. The tape of the hearing, or a portion of the tape, can also be considered.

process.[171] Appeals Council decisions affirming or revising an administrative hearing decision can then be reviewed in the federal district courts.[172]

2. Other Disability Programs

There is a remarkable degree of similarity in the administrative procedures used to adjudicate federal disability benefits, considering the differences in the agencies involved and the substantive standards that are applied. This is true generally, so that for each program there is an administrative step that more or less parallels the initial decision, reconsideration, administrative hearing and Appeals Council steps followed by the Social Security Administration. It is also true to a lesser extent with respect to the role of medical decisionmakers in the process. Thus, there is a concentration of use of doctors at the initial stages in all programs, as is the case with the Social Security Administration, although the degree of involvement differs.

The coverage in this section of administrative procedures used in other programs is relatively extensive, for two reasons. First, as with the comparative material presented earlier on disability standards, it helps put current Social Security Administration practice in context. Second, the experience of other programs can be helpful in developing models for the use of medically-trained decisionmakers and in formulating and supporting recommendations for change in the Social Security program.

a. Railroad Retirement Benefits

Railroad Retirement disability benefits are administered according to rules and regulations promulgated by the Railroad Retirement Board pursuant to the Railroad Retirement Act.[173] Railroad Retirement procedures are similar in many respects to those used by the Social Security Administration for processing Social Security Disability Insurance Benefits and Supplemental Security Income.[174] One major difference, however, is the fact that virtually all disability determinations are made at the Board's headquarters in Chicago. Appeals are also handled by the Board in Chicago, through its Bureau of Hearings and Appeals.

i. Initial Determinations: Bureau of Retirement Claims

The Railroad Retirement Board's Bureau of Retirement Claims is responsible for making initial decisions on applications for Railroad Retirement disability benefits.[175] The Bureau is located at the Board's headquarters in Chicago. Although a claimant usually files an initial application at a local district or regional office, the application is then forwarded to the Bureau. The district office does little more than assure that an application is complete before forwarding it to Chicago. Once the disability evaluation

---

171. *See* 20 C.F.R. §§ 404.979, .981; 416.1479, .1481. If the Council denies or dismisses the request, the hearing decision is considered the final decision. *See id.* §§ 404.981, 416.1481.

172. 42 U.S.C. §§ 405(g), (h) (1982 & Supp. IV 1986).

173. *See* 45 U.S.C. § 231f(b)(5) (1982). Current regulations are published at 20 C.F.R. §§ 200-295 (1988).

174. For most claimants the disability standards for the two programs are also substantially the same. *See* text accompanying notes 78-91, *supra*.

175. 20 C.F.R. § 260.1(a)(1).

process is underway, the district office will, when requested, help obtain additional medical evidence.[176]

Bureau staff personnel in Chicago process applications for disability benefits according to procedures similar to those used by state Disability Determination Services in the Social Security program.[177] Disability claims examiners review medical and vocational evidence to determine whether the applicant meets applicable requirements for disability benefits.[178] They are also responsible for developing additional medical evidence, if necessary. The examiners can seek the assistance of part-time medical consultants on contract with the Board at any time in the process. Unlike the Social Security program, there is no requirement that a medical consultant sign off on disability decisions; examiners are free to use, or not to use, medical consultants while deciding a disability claim.[179]

The Bureau must notify claimants of its decision in writing.[180] A claimant may then request reconsideration of an adverse decision.[181] A reconsideration decision, based on the existing file and any additional evidence submitted by the claimant, is made by a disability claims examiner who was not involved in the initial determination.[182] The procedures followed are essentially the same as those used to make the initial decision.

ii. Bureau of Hearings and Appeals

If a claim is denied again on reconsideration, the claimant has the right to appeal to the Bureau of Hearings and Appeals.[183] The Director of Hearings and Appeals appoints a referee to conduct a hearing, if requested, and to decide the appeal.[184] If necessary, the referee can also request additional evidence, including medical reports.[185] Referees then make their decision on the basis of the entire record. They do not use medical consultants in this process, nor do they give much weight to the opinion of the medical consultants used by the Bureau of Retirement claims, unless that opinion is supported by independent medical evidence.[186]

---

176. Interview with John R. Feldheim, Deputy Associate Director for Disability and Medicare Programs, Michael I. Collins, Chief, Disability Programs - Section B, LuBertha M. Wiley, Chief Disability Programs - Section A, Lori A. Watkins, General Attorney, and Grace Koesler, Director, Office of Hearings and Appeals, Bureau of Retirement claims, Railroad Retirement Board (June 10, 1988) [hereinafter RRB interview].

177. Bureau staff see themselves as operating much like a national Disability Determination Service. *Id.*

178. Railroad Retirement disability standards are discussed at text accompanying notes 78-91, *supra*. For most claims the standards are essentially identical to those used for Social Security disability benefits, including use of the Social Security Administration's sequential evaluation process. *See* Burleson v. Railroad Retirement Board, 711 F.2d 861, 862 (8th Cir. 1983) ("standards and rules for determining disability under the Railroad Retirement Act are identical to those under the more frequently litigated Social Security Act"). *See also* Arp v. Railroad Retirement Board, 850 F.2d 466, 467 (8th Cir. 1988) ("[t]he Board may use regulations promulgated under analagous provisions of the Social Security Act in determining disability under the Railroad Retirement Act"); Estes v. Railroad Retirement Board, 776 F.2d 1436, 1438 (9th Cir. 1985).

179. This difference has caused some tension on cases where there is overlap in coverage between the two programs. RRB Interview, *supra* note 176. The role of medical consultants is discussed in greater detail in Part IV of this report.

180. 20 C.F.R. § 260.2.

181. *Id.* § 260.3(a).

182. *Id.* § 260.3(e).

183. *Id.* § 260.5(a).

184. *Id.* § 260.5(d).

185. *Id.* §§ 260.5(e), (f).

186. RRB interview, *supra* note 176.

The final level of administrative review is an appeal to the Railroad Retirement Board.[187] The Board rarely accepts new evidence at this stage, relying in most cases on the record developed by the referee; the Board may affirm, reverse, or remand the claim for further administrative action.[188] The Board's decision is the final administrative decision on the application. Judicial review may be sought at a federal court of appeals within one year of the Board's decision.[189]

b. Civil Service Benefits

Civil Service disability claims are decided initially at the Office of Personnel Management in Washington. The procedures used are similar to, but less complex than, those used for Social Security and Railroad Retirement disability adjudications. There are then two levels of administrative appeal, both under the authority of the Merit Systems Protection Board: first a hearing before a single administrative judge, and then review by the full three-member Board.

i. Initial Determinations: Office of Personnel Management

Civil Service Disability benefits are administered by the Office of Personnel Management.[190] Applications are filed at the employee's agency, and then routed through a central records center to the Office of Personnel Management.[191] In limited circumstances, a federal agency can file for disability retirement benefits on behalf of an employee; these applications are also submitted to the Office of Personnel Management.[192]

A Civil Service disability claim is evaluated first at the central Employees Service and Records Center for purposes of assessing eligibility unrelated to disability, based largely on official retirement records kept by the employing agency.[193] The Washington office of the Office of Personnel Management, however, is responsible for making all initial determinations of disability.[194] Although regulations state that the responsibility for providing evidence is shared by the claimant and the employing agency, the claimant

---

187. 20 C.F.R. § 260.9 (1988).

188. *Id.* § 260.9(e).

189. Appeals can be heard by one of three courts of appeals: the Seventh Circuit, the D.C. Circuit, or the court of appeals for the applicant's residence. 45 U.S.C. §§ 231g, 355(f) (1982, Supp. V 1987).

190. *See generally* 5 U.S.C. § 8347(a) (1982); 5 C.F.R. §§ 831.101-.2107 (1988). Prior to January 11, 1979, the program was administered by the Civil Service Commission.

191. Interview with Irving S. Shapiro, Chief, Michael J. Barrett, Deputy Chief, Elizabeth I. Meader, Chief, Initial Claims Branch, Mark E. Bradley, M.D., M.P.H., Consultant, and James Vorosmarti, M.D., Consultant, Disability and Special Entitlements Division, Office of Personnel Management (July 20, 1988) [hereinafter OPM interview]. There are slightly different procedures for military personnel. *See* 5 C.F.R. § 831.104.

192. Agency applications are administered in essentially the same manner as an application filed by an employee, although there are some special procedures designed to protect the employees' employment rights, including a broader scope of judicial review. *See generally* 5 C.F.R. §§ 831.1203(a)(1), .1204; 5 U.S.C. § 8347(d)(2). There are no significant differences with respect to the administrative adjudication of disability.

193. OPM interview, *supra* note 191. *See* 5 C.F.R. §§ 831.102, .104, .501 (c). This role is similar to that of the Social Security Administration district offices before a claim is -- or is not -- forwarded to the Disability Determination Service for a disability determination. *See* text accompanying notes 137-40, *supra*.

194. The employee's agency plays only a limited, clerical role in forwarding applications to the Office of Personnel Management for substantive evaluation. OPM interview, *supra* note 191.

is expected to come forward with initial evidence establishing his or her entitlement to benefits.[195]

The practice at the Office of Personnel with respect to developing an administrative record is quite different from that followed by the Social Security Administration. Thus, in most cases the initial decision is based on medical evidence supplied by the claimant.[196] However, if the Office decides that it needs additional medical evidence it can require a medical examination by a designated physician.[197] Most claims are reviewed initially at the Office of Personnel Management by a medical consultant, rather than a disability claims examiner.[198] The consultant is expected to recommend a disability decision based on the medical evidence in the record, or, if the record is thought to be incomplete, after obtaining necessary additional information. The disability claims examiner then reviews the file and makes the disability decision. The review by the examiner tends to be relatively cursory when the consultant recommends granting benefits; the examiner reviews the claim far more carefully when the consultant recommends a denial.[199]

The Office of Personnel Management then issues a written initial decision.[200] A claimant can seek reconsideration of an adverse initial decision by a representative of the Associate Director for Compensation.[201] Reconsideration is only a limited paper review within the Office before a case can be certified for a *de novo* appeal before the Merit Systems Protection Board.[202] Claimants are, however, encouraged to submit additional evidence with their reconsideration requests, and most claimants do so.[203]

ii. Merit Systems Protection Board

Civil Service disability decisions issued by the Office of Personnel Management can be appealed to the Merit Systems Protection Board.[204] The Board consists of three members, including a chair and a vice-chair.[205] Appeals are heard by the Board at two levels: a full, *de novo* administrative hearing held by an administrative judge, and a discretionary review or reopening of the administrative judge's decision by the full Board. The initial appeal to an administrative judge can be made on the basis of documentary evidence alone, or on the basis of evidence presented at a hearing.[206] The

---

195. *See* 5 C.F.R. § 831.502(b).

196. OPM interview, *supra* note 191.

197. *See* 5 C.F.R. § 831.502(c). The regulations states specifically that benefits can be denied for refusal to submit to such an examination. Social Security regulations include a similar provision. *See* 20 C.F.R. §§ 404.1518, 416.918.

198. OPM interview, *supra* note 191. In a few easily decided cases where eligibility is so clear that a medical opinion is not required, the claim may be processed by the Office's administrative branch. *Id.*

199. *Id.* The role of medical consultants is discussed in greater detail in Part IV of this report.

200. The decision must include findings of fact and relevant conclusions. *See* 5 C.F.R. § 831.1205(b).

201. *See id.* § 831.109.

202. A decision of the Office of Personnel Management is not considered final for purposes of appeal until a request for reconsideration has been made and denied. *See* 5 C.F.R. §§ 831.109(f), .110.

203. OPM interview, *supra* note 191.

204. 5 U.S.C. §§ 7701, 8347(d)(1) (1982); 5 C.F.R. § 1201.3(a) (1988).

205. 5 C.F.R. §§ 1200.1, .2 (1988). *See generally* 5 U.S.C. §§ 1201-3. Board members are appointed by the President, subject to Senate confirmation; the term of appointment is seven years. *Id.*

206. *See generally* 5 C.F.R. § 1201.24(a).

appeal is commenced by filing a petition; the Office must then respond specifically to each allegation in the petition and submit copies of all documents in the record.[207]

Appeals in Civil Service disability cases are technically adversarial, and therefore, the Office can appear at hearings. Until the past few years, the Office appeared rarely.[208] Recently, the Office has begun to appear more often, but it still does not appear in all cases.[209] Although the Board will consider new and supplemental evidence at the hearing level, it will not consider any proof of an entirely new basis for disability.[210] Administrative judges can exercise broad powers while hearing an appeal, much like an administrative law judge in a Social Security hearing. These powers include issuing subpoenas and ordering the production of evidence; Board administrative judges cannot, however, order medical examinations.[211]

The Board hearing is the last opportunity for a claimant to present evidence of disability for the record; failure to present witness testimony cannot be corrected at the second level of Board appeal.[212] The administrative judge issues an initial decision in the case following the completion of all preceedings and the closing of the record.[213] The decision must include specific findings of fact and conclusions for all material issues of fact and law presented by the record, and reasons and bases for those findings and

---

207. *Id.* § 1201.25(a). The Office, however, has been found to have "substantially complied" with these regulations by submitting the case file and a copy of the reconsideration decision. *See* Miller v. Office of Personnel Management, 7 M.S.P.R. 469, 473 (1981). The administrative judge may reject submissions if they are not properly assembled, tabbed, or filed in accordance to an order. Bradsher v. Office of Personnel Management, 21 M.S.P.R. 694, 697 (1984). A failure to exercise due diligence in complying with orders without good cause warrants the sanction of striking the Office's response to a petition for review. *Id.*

208. The General Accounting Office criticized the Office's failure to appear in a 1983 report. *See* U. S. General Accounting Office, "Most Civil Service Disability Retirement Claims Are Decided Fairly, But Improvements Can Be Made" 20 (1983).

209. OPM interview, *supra* note 191. Representatives of the Office participate most regularly at pre-hearing conferences, at which time they may settle the claim. *Id.*; Interview with Martin Baumgartner, Regional Director and Chief Administrative Judge, and Howard J. Ansorge, Administrative Judge, Merit Systems Protection Board, Chicago Office (June 17, 1988) [hereinafter Chicago MSPB interview]. The Board will "consider *de novo* all the relevant evidence presented by both parties, whether offered at a hearing or transmitted as part of the administrative record." Chavez v. Office of Personnel Management, 6 M.S.P.R. 404, 413 (1981). *See also* Cook v. Office of Personnel Management, 31 M.S.P.R. 683, 686 (1986); Fench v. Office of Personnel Management, 30 M.S.P.R. 503, 505 (1986).

210. *See* Chavez v. Office of Personnel Management, 6 M.S.P.R. 404, 413 n. 14 (1981) ("since we have jurisdiction under 5 U.S.C. § 8347(d) only to consider matters 'appealed' to us, we do not consider in such cases evidence relating to a totally different or additional medical condition which was never the subject of an appellant's application to OPM"); Nulph v. Office of Personnel Management, 29 M.S.P.R. 79, 80 (1985). Thus, in Bilancia v. Office of Personnel Management, 8 M.S.P.R. 77, 78-9 (1981), the Board refused to consider a disability case based on anxiety and depression when initially only physical grounds were presented as a basis for the application. *See also* Pecukonis v. Office of Personnel Management, 34 M.S.P.R. 411, 414 (1987). (Board refused to consider disability claim based on liver disease when original claim was based solely on peripheral neuropathy).

211. *See* 5 C.F.R. § 1201.41(b). The judge should request that the parties submit additional evidence if necessary rather than dismiss an appeal because there was insufficient proof. *See* Juve v. Office of Personnel Management, 33 M.S.P.R. 17, 20 (1987) ("the administrative judge should have directed [the Office of Personnel Management] to provide explanatory material to enable him to make the required finding of fact"). *See also* Clinton v. Office of Personnel Management, 38 M.S.P.R. 221, 223 (1988) ("administrative judge should request . . . additional information whenever the information submitted by the [claimant] is confusing or incomplete"). This obligation exists as well in cases decided without hearings. *See* Rosenberg v. Commodity Futures Trading Commission, 7 M.S.P.R. 664, 666 (1981).

212. *See* Dougherty v. Office of Personnel Management, 36 M.S.P.R. 117, 120 (1988) (claimant not allowed to submit evidence before the Board that was untimely filed and properly rejected by administrative judge); Nathan v. Office of Personnel Management, 15 M.S.P.R. 359, 360 (1983) (subjective evidence of pain available at the time of hearing could not be presented on appeal even though presiding official noted that introduction of such evidence may have established disability). *See also* 5 C.F.R. § 1201.115(a).

213. 5 C.F.R. § 1201.111(a).

conclusions.[214] The initial decision becomes final and subject to judicial review, unless a petition for review is filed with the Board.[215]

A party can petition the Board for review of an administrative judge's decision; in addition, the Board can, on its own motion, reopen a presiding official's decision.[216] There are two grounds for reviewing a hearing decision on petition by a party: when "[n]ew and material evidence is available that, despite due diligence, was not available when the record was closed," and when "[t]he decision of the presiding official is based on an erroneous interpretation of statute or regulation."[217] Notwithstanding the narrow focus of these grounds for review, the Board seems to allow for at least a liberal reading of the grounds.[218] A challenge to an administrative judge's factual determinations as such is not a basis for review.[219]

When the Board decides to reopen or review a decision, it can take whatever action it decides is necessary to dispose of the case, or can remand the case for a further hearing or further development by the Office of Personnel Management.[220] The Board is likely to remand a case, however, when new evidence provides a basis for review but some other factual development may also be necessary.[221] The Board's decision to deny

---

214. *Id.* § 1201.111(b); Ciccone v. Department of Air Force, 37 M.S.P.R. 594, 597 (1988). *See also* Pledger v. Department of the Navy, 34 M.S.P.R. 456, 458 (1987).

215. *See* 5 C.F.R. § 1201.113.

216. 5 C.F.R. §§ 1201.114(a), .117. *See, e.g.*, Schultz v. Office of Personnel Management, 10 M.S.P.R. 431, 434 (1982) (evidence previously available not submitted because claimant told new medical examination would be scheduled before decision reached; Board reopened on own motion to consider this evidence because new examination was not scheduled). *See also* Stephens v. Office of Personnel Management, 30 M.S.P.R. 680, 681-82 (1988) (Board reopened case to decide whether a Court of Appeals decision overruling the basis for the previous decision should be applied retroactively).

217. 5 C.F.R. § 1201.115. The "new and material" evidence requirement means that the Board will not grant a petition for review to allow an appellant to cure a claim that was documented poorly at the hearing. *See e.g.*, Pecukonis v. Office of Personnel Management, 34 M.S.P.R. 411, 415-416 (1987) (medical reports pre-dating closing of record not new evidence). On the other hand, the Board will consider truly new evidence not available while the record was open. *See e.g.*, Robinson v. Office of Personnel Management, 21 M.S.P.R 744 (1984) ("new evidence" requirement met where doctor was incapacitated at the time of the hearing and therefore was unable to prepare a report). Patillo v. Office of Personnel Management, 40 M.S.P.R. 452, 455 (1989) (Letter concerning disability from Army agency contradicting earlier letter from the same agency considered "new" evidence). Paolera v. Office of Personnel Management, 7 M.S.P.R. 581, 582 (1981) (report of heart condition where infarction occurred only after the record closed). Even if new, the evidence must "be of sufficient weight to warrant a finding different from that in the initial decision." Janke v. Office of Personnel Management, 7 M.S.P.R. 140, 141 (1981); *accord* Murphy v. Department of Health and Human Services, 34 M.S.P.R. 534, 536 (1987).

218. *See e.g.*, de Matteo v. Office of Personnel Management, 7 M.S.P.R. 334, 338 (1981) ("ordinarily" the Board will not review a case unless the criteria of 5 C.F.R. § 1201.115 are met); Waite v. Office of Personnel Management, 9 M.S.P.R. 533 (1982) (rule relaxed because claimant had good reason to believe that evidence was entered by the Office of Personnel Management that actually was not).

219. The Board distinguishes petitions contesting factual findings, credibility determinations and interpretations of evidence, which generally will be denied, from petitions alleging that the administrative judge applied an improper standard of proof. The latter amounts to an erroneous interpretation of law and is therefore subject to review. *See* Cope v. Dept. of the Navy, 7 M.S.P.R. 546, 548 (1981) ("a misapplication of the proper standard of proof [is] sufficient to warrant a review of the presiding official's fact finding"). *See also* Livingstone v. Office of Personnel Management, 30 M.S.P.R. 335, 338 (1986). Review will be denied, however, if the Board finds the errors were, in effect, harmless. *See* Sears v. Office of Personnel Management, 33 M.S.P.R. 595, 598 (1987) ("administrative judge's procedural error is of no legal consequence unless it is shown that it has adversely affected a party's substantive rights"). The Board will review administrative judges' credibility determinations, only when it finds that the reasoning on which the determination was made was erroneous. Madison v. Department of Air Force, 32 M.S.P.R. 465, 473 (1987). *Cf.* Cordioli v. Department of Navy, 38 M.S.P.R. 374, 377 (1988) (the administrative judge must also "adequately explain bases" of credibility determinations).

220. 5 C.F.R. § 1201.116.

221. *See, e.g.*, Harrison v. Office of Personnel Management, 38 M.S.P.R. 218, 221 (1988); Paolera v. Office of Personnel Management, 7 M.S.P.R. 581, 582 (1981) (new evidence of heart condition but insufficient to show

a request for review or its decision on the merits is a final decision subject to judicial review in the Court of Appeals for the Federal Circuit.[222]

c. Veterans Benefits

Veterans compensation and pension benefits are administered by the Compensation and Pension Service in the Veterans Benefits Administration of the Department of Veterans Affairs.[223] The key decision-making authority at the initial level is a three-member Rating Board. Until recently, Rating Boards also held hearings; beginning in late 1988, the responsibility for holding hearings was transferred to hearing officers. Rating Board decisions are reviewed by three-member panels of the Board of Veterans Appeals.

The major differences in processing Veterans disability claims stem from the structure and authority of these three-member panels. Both are made up of one doctor member and two non-medical members. The decisions of both panels are considered highly reliable, to the extent that until recently judicial review of Board of Veterans Appeals decisions was precluded.[224] Overall, one finds that the Department expects the Veterans Benefits Administration, the Rating Boards and the Board of Veterans Appeals to take an active and authoritative role in the process, leaving claimants with less independence than is the case with other programs. One indication of this attitude is the fact that attorneys are prohibited from charging more than ten dollars in fees in Veterans benefits cases, except that beginning in the fall of 1989, attorneys will be able to receive more substantial fees in certain cases.[225]

i. Initial Determinations: Rating Boards

Applications for disability compensation or pension benefits are filed at Department of Veterans Affairs regional offices or at another agency authorized by the Veterans Benefits Administration to receive applications.[226] The Administration is required to assist applicants, including in the development of evidence necessary to allow a full and fair determination of eligibility.[227] The initial decision is made in two steps. First, an "authorization unit" examines the application for completeness, verifies the veterans' service record, and requests any relevant information or evidence that might be available from the claimant. This unit also evaluates the application with respect to nonmedical issues, such as the veterans' income in pension cases, and has authority to implement final decisions. If a claimant does not meet the nonmedical eligibility requirements, the authorization unit may itself disallow the claim. However, if a possibility of entitlement exists, the claim is forwarded to the Rating Board.[228]

---

extensive heart damage). *Cf.* White v. Office of Personnel Management, 19 M.S.P.R. 558, 559 (1984) (new evidence did not meet criteria for review of denial of disability benefits but could form basis for a new disability application).

222. 5 U.S.C. §§ 7703(a)(1), (b)(1); 5 C.F.R. §§ 1201.116(b), .119.

223. Authority to decide eligibility for veterans benefits has been delegated to the Chief Benefits Director. 38 C.F.R. § 3.100 (1988).

224. *See* text accompanying note 226, *infra.*

225. The new fee rules, which were included in the same legislation establishing judicial review, are limited to cases taken after a denial by the Board of Veterans Appeals.

226. *See generally* 38 C.F.R. §§ 3.150-155.

227. *Id.* § 3.103(a).

228. Veterans Administration Manual M21-1 § 22.08.

The Rating Board is the primary fact finder and decisionmaker in the Veterans Benefits Administration disability adjudication process. The Board is responsible for evaluating all of the medical evidence in the record and on the basis of that evidence assigning a percentage disability rating to the claim.[229] Rating Boards consist of three to more than ten people, one of whom is a medical doctor.[230] They decide claims in groups of three, one member of which is the medical member of the Board. The nonmedical members, known as rating specialists, are usually occupational disability specialists.[231] The Rating Board operates under certain general guidelines, in addition to the specific standards set forth in the Schedule for Rating Disabilities. The Board must decide claims on the basis of full and complete medical information,[232] and must resolve reasonable doubts in favor of the claimant.[233]

When a claim is forwarded to the Rating Board, it is assigned randomly to one of the nonmedical rating specialists. This specialist reviews and evaluates the medical evidence, and assigns a preliminary rating. The specialist can also request additional medical evidence, usually in the form of an examination at the local Veterans Benefits Administration medical facility. The Department recently published proposed rules authorizing Adjudication Officers to request independent medical opinions, a practice that had been limited to the Board of Veterans Appeals.[234] If there is a question about a medical aspect of the rating or the need to develop additional evidence, or if the specialist is unsure as to how some of the evidence should be interpreted, the physician member may be asked to review the file and give a recommendation.[235] The file is then passed on to the second lay specialist and the medical member, usually in that order. Each member has equal authority to assess the evidence, including the need for additional evidence, and each member must sign the final decision. Most decisions are unanimous; if there is a dissenting opinion, the disagreement is usually resolved within the regional office.[236]

The physician member thus acts in two roles: first as a consultant to the rating specialists, if asked, and then as a member of the Board when reviewing the preliminary rating after it is signed by the nonmedical rating specialists. In both roles, however, the

---

229. The standards for assigning disability ratings are discussed at text accompanying notes 326-41, *infra*.

230. Veterans Administration Manual M21-1 § 45.01b. Thus, the current staff in Nashville includes eight rating specialists and one doctor, all of whom are full-time employees. Interview with Mary Fielder, Assistant Adjudication Officer, Veterans Administration Regional Office, Nashville, Tennessee (March 18, 1988) [hereinafter Nashville VA interview]. The ratio of specialists to doctor is higher in San Francisco. Interview with Leo Wurschmidt, Director, Tom Verrill, Adjudication Officer, Richard F. Riordan, M.D., Medical Rating Specialist, and Thomas Jacobson, Rating Specialist, Veterans Administration Regional Office, San Francisco, California (August 5, 1988) [hereinafter San Francisco VA interview].

231. Nashville VA interview, *supra* note 230; VA interview, *supra* note 5.

232. 38 C.F.R. § 4.2 (1988).

233. *See id.* § 4.3 ("[w]hen after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant"). *See also id.* § 4.7 (the higher of two possible ratings should be chosen when "the disability picture more clearly approximates with the criteria required for [the higher] rating. Otherwise, the lower rating will be assigned").

234. *See* 54 Fed. Reg. 43,436 (1989). The proposed regulations implement the Veterans' Judicial Review Act, Pub. L. No. 100-687, § 103(a), 102 Stat. 4107 (1988). Board of Veterans Appeals practice is discussed at text accompanying notes 252-66, *infra*.

235. At this point, the physician member acts as a medical consultant to the rating specialist, analyzing the more difficult medical issues. Nashville VA interview, *supra* note 230. The role of the medical member of the Board in developing the record is discussed in greater detail at text accompanying notes 487-547, *infra*.

236. The medical member's role in reaching a final decision and in resolving conflicts is discussed at text accompanying notes 630-62, *infra*.

physician member tends to act like a medical expert, reviewing the medical evidence and evaluating the medical issues presented in the claim.[237]

After all three members have signed a rating, it is returned to the authorization unit for implementation. Rating decisions are prepared in accordance with a specific outline, the most important components of which include a listing of any combat disabilities, a finding concerning employability, if relevant, and a full statement of relevant facts, discussion of the facts, and a conclusion on eligibility.[238]

A claimant can seek reconsideration following an adverse initial decision.[239] The full record is reviewed, including any additional evidence submitted in support of the request for reconsideration, and referred again to the Rating Board if warranted by the medical evidence.[240] This review is done in essentially the same manner as an initial decision. A written notice of the reconsideration decision is sent to the claimant, together with a full explanation of the reasons if the claim is again denied.[241]

ii. Regional Office Hearings

Claimants are entitled to a hearing at the Veterans Benefits Administration either before or after an initial determination is made.[242] Claimants can also waive any hearing, and most claimants proceed without a hearing to the Board of Veterans Appeals. Until recently, hearings conducted as part of the original determination were held by Rating Board members; however, the Administration now uses a non-medical "hearing officer" to conduct hearings requested as part of an appeal.[243] Whether a hearing is held prior to or after an initial decision, the person conducting the hearing is expected to assist a claimant in framing the issues and developing relevant evidence.[244] When Rating Boards were conducting hearings, the physician member was seen as being effective in raising important questions and helping claimants frame the medical issues involved in the claim.[245]

There is no decision as such issued following a hearing; instead, any initial decision, made with or without a hearing, is issued in the form of a Notice of Decision.[246] The

---

237. At the Nashville office, for example, the rating specialists usually defer to the physician's opinion; the members of the Board expect the doctor to act more as a medical professional and less as a technician. Nashville VA interview, *supra* note 230.

238. *See* Veterans Administration Manual M21-1 § 49.11-.17h.

239. 38 C.F.R. §§ 3.160(d), 6.206. The Veterans Administration has very liberal rules allowing reopening of claims even after the time to request reconsideration has passed. *See generally* 38 U.S.C. § 210(c) (Supp. V 1987); 38 C.F.R. § 3.160(e).

240. *See generally* Veterans Administration Manual M21-1, Chapter 27.

241. *Id.*

242. *See* 38 C.F.R. § 3.103(c) (claimant entitled to a hearing "at any time on any issue").

243. VA interview, *supra* note 5. This change is due at least in part to litigation challenging the use of Rating Boards to hear appeals from their own decisions. *Id.*

244. 38 C.F.R. § 3.103(c). The person conducting the hearing is expected "to explain fully the issues and to suggest the submission of evidence which the claimant may have overlooked and which would be of advantage to his position." *Id.*

245. VA interview, *supra* note 5; Interview with Bill Kirby, National Commander, Rick Heilman, National Legislative Director, Art Wilson, National Services Director, Charlie Thompson, Assistant Services Director, Jessie Brown, Assistant to National Adjunct, Richard Patterson, Supervisor, National Appellate Office, Jim Stewart, Supervisor, Washington National Office, Disabled American Veterans (August 24, 1988) [hereinafter DAV interview].

246. A single notice is issued if no hearing was requested or if a hearing was requested before an initial decision was made; a second notice is issued following a hearing requested after an initial adverse decision.

Notice of Decision must state the reason for the decision, including a rating decision if one was made.[247] A claimant can respond to an adverse Notice of Decision by filing a Notice of Disagreement, in which case the claim is reviewed by the regional office Adjudication Officer.[248]

The Administration issues a Statement of the Case in response to a Notice of Disagreement, which is the last action taken by the Administration before an appeal can be filed with the Board of Veterans Appeals.[249] The Statement of the Case must include a summary of the evidence relevant to the issues in dispute; a summary of applicable law and regulations, including appropriate citations; and a statement of the reasons for the decision reached on each issue raised in the case.[250] The purpose of the statement of the case is to communicate the basis for the decision and to allow an effective appeal.[251]

iii. Board of Veterans Appeals

An appeal to the Board of Veterans Appeals is initiated by filing a Substantive Appeal.[252] A Substantive Appeal must state specifically all legal and factual arguments the claimant wishes to present, and must, whenever possible, respond to the reasoning contained in the Statement of the Case.[253] Before the Board assumes jurisdiction over the appeal, the office which made the initial decision must file a formal Certification of Appeal which identifies the issues in the appeal and certifies that all procedural requirements have been met.[254] Instead of certifying the appeal, the office may award benefits, take further action to develop evidence, or notify the claimant of errors of fact or law asserted in the substantive appeal and allow for amendment.[255]

The Board of Veterans Appeals, which has more than sixty members, sits in panels of three, referred to as Board Sections.[256] In all disability cases, one of the members of the panel is a physician, although not necessarily a specialist in the disease or injury involved in the appeal.[257] Board Sections are grouped, however, according to general areas of medical specialization, and cases are sent to one Section or another based on a first reading of the disability involved.[258]

---

247. *See* 38 C.F.R. § 3.103(e).

248. *Id.* § 19.118 (1988). The Adjudication Officer can develop further evidence or review the decision on the basis of the existing record. The notice must be filed within one year after the notice of decision was mailed. *Id.* § 19.129(a).

249. *See* 38 C.F.R. § 19.119(b).

250. *Id.* § 19.120(b).

251. *See id.* § 19.120(a) (the statement "should be complete enough to allow the appellant to present written and/or oral arguments before the Board of Veterans Appeals"). *See also* Veterans Administration Manual M21-1 § 18.07(a).

252. *See* 38 C.F.R. § 19.123(a).

253. *See id.* § 19.123(a). Claimants are presumed to agree with facts in the statements of the case unless an exception is noted. *Id.* § 19.121(b)(3).

254. *Id.* § 19.123(b).

255. Veterans Administration Manual M21-1 § 18.13.

256. 38 C.F.R. § 19.161. Members of the Board are assigned to panels by the Chair. *Id.*

257. The Board has rejected suggestions that the physician member in mental disability cases be a psychiatrist, noting that specialists at the Veterans Administration and at accredited medical schools are available for expert medical advice when necessary. *See* 48 Fed. Reg. 6963 (1983).

258. BVA interviews, *supra* note 5.

Appellants may submit new medical evidence directly to the Board.[259] Appellants may also request that the Board obtain expert medical opinions from the Veterans Administrations' Chief Medical Director or from independent medical experts, and the Board itself may seek expert opinions on its own motion.[260] Board Sections follow procedures similar to those used by Rating Boards. The claim is reviewed first separately by the two non-medical members, sometimes in consultation with the medical member. The medical member then reviews the whole record again as a decisionmaker.[261] The Board will also hold a hearing, if one is requested by the appellant.[262]

The Board issues a formal written decision, which must include separate findings of fact, conclusions of law and reasons for the decision.[263] The Board's decision can be reconsidered at any time in cases of "obvious error or law or fact," or when "new and material evidence" is discovered from official service department records or forms, including officially corrected records.[264] Reconsideration hearings are held by panels composed of members of the original panel, if available, and supplemented by additional members assigned by the Chair.[265] Currently, there is no judicial review of decisions of the Board of Veterans Appeals, except for constitutional issues; however, beginning sometime after September 1, 1989, decisions of the Board will be appealable to a new Article I Court of Veterans Appeals and then to the Court of Appeals for the Federal Circuit.[266]

d. Black Lung Benefits

Disability adjudications in the Black Lung program are fundamentally different from those in the other programs included in this study because they are conducted in an essentially adversarial context. Only at the initial stages, when a miner's claim is first received at the Office of Worker's Compensation programs, is the process controlled exclusively by the miner and the agency. As the initial determination procedures progress, and throughout any administrative appeals, the process becomes dominated by adversarial relationships between miners and coal companies or the Department of Labor on behalf of the Black Lung Disability Trust Fund.

i. Initial Determination: Division of Coal Mine Workers Compensation

Claims for Black Lung disability benefits are processed by the Division of Coal Mine Workers' Compensation of the Department of Labor's Office of Workers'

---

259. However, if the evidence is submitted before the record was transmitted to the Board, it will forward the evidence to the original Rating Board which will prepare a supplemental Statement of the Case. *See* 38 C.F.R. § 19.174.

260. *See id.* C.F.R. §§ 19.176-.178. The Board's use of medical experts is discussed in greater detail at text accompanying notes 568-70, *infra.*

261. BVA interviews, *supra* note 5. The roles of the nonmedical and the medical members of the Board in reaching a final decision on an appeal are discussed in greater detail at text accompanying notes 630-62, *supra.*

262. 38 C.F.R. §§ 19.157, 19.160, .165. Board policy is to use hearings, when held, to the "fullest extent to attain a complete record." *See* Veterans Administration Manual MBVA-1 § 502; 38 C.F.R. § 19.157(b).

263. 38 C.F.R. §§ 19.180(c).

264. *Id.* § 19.185.

265. *Id.* § 19.189(b).

266. Veterans Judicial Review Act of 1988, Pub. L. No. 100-687, 102 Stat. 4113-25 (1988). September 1, 1989 was the effective date of the law authorizing the court; however, the court will begin hearing cases only in early 1990.

Compensation Programs. The claimant must file within three years of a medical determination that he or she is totally disabled due to pneumoconiosis.[267] Disability determinations are made by Deputy Commissioners of the Office of Worker's Compensation programs at regional offices around the country.[268] The Deputy Commissioner's office must "take such action as is necessary to develop, process, and make determinations with respect to the claim."[269] These actions include conducting conferences, scheduling medical examinations, and issuing subpoenas for the production of documents.[270]

The most important part of early claim development is the gathering of medical evidence. In order to facilitate this, the Deputy Commissioner is empowered to order examinations by outside medical consultants, so that all relevant medical evidence can be obtained.[271] The Black Lung Disability Trust Fund will pay for one complete physical examination at the outset of the development of a claim.[272] In addition, the parties will submit evidence and counter-evidence of their own.[273]

Claims Examiners are responsible for the actual processing of claims. They rely mainly on four types of medical evidence: x-rays, pulmonary function tests, blood gas studies, and physicians' reports.[274] The Deputy Commissioner issues an initial eligibility finding after the evidence is accumulated and evaluated.[275] Claims Examiners and Senior Claims Examiners participate in this process. There are no formal mechanisms for using medical consultants at this stage. If the claim is denied, the miner can submit new evidence for reconsideration or request a hearing; if new evidence is offered and the claim is denied on reconsideration, the claimant can still request a hearing.[276]

Before the hearing takes place, the parties can meet for an informal or pre-hearing conference at the various regional offices of the Division of Coal Mine Workers' Compensation.[277] At this conference, the parties, with their representatives, if any, stake out their positions relative to the initial findings.[278] After the conclusion of the

---

267. 20 C.F.R. § 725.308 (1988). There are some special filing rules as well, due to the importance of the filing date for deciding which presumptions apply. For example, claims are considered filed when delivered "unless a loss or impairment of benefit rights would result," in which case the postmark becomes the filing date. *Id.* § 725.303(b).

268. *Id.* § 725.304(b). A miner can apply at Social Security Administration or Department of Labor offices; all claims are forwarded to regional offices for processing.

269. *Id.* § 725.401.

270. *Id.* §§ 725.351(a), .405. The claimant has the responsibility to provide "a complete and detailed history" of his or her coal mine employment and proof of other matters, such as age and marital status. *Id.* §§ 725.404(a), (b).

271. *Id.* §§ 725.405, 406; 718.101. If the deputy commissioner decides ineligibility has been established, he or she can halt the evidentiary development. *Id.* § 725.405(e).

272. *See* 20 C.F.R. § 725.406(c).

273. Procedures for developing medical evidence in Black Lung claims, including the use of outside medical examinations, is discussed at text accompanying notes 559-87, *infra*.

274. *See id.* §§ 727.203(a)(1)-(4); 718.102-.106. The relevance of this evidence to the Black Lung disability standard is discussed at text accompanying notes 119-28, *supra*.

275. 20 C.F.R. § 725.410.

276. *Id.* § 725.410(c)(2).

277. Interviews with John LeBresch, Supervisory Claims Examiner, Deputy Commissioner's Office, Pikeville, Kentucky, Office of Workers Compensation Programs, Department of Labor (June and August, 1988) [hereinafter Pikeville DOL interviews].

278. *Id.* Any issue resolved at this conference cannot be brought up at a subsequent hearing. *Id.*

conference the Deputy Commissioner issues a decision, which usually contains only conclusory assertions as to the particular issues in dispute.[279]

ii. Administrative Hearing

Administrative hearings are held in Black Lung cases when a party requests a hearing from a final decision by the Deputy Commissioner.[280] All essential material from the claims file, including all evidence, decisions and the Deputy Commissioner's statement of resolved and unresolved issues in the case, is forwarded to the Office of Administrative Law Judges.[281] The hearings are *de novo* and adversarial. If there is no responsible coal mine operator, the claimant is opposed by the Department of Labor; in cases with a responsible operator, the operator may oppose the claimant on eligibility or the department on responsibility, and the Department may oppose the claimant on eligibility as well. Any party can be represented at the hearing.

Because of the importance of technical medical evidence in Black Lung cases, there are special rules concerning the admission of medical reports. Medical reports cannot be submitted at a hearing unless sent to all parties at least 20 days before the hearing.[282] In order to encourage full adjudications at the deputy commissioner level, there is also a prohibition against the submission at a hearing of any evidence available to a party but not submitted while the claim was pending before a Deputy Commissioner.[283] Testimony can be presented by witnesses, or by deposition or interrogatories.[284]

The issues at a hearing are limited to those set forth by the Deputy Commissioner or any other issue raised in writing at the time the claim was pending before the Deputy Commissioner.[285] Administrative law judges are under a duty "to develop fairly all sources of evidence," particularly when an unrepresented claimant does not have the

---

279. *Id.* This practice varies considerably from office to office. In the Pikeville, Kentucky office, for example, the deputy commissioner issues decisions from informal conferences in the form of an opinion, complete with citations to relevant statutes and prior decisions (mostly from the Benefits Review Board). *Id.*

280. 20 C.F.R. § 725.450, .452 (1988). Hearings can be held also upon direct referral by the Deputy Commissioner adjudicating the claim. *Id.* § 725.415.

281. *Id.* § 725.421.

282. 20 C.F.R. § 725.456(b)(1). The 20-day rule can, however, be waived. *See* Hoffman v. Peabody Coal Company, 40 BLR 1-52, 1-58 (1981). The Board has declined to require that an administrative law judge make a specific finding that good cause did not exist to apply the 20-day rule as written. *See* Jennings v. Brown Badgett, Inc., 9 BLR 1-94, 1-96 (1986). There is also a "good cause" exception to this rule, which allows the report to be introduced but requires that the record be kept open for at least 30 days after the hearing to allow for submission of rebuttal evidence. *See* Buttermore v. Duquesne Light Co., 8 BLR 1-36 (1985); DeLara v. Director, 7 BLR 1-110, 1-111-112 (1984).

283. 20 C.F.R. § 725.456(d). Such evidence can be admitted, however, if offered by another party or upon a showing of "extraordinary circumstances." *Id.*

284. *Id.* §§ 725.457-.458. Written notice of the intention to present an expert witness must be provided at least ten days before the hearing. *Id.* § 725.457(a).

285. *Id.* § 725.463(a). Issues "not reasonably ascertainable" when the claim was being adjudicated by the Deputy Commissioner can also be raised; however, in such instances the administrative law judge has the option to remand the claim for determination of the new issue by the Deputy Commissioner rather than deciding the issue at the hearing. *Id.* § 725.463(b). The "reasonably ascertainable" rule is applied equally to claimants and the Department. Thus, in a recent case the Board reversed a decision of an administrative law judge who allowed the Department to litigate matters that were raised "at the last possible moment" without the Department presenting an "excuse for [its] inaction." Thornton v. Director, 8 BLR 1-277, 1-279 (1985).

capacity to handle the case adequately.[286] They do not, however, order new medical examinations.[287]

The hearing record is closed after the hearing or after a period of time allowed for submission of additional evidence.[288] The administrative law judge then issues a decision and order, which must be based on the evidence in the record and must include findings of fact and conclusions of law.[289] A party can seek reconsideration of the decision or file a notice of appeal with the Benefits Review Board; if reconsideration is requested, an appeal can be filed with the Benefits Review Board after disposition of the reconsideration request.[290]

iii. Benefits Review Board

The Benefits Review Board consists of a chairman and four associate members, all appointed by the Secretary of Labor, who also has authority to appoint up to four additional temporary members.[291] The Board hears cases in panels of three members, and will rehear cases *en banc*.[292] The substantive issues in the appeal are identified in a "petition for review" filed by the appealing party, which must identify the questions of law or fact raised by the appeal and must be accompanied by a brief, memorandum of law, or other statements supporting the petition for review.[293] The Benefits Review Board acts as an administrative appellate tribunal.[294] The Board reviews administrative hearing decisions to assure that "the findings of the administrative law judge are

---

286. *See* Laughlin v. Director, 1 BLR 1-488, 1-493 (1978). See also York v. Director, 5 BLR 1-833, 1-835-40 (1983), where the Board cited a number of Social Security cases establishing the same proposition. See text accompanying notes 159-60, supra. Cf. Belcher v. Beth-Elkhorn Corp., 6 BLR 1-1180, 1-1181 (1984) (Board rejected contention that the ALJ must develop evidence favorable only to claimant "particularly...where the claimant is represented by counsel").

287. Interview with John M. Vittone, Associate Chief Administrative Law Judge, C. Martin Bober, Administrative Law Judge, Nicholas D. DeGregorio, Administrative Law Judge, Office of Administrative Law Judges, Department of Labor (October 13, 1988) [hereinafter OALJ interview]. This is very different from Social Security practice, where administrative law judges can and do order consultative examinations. *See* text accompanying notes 156-57, *infra*.

288. The judge is under no obligation to allow additional evidence to be submitted if the evidence could have been presented at the hearing. *See* Hoffman v. Peabody Coal Company, 4 BLR 1-52, 1-54-59 (1981).

289. 20 C.F.R. § 725.477. A decision that does not explain the conclusion reached clearly enough for the Benefits Review Board to review the case will be remanded. *See, e.g.*, Peabody Coal Co. v. Hale, 771 F.2d 246, 249 (7th Cir. 1985) ("if this Court is to perform its function of review . . . more than unexplained conclusions and findings [by the administrative law judge] are necessary"); Wojtowitz v. Duquesne Light Co., 12 BLR 1-162, 1-165 (1989); Dixon v. Director, 8 BLR 1-150, 1-151 (1985). Cf. Kendrick v. Kentland-Alcorn Coal Corporation, 5 BLR 1-730, 1-731 (1983) (decision acceptable if it is "from context or otherwise, . . . possible to discern the reasoning of the administrative law judge and to determine the existence of substantial evidence to support that reasoning").

290. *See* 20 C.F.R. § 725.479.

291. The permanent membership was increased from three to five in 1984. *See* Longshore and Harbor Workers' Compensation Act Amendments of 1984, Public Law No. 98-426, 98 Stat. 1639 (1984); 20 C.F.R. § 801.201.

292. 20 C.F.R. § 801.301. *See also* Borgeson v. Kaiser Steel Corporation, 12 BLR 1-169 (1989); Grieco v. Director, 10 BLR 1-139 (1987).

293. *Id.* § 802.211. The other parties then have the opportunity to file a responding brief, memorandum or statement; any party receiving such a response may then file a reply. *Id.* §§ 802.212, .213.

294. As the Board once stated, "[w]e reject the . . . characterization of the Board as an administrative agency. The Board is ... an independent judicial tribunal with exclusive jurisdiction to consider and decide appeals raising substantial questions of law or fact under the Black Lung Benefits Act." McCouskey v. Seigler Coal Company, 2 BLR 1-1248, 1-1251 (1981). *See also* McFarland v. Peabody Coal Company, 8 BLR 1-163, 1-165 (1985) (rejecting "Director's contention that the Board lacks the authority to consider the validity of the Secretary's regulations").

supported by substantial evidence, are not irrational and are in accordance with applicable law."[295]

The Board decides cases generally without oral argument, although argument can be requested under special circumstances.[296] If the administrative law judge's findings of fact and conclusions of law are considered adequate to meet the objections raised, the Board can issue a summary decision; otherwise, the Board must issue a written decision which discusses the issues raised and applicable law.[297] The Board can affirm, reverse, or otherwise modify the decision of the administrative law judge, or can remand the case for further administrative proceedings.[298] Board decisions can be appealed to the federal courts of appeals.[299]

---

295. Taranto v. Barnes and Tucker Company, 4 BLR 1-308, 1-310 (1981). *See also* Robertson v. Peabody Coal Company, 11 BLR 1-120, 1-121 (1988); Hon v. Director, 699 F.2d 441, 444-45 (8th Cir. 1983). As stated in applicable federal regulations, "[F]indings of fact and conclusions of law may be set aside only if they are not, in the judgment of the Board, supported by substantial evidence in the record considered as a whole or in accordance with law." 20 C.F.R. § 802.301.

296. Oral argument may be granted when the appeal presents novel issues, involves a substantial question of law with conflicting decisions among the administrative law judges, or if "the interests of justice" will be served. 20 C.F.R. § 802.304.

297. *Id.* §§ 802.404(b), (c).

298. *Id.* § 802.404(a). A remand can be to the deputy commissioner or an administrative law judge. *Id.* § 802.405(a).

299. 33 U.S.C. § 921(c) (1982), incorporated into the Black Lung Benefits Act at 30 U.S.C. § 932(a) (Supp. V 1987). The Board will reconsider its decision under limited circumstances. *See* 20 C.F.R. § 802.407.

III. MEDICAL-LEGAL ISSUES AND MEDICAL QUESTIONS PRESENTED FOR DECISION IN DISABILITY ADJUDICATIONS

Medical-legal issues are at the center of every disability claim. This does not mean, however, that there are difficult medical questions presented in every disability adjudication. Thus, resolution of a claim based on a complex rule or regulation for applying a particular disability standard may involve little or no dispute over the nature and extent of the claimant's medical condition. When there are medical-legal issues in dispute, they can vary considerably in importance and difficulty not only from program to program and from claim to claim, but also for the same claim at different levels of the administrative process.[300]

The nature of the medical-legal issues presented for decision in a disability adjudication depends in the first instance on the disability standard being applied. The Social Security disability standard is so complex that, depending on the claimant's medical and vocational circumstances, very different types of medical-legal issues can dominate the disability determination process. Similarly, the differences in disability standards found in other federal disability programs result in differences in the types of medical-legal issues encountered while adjudicating claims. Nonetheless, despite the complexity of the Social Security standard and the significant differences in standards applied in other federal disability programs, the important medical-legal issues that must be resolved by disability adjudicators can be separated into a few general types. For some claims, one type of issue will dominate; for others, a number of different types will arise in the course of adjudicating eligibility for benefits.

In constructing models for the use of medically trained decisionmakers in Social Security disability adjudications, a classification of medical-legal issues can serve as a bridge between the substantive law and policy reflected in the disability standard and the administrative process needed to resolve the sometimes difficult medical questions presented for decision. It does not follow, however, that the identification of particular types of medical-legal issues leads to meaningful groupings of medical questions that must be resolved. A brief look at the nature of the medical questions presented in most disability claims and the nature of the evidence needed to resolve those questions confirms that models for the use of medically-trained decisionmakers must take into account, but cannot be based solely on, the various types of medical-legal issues raised.[301]

This section is divided into two parts. First, the important medical-legal issues presented for decision in the Social Security program and the other federal disability programs included in this study will be grouped into general types. Also, the medical content of these issues will be discussed, including the types of medical decisions or

---

300. Determinations based on the Social Security Administration's Listing of Impairments, for example, are far more common at the initial determination stage than on administrative appeal. Most claims with a strong case based on the Listing are -- or should be -- decided favorably at the initial or reconsideration level and therefore never reach the hearing level. *See generally* text accompanying notes 322-25, *infra*. As stated more generally at the Office of Hearings and Appeals, the focus of the administrative law judge's inquiry is on the consequence of a claimant's impairment, as opposed to whether there is an impairment, which is a question that should be resolved at the Disability Determination Services. OHA interview, *supra* note 32.

301. At the Board of Veterans Appeals, the view was expressed that most disability claims involve more of a factual determination than expert medical issues, and as a result there is more weighing of evidence than testing diagnoses. BVA interviews, *supra* note 5. Other administrative appeal judges feel the same way. Chicago OHA interviews, *supra* note 157; MSPB interview, *supra* note 209. In many Social Security cases, the main issue on appeal is the credibility of the claimant's subjective statements of pain. Nashville OHA interview, *supra* note 230. *See generally* text accompanying notes 436-55, *infra*.

evaluations involved. In the second part, the nature of the evidence needed to prove disability is explored briefly.

A. Types of Medical-Legal Issues Presented

Three general types of medical-legal issues are raised commonly in adjudications under the federal disability programs included in this study. All three are found in Social Security disability adjudications; two are found in other programs as well. Depending on the program and the individual claimant's circumstances, the resolution of one or more of these types of issues may be of critical importance, while the resolution of other issues may be important to only one of a number of alternative methods for proving disability.

First, a finding of disability can rest on the existence of a particular medical condition, coupled with a finding of degree of severity. A Social Security claimant, for example, can establish disability by proving that he or she has peptic ulcer disease with recurrence after surgery or evidence of other complications;[302] a Black Lung claimant must suffer from pneumoconiosis, or black lung disease, also to a specified degree of severity. A variation on this type of issue, which can be of special importance when eligibility must be based on the existence of a specified condition, is whether a claimant's condition amounts to the medical equivalent of a specified condition.

Second, disability can be proved not on the basis of a particular medical condition, but instead on the basis of functional limitations caused by any identified medical condition or combination of conditions. Benefits are not granted because of the existence of functional limitations, but rather because, in some cases, certain functional limitations are themselves sufficient to establish the inability to engage in substantial gainful activity. Thus, a Social Security disability adjudication can turn on whether the claimant's heart condition, or any other condition, prevents him or her from lifting more than 20 pounds or from standing more than one or two hours during an eight-hour work day.

Third, disability can be established on proof of medically-based functional limitations tied to particular vocational circumstances. In Social Security adjudications, the critical issue can be the claimant's ability to perform work he or she has done in the past, or it can be the claimant's ability to handle other jobs identified as existing in the national economy. Similarly, Civil Service claimants must show that their medical condition prevents them from performing their work at a satisfactory level; veterans seeking pension benefits must show that their medical conditions prevent them from performing any job.

There are also important medical-legal issues which arise in disability adjudications in a more general context, such as when there is a legal question relating to the relevance, admissibility or general effect of medical evidence, or the proof of a particular type of medical condition. These issues usually relate to the complexity or subjectivity of the medical facts involved, and the resulting difficulty in defining

302. 20 C.F.R. § 404, Subpart P, Appendix 1 § 5.04 (1988).

appropriate legal norms to be applied.[303] Two prominent examples, disabilities based on pain or on a mental impairment, are discussed in detail below.[304]

Each of the three types of medical-legal issues is presented more fully below, followed by discussions of disability based on pain and on a mental impairment as examples of important special issues which fall outside the three general types. Together, these issues illustrate the medical-legal context in which medical questions are presented for decision in federal disability adjudications.

1. Specified Medical Conditions

The notion that disability can be defined narrowly and, presumably, accurately and effectively, is particularly appealing to government agencies charged with making disability decisions and allocating scarce resources based on those decisions.[305] As a result, disability standards, sometimes in the general statute itself but more commonly in implementing regulations, usually include in some form a group of specified medical conditions which, if shown to exist to a specified degree of severity, automatically establish eligibility for benefits. In the Black Lung program, a single specified condition -- pneumoconiosis -- is a *sine qua non* for entitlement; however, in most programs the specified conditions are used as shorthand examples of conditions which meet the requirements of a broader disability standard. Prime examples, which will be discussed in some detail below, are the Social Security Administration's "Listing of Impairments" and the Veterans Administration's "Schedule for Rating Disabilities."

Some specified conditions are so simple and direct that they are certainly efficient. Under the Railroad Retirement program, for example, the Railroad Retirement Board has set out seven impairments which it presumes to be totally disabling.[306] The list includes some very specific conditions, such as the loss of one or more limbs, as well as very serious yet more broadly defined conditions, such as "being permanently helpless."[307] Although portions of the Veterans Administration's Schedule and the Social Security Administration's Listing are just as simple, both the Schedule and the Listing include specified conditions that are difficult to diagnose and require particular findings that can be complex and subjective. Moreover, a finding that a claimant has an

---

303. There are, of course, complex and even subjective medical matters touching on disability determinations that can be and are dealt with clearly in the law. Thus, the eligibility requirements set out for some impairments in both the Social Security Administration's Listing of Impairments and the Veterans Administration's Schedule for Rating Disabilities can be quite complex, and the medical basis for functional capacity assessments can be very subjective.

304. *See* text accompanying notes 436-69, *infra*.

305. This can take the form of calls for "objectivity" in the disability adjudication process. The most recent large-scale effort to increase objectivity has focused on claims based on pain in the Social Security program. *See* Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 3(b)(1), 98 Stat. 1794 (1984) (requiring appointment of commission on the evaluation of pain); Report of the Commission on the Evaluation of Pain (1986). *See generally* text accompanying notes 436-55, *infra*.

306. 20 C.F.R. § 208.17(b). Proof of a few other similarly limited but not so precise conditions, such as being "permanently helpless," will also establish total disability. *Id.* *See generally* text accompanying notes 78-91, *supra*.

307. The seven impairments are: (1) loss of, or permanent loss of use of, both feet; (2) loss of, or permanent loss of use of both hands; (3) loss of, or permanent loss of use of, one hand and one foot; (4) permanent industrial blindness (corrected vision of 20-200 or less in both eyes); (5) permanent total loss of hearing in both ears (inability to hear the conversational tone of voice at any distance) unless offset or capable of being offset by hearing aid; (6) being permanently helpless or permanently bedridden; (7) aphonia (complete loss of phonetic vocalization from organic cause). 20 C.F.R. § 208.17(b).

impairment or combination of impairments that is the medical equivalent of a listed impairment can be substituted for most purposes.[308]

The use of specified conditions can result in trade offs of efficiency for accuracy, and can raise serious questions of fairness when a claimant must base disability on one of these shorthand definitions to the exclusion of a broader disability standard.[309] The extent to which there is a problem will depend on the particular criteria used and the disability standard being implemented. Criteria that are kept very simple would seem to pose the greatest risk of sacrificing accuracy, which may explain why the requirements for establishing disability based on some specified conditions are so complex. At the same time, there are some fully disabling conditions that can be identified quite easily.[310] Also, the use of specified conditions can be limited to cases where the conditions involved are particularly appropriate for this type of evaluation or where the disability standard requires, or is at least susceptible to, a reduction to findings of specified conditions. Thus, the Social Security Administration's Listing of Impairments is used only to establish disability for a limited category of clearly disabling conditions which, for most claimants, is not an exclusive method for proving eligibility. Moreover, a finding that a claimant has an impairment, or combination of impairments, that is the medical equivalent of a listed impairment can be substituted for most purposes.[311]

The question of the underlying medical validity of disability determinations is presented with special focus when particular conditions are identified as the sole basis for proof of disability. The very idea that certain conditions can be specified in advance as evidence that a particular individual is disabled has been criticized as contrary to any well-ordered view of medical determinations of disability. This impairment-based approach is seen as fundamentally flawed; instead, claimants' total circumstances, including self-reported assessments of their own capacity to work, should guide disability determinations. Thus, at recent hearings before the Disability Advisory Council, a group of physicians testified that "work incapacity cannot be directly inferred from medical impairment, but rather is also attributable to a variety of social and psychological factors."[312] Even when the statutory disability standard itself requires a finding that a specified medical condition exists, there can be debate over the soundness of that requirement from a medical point of view. Thus, with respect to the Black Lung program, there has been a great deal of conflict within the medical community as to the definition of black lung disease and its disabling effects.[313]

---

308. Medical equivalence determinations in the Social Security and Veterans programs are discussed at text accompanying notes 357-76, *infra*.

309. Thus, surviving spouses seeking disability benefits under the Social Security program and children seeking disability benefits under the Supplemental Security Income program must usually prove disability through the Listing. Recent cases, however, have supported a broader basis for evaluating these claims. *See* text accompanying notes 60-76, *supra*. Concerns about accuracy and fairness have been raised with respect to the use of medical-vocational guidelines by the Social Security Administration to establish that jobs exist that claimants with a given residual functional capacity can perform. The guidelines have, however, been upheld by the Supreme Court. Heckler v. Campbell, 461 U.S. 458 (1983). *See* Capowski, *Accuracy and Consistency in Categorical Decision-Making: A Study of Social Security's Medical-Vocational Guidelines - Two Birds with One Stone or Pigeon-Holing Claimants?*, 42 Maryland L. Rev. 329, 349-53 (1983). *Cf.* J. Mashaw, *supra* note 27, at 79-98.

310. Total paralysis is a simple example. Disability based on AIDS is usually established in large part by standard tests. *See* S.S.R. 86-20 (Cum. Ed. 1986); 20 C.F.R. Part 416, Subpart I, Appendix 1.

311. Medical equivalence determinations in Social Security and Veterans programs are discussed at text accompanying notes 357-76, *infra*.

312. Report of the Disability Advisory Council 97 (1988). *See also*, Statement of Norton M. Hadler to the Disability Advisory Council, *supra* note 6.

313. *See generally* Fox & Stone, *Black Lung: Miner's Militancy and Medical Uncertainty, 1968-1972*, 54 Bulletin of the History of Medicine 43 (1980); Smith, *Black Lung: The Social Production of Disease*, 11 International J. of Health Services 343 (1981).

a. Social Security: Listing of Impairments

A Social Security claimant can prove disability by meeting specified criteria set out for identified physical and mental impairments in the Social Security Administration's Listing of Impairments.[314] The Listing criteria address only medical conditions, as opposed to vocational factors, and are intended to be rigorous: an impairment that meets the applicable criteria is considered "severe enough to prevent a person from engaging in any gainful activity."[315] The Listing is divided into 13 sections, each of which covers a different major body system.[316]

For each body system there is an introductory section, which defines various terms and requirements found in the specified criteria for the impairments included for that body system, and a "Category of Impairments" which includes the necessary findings for each listed impairment.[317] The findings can include signs, symptoms or results of laboratory tests. For example, arthritis of the spine is disabling when motion is limited to a specified degree and x-rays show either calcification of two specific major ligaments or ankylosis of both of the joints between the hip and the spine accompanied by an abnormal appearance of the joints.[318] A disability determination based on the Listing must include evidence of both diagnosis and specific findings which address the severity of the listed impairment: "A finding that an impairment meets the listing will not be justified on the basis of a diagnosis alone."[319] The Listings were revised substantially in 1985, primarily with respect to the adult listings for mental impairments.[320]

Although the Listing criteria are mandatory only for surviving spouse's disability benefits and child's Supplemental Security Income claims, determinations based on the Listings are relatively common for all types of benefits at the initial decision and reconsideration levels; they are, however, extremely rare at the hearing level except for those types of claims.[321] Notwithstanding the relatively technical nature of much of the Listing criteria, the Social Security Administration has not acted forcefully in placing authority for making Listing-based determinations with doctors. Despite express policy statements placing primary responsibility for determining whether a claimant's condition

---

314. For purposes of Disability Insurance Benefits, Childhood Disability Benefits and adult Supplemental Security Income, the Listing establishes only a non-exclusive basis for proving disability; regulations provide that disability must be proved according to the criteria in the Listing for purposes of surviving spouse's disability benefits and child's Supplemental Security Income, although those regulations have been challenged recently. *See* text accompanying notes 60-76, *supra*.

315. 20 C.F.R. §§ 404.1525(a), 416.925(a).

316. It is also divided into two parts: Part A deals with those impairments which affect adults and children in the same manner; part B deals with impairments which affect only children. *Id.* §§ 404.1525(b), 416.925(b). Part B applies primarily to child's Supplemental Security Income claims. *See* text accompanying notes 71-73, *supra*.

317. When the requirements of a listing have been met the claimant must be found disabled, even if the evidence showed that the claimant had been able to perform substantial gainful activity in the past with the same impairments. *See* Ambers v. Heckler, 736 F.2d 1467, 1470 (11th Cir. 1984) ("consideration of the fact that [the claimant] could return to her past work is not a relevant inquiry once she met the listing"). *See generally* 20 C.F.R. §§ 404.1520(a), 416.920(a) ("If we find that you are disabled or not disabled at any point in the [sequential evaluation process] we do not review further").

318. *Id.* § 404, Subpart P, Appendix 1 § 1.05A.

319. *Id.* §§ 404.1525(d), 416.925(d). *See also* S.S.R. 83-19 (Cum. Ed. 1983).

320. *See* 50 Fed. Reg. 35,038, 50,068 (1985). The mental impairment listings, which were to expire in 1988 after further revisions were to be implemented, were extended through August 1990. 53 Fed. Reg. 29,878 (1988).

321. There is, however, a tendency in Disability Insurance Benefits and Supplemental Security Income cases for some adjudicators to let the disability determination process continue unless eligibility based on the Listing is very clear. DDS interviews, *infra* notes 322, 368, 389; OHA interviews, *supra* notes 32, 157, 159.

meets or equals the requirements of the Listing with the medical member of the team, claims examiners at the Disability Determination Services, where most Listing determinations are made, treat claims decided on the basis of a listed impairment much like any other.[322] The general view of the Office of Hearings and Appeals is that a medical advisor is not needed when the issue is whether a claimant meets the Listing criteria, so long as all of the pertinent evidence is in the file.[323] Some administrative law judges who favor the use of medical advisors at hearings point to the Listing-based claims as cases where medical advisors can be most useful.[324] Others, assuming as does the Office of Hearings and Appeals that the Disability Determination Services either resolve most Listing-based claims or at least develop the evidence necessary to facilitate the decision on appeal, feel that special medical assistance is unnecessary.[325]

b. Veterans Benefits: Schedule for Rating Disabilities

The vast majority of Veterans disability claims are decided on the basis of the Veterans Benefits Administration's Schedule for Rating Disabilities, particularly claims for compensation benefits.[326] The concept and form of the Schedule is similar to that of the Social Security Administration's Listing of Impairments, except that the Schedule provides for percentage ratings for cases of less than total disability, as required under the compensation benefits disability standard.[327] The Schedule is organized according to fourteen separate body systems or types of physical or mental conditions, with detailed descriptions of diseases and injuries included within each of the systems or types of conditions. Percentage ratings, ranging from 10 to 100 percent, are listed for each disease or injury based on estimated loss of earning capacity.[328] In addition to the Schedule itself, Rating Boards are provided with manuals to guide them in making rating decisions.[329]

Disability ratings in the Schedule are based on a functional approach to the body's systems and the effect of limitations on the ability to work: "The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including

---

322. *See* POMS DI 24501.010B.1 ("The DDS medical/psychological consultant has the fundamental responsibility . . . to determine if a listing . . . is met or equalled"). The Illinois practice, however, is typical: medical consultants are available to answer questions or resolve doubts about evidence relating to a listing, but the decision as to whether the claimant meets the criteria is reviewed by the consultant together with the entire record and approved or disapproved only at the end of the process. Interview with Jack Bell, Deputy Director, Bureau of Disability Determination Services, Illinois Department of Rehabilitation Services (November 14, 1988) [hereinafter Illinois DDS interview]. The medical consultant's role in the initial decisionmaking process is discussed in detail in Part IV of this report.

323. OHA interview, *supra* note 32. *See also* S.S.R. 83-19 (1983) ("By comparing the clinical signs, symptoms and laboratory findings from the evidence of record with those in the listing, the administrative law judge (ALJ) can usually readily determine whether the listing is met").

324. Chicago OHA interviews, *supra* note 157.

325. Some judges will consider using a medical advisor only for exceptionally difficult Listing cases. Nashville OHA interview, *supra* note 159.

326. Very few compensation cases are decided outside the Schedule or on the basis of a finding of unemployability. Proof of total disability based on unemployability are discussed at text accompanying notes 425-34, *infra*

327. *See* text accompanying notes 99-102, *supra*.

328. 38 C.F.R. § 4.1 (1988) (ratings represent "the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations").

329. *See, e.g.*, Veterans Administration Manual M21-1, Chapter 50 ("Rating Procedure Relative to Specific Issues"). The Rating Boards are bound by the manual; the Board of Veterans Appeals is not. VA interview, *supra* note 5.

employment."[330] Rating decisions based on the Schedule are not supposed to be narrow decisions; instead, adjudicators are directed specifically to evaluate the medical evidence "in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present."[331] Although medical evidence from all sources will be considered, in compensation cases there must be an examination from a physician at a Department of Veterans Affairs medical facility in the record in order to complete a rating; private source evidence is used to supplement the examination from the medical facility, depending on the quality of the medical facility examination and the availability of information from private medical sources.[332] Pension claims, on the other hand, can be supported entirely on the basis of evidence from private sources.[333]

Any rating decision in a compensation case must also include a finding of service connection,[334] which is seen by the Veterans Benefits Administration as a legal decision based on medical evidence. Accordingly, reports from medical sources, including reports from doctors at the Department's own medical facilities, can address only the veteran's illness or impairment; the Veterans Benefits Administration, including, of course, doctors on its Ratings Boards and its Board of Veterans Appeals, must decide whether the service connection requirement is met.[335]

Difficulty in proving service connection has been at the heart of the controversy surrounding claims based on exposure to radiation and Agent Orange. The Department of Veterans Affairs does not recognize disabilities caused by exposure to Agent Orange during the Vietnam war as service connected, except for chloracne.[336] Instead, the Department asserts that evidence linking Agent Orange to cancer, nerve damage, sterility, and other disorders, is inconclusive.[337] In an effort to move the Department on this issue, Congress passed the Veterans' Dioxin and Radiation Exposure Compensation Standards Act which directed the promulgation of regulations addressing standards and criteria for resolving claims based on dioxin and radiation exposure.[338] Following recent successful litigation challenging the implementation of the Act, the Department has published proposed regulations which would establish guidelines for finding a "significant statistical association" between exposure to dioxins or radiation and disease.[339] The Department also rarely recognizes any service connection for disabilities

---

330. 38 C.F.R. § 4.10. The regulation continues: "In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity." *Id.*

331. *Id.* § 4.2.

332. Veterans Administration procedures for obtaining and evaluating medical reports are discussed in detail in Part IV of this report.

333. VA interview, *supra* note 5; Interview with John H. Bartruff, Adjudication Officer, Veterans Administration Regional Office, Winston-Salem, North Carolina (November 18, 1988) [hereinafter Winston-Salem VA interview].

334. *See* text accompanying notes 95, 103-05, *supra*.

335. VA interview, *supra* note 5.

336. Veterans Administration Manual PG 21-1 § O-18-1.

337. *See generally*, Veterans Administration, *Worried About Agent Orange?* (1982); Murphy, *A Critique of the Veterans Administration Claims Process*, 52 Brooklyn L. Rev. 533 (1986). Veterans and their representatives do not have the capacity to develop this evidence, if it is there. DAV interview, *supra* note 245; Interview with Richard O'Dell, Vice President, Vietnam Veterans of America, and Richard Addlestone, Director, and Michael Wildhaber, Staff Attorney, Vietnam Veterans of America Legal Services (August 24, 1988) [hereinafter VVA interview].

338. Pub. L. No. 98-542, 98 Stat. 2725 (1984).

339. *See* 54 Fed. Reg. 30,099 (1989). The case was Nehmer v. United States Veterans Administration, No. C-86-6160 (N.D. Ca. 1989).

alleged to have been caused by veterans exposure to radiation during nuclear weapons tests following World War II.[340] In response, Congress passed the Radiation-Exposed Veterans Compensation Act of 1988, which provides for presumptive service connection for thirteen types of cancers when a veteran participated in certain "radiation risk activity."[341]

c. Proof of Pneumoconiosis for Black Lung Benefits: The Interim Presumption

In a sense, the Black Lung disability standard is the most focused of all on a specified medical condition. The Black Lung Benefits Act is directed specifically at persons suffering from one particular disabling disease, pneumoconiosis.[342] Accordingly, there are regulations which set out specific findings from x-rays or a biopsy required to prove that the claimant suffers from disabling pneumoconiosis.[343] Applying these regulations is much like applying the Listing of Impairments, except that there are special difficulties associated with the reading of x-ray evidence.

In practice, however, most Black Lung claims do not involve direct proof of the existence of disabling pneumoconiosis, let alone direct proof that the miner's disability resulted from coal mine employment. Instead, disability is proved usually with the aid of one or another presumption of total disability due to pneumoconiosis, the most important of which has been the Department of Labor's "interim presumption."[344] Although the interim presumption applies only to claims filed before March 31, 1980, many claims based on the interim presumption are still under adjudication. Moreover, the Supreme Court ruled recently that certain claims previously denied because the interim presumption did not apply must be reviewed according to a substantially similar presumption found in Social Security Administration regulations.[345]

There are four methods of proof that can be used to invoke the interim presumption of total disability due to pneumoconiosis: a chest x-ray or biopsy evidence establishing the existence of pneumoconiosis, ventilatory studies demonstrating the presence of a chronic respiratory or pulmonary impairment, blood gas studies demonstrating significant

---

340. *See generally*, Favish, *Radiation Injury and the Atomic Veteran: Shifting the Burden of Proof on Factual Causation*, 32 Hastings L.J. 933 (1981). *See also* Bennett, *The Feres Doctrine, Discipline, and the Weapons of War*, 29 St. Ls. U.L.J. 283, 393-96 (1985). For a study concluding that nuclear tests participants did not suffer from a significantly greater incidence of cancer than the general population, see Caldwell, *et al.*, *Mortality and Cancer Frequency Among Military Nuclear Tests (Smoky) Participants*, 1957-1979, 7 J.Am.Med.A. 620 (1983).

341. Radiation-Exposed Veterans Compensation Act of 1988, Pub. L. No. 100-321, 102 Stat 485 (1988). For a history of the long battle fought by veterans for recognition of the service connection, see Titus & Bowers, *Konizeski and the Warner Amendment: Back to Ground Zero for Atomic Litigants*, 1988 Brigham Young U.L. Rev. 387 (1988).

342. Pneumoconiosis is defined in the Black Lung Benefits Act as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) (1982).

343. *See* 20 C.F.R. §§ 410.414(a), 718.202(a)(1) & (2).

344. The various available presumptions are discussed generally at text accompanying notes 116-25, *supra*. Early Black Lung regulations implementing the general disability standard, including the interim presumption, were at the same time overinclusive and underinclusive: they were overinclusive because Congress intended for them to be relatively generous to miners who could not prove total disability using traditional methods of proof; they were underinclusive because no set of presumptions and standards could encompass the universe of miners who suffered disabling disease from coal mine employment. More recent legislation and regulations have attempted to cut back on the liberalizing influence of the earlier rules, so that claims filed in the past few years face somewhat more rigorous standards.

345. *See* Pittston v. Sebben, ____ U.S. ____, 109 S.Ct. 414 (1988). *See generally* text accompanying notes 117-18, *supra*. The presumption is at 20 C.F.R. §§ 410.490(b)(1)(i), (b)(2).

problems with the transfer of oxygen from the lungs to the blood, or other medical evidence indicating a totally disabling respiratory or pulmonary impairment.[346]

X-ray or biopsy evidence can be used to invoke the interim presumption if it meets specified criteria for establishing the existence of simple pneumoconiosis.[347] Pulmonary function studies must show lung capacity values equal to or less than those listed in a table published in the regulations.[348] Blood gas studies, which measure the ability of the lungs to transport oxygen throughout the body, will support invoking the presumption with a reading of values equal to or less than those listed on the table.[349] Other medical evidence which can be used to invoke the interim presumption includes "the documented opinion of a physician exercising reasoned medical judgment, [which] establishes the presence of a totally disabling respiratory or pulmonary impairment."[350]

The interim presumption is rebuttable by any of four specified methods: proof that the miner is still working at his or her usual coal mine job or comparable employment, that the miner is capable of such employment, that the miner's disability did not arise out of coal mine employment, or that the miner does not have pneumoconiosis.[351] Rebuttal must be based on the specified criteria in order to be effective; other types or amounts of evidence cannot rebut the presumption once it has been invoked.[352] The first two methods for rebutting the interim presumption raise vocational and medical-vocational issues; the third goes to the issue of causality. Only the final method for rebutting the interim presumption goes directly to the absence of pneumoconiosis.[353] All types of medical evidence, other than a negative x-ray reading, can be used to rebut the presumption on this basis.[354]

---

346. 20 C.F.R. §§ 727.203(a)(1)-(4). The different methods for invoking the presumption are alternative and not cumulative; therefore, the interim presumption is invoked if any of the criteria are met. *Id.* § 727.203(a). Thus, if sufficient evidence is presented to establish one of the medical criteria, deficient evident relative to another set of criteria has no effect. Blaize v. Old Ben Coal Company, 3 BLR 1-710, 1-714 (1981). *See also*, Mullins Coal Co. of Virginia v. Director, 484 U.S. 135, 108 S.Ct. 427, 429 (1987), *reh'g denied*, 108 S.Ct. 787 (1988).

347. 20 C.F.R. § 727.203(a)(1). X-ray evidence must show pneumoconiosis classified as Category 1, 2, 3, A, B, or C, according to accepted systems of classification. *Id.* §§ 410.428(a)(1). Biopsy evidence must reveal pneumoconiosis. *Id.* at 410.428(a)(3).

348. 20 C.F.R. § 727.203(a)(2). The Supreme Court decided recently that a preponderance of the evidence standard must be used in weighing evidence submitted to invoke the interim presumption. Accordingly, although one qualifying positive result never requires the invocation of the presumption, "in some cases the presumption *may* be invoked by a single item of evidence...." *Mullins*, 108 S.Ct. at 439 n. 29 (emphasis in original).

349. *See* 20 C.F.R. § 727.203(a)(3). Either at-rest or after-exercise values can be used. *See* Robertson v. Alabama By-Products Corporation, 7 BLR 1-793, 1-795 (1985); Vigil v. Director, 8 BLR 1-99, 1-101 (1985). As with x-rays and pulmonary studies, blood gas studies must be weighed prior to invocation. *See* King v. Tennessee Consolidation Coal Company, 6 BLR 1-87, 1-93-94 (1983); *Mullins*, 108 S.Ct. at 439.

350. 20 C.F.R. 727.203(a)(4). A single medical report stating that a claimant has a totally disabling respiratory or pulmonary impairment can invoke the interim presumption if the report is sufficiently documented and well reasoned. All medical evidence must be weighed prior to invoking the presumption on this basis. *See* Stephens v. Bethlehem Mines Corporation, 8 BLR 1-350, 1-351-52 (1985); *Mullins*, 108 S.Ct. at 439.

351. 20 C.F.R. § 727.203(b)(1)-(4). *See generally* Cicconi, *Recent Developments in Black Lung Litigation: Rebuttal of Interim Presumption*, 85 West Va. L. Rev. 851 (1983).

352. *See* McCluskey v. Zeigler Coal Company, 2 BLR 1-1248, 1-1272-73 (1981). *See also* Mullins, 108 S.Ct. at 432.

353. 20 C.F.R. § 727.203(b)(4). Proof that the claimant suffers from a disability other than pneumoconiosis will satisfy this basis for rebuttal as well. *See* Blaize v. Old Ben Coal Co., 3 BLR 1-710, 1-717 (1981) (evidence established that claimant had emphysema rather than pneumoconiosis). *See also* Warman v. Pittsburg and Midway Coal Mining Co., 839 F.2d 257, 260 n. 2 (6th Cir. 1988).

354. *See Blaize*, 3 BLR at 1-717 (1981); Campbell v. Consolidation Coal Company, 6 BLR 1-314, 1-320-21 (1983). Negative x-rays alone are not sufficient because such evidence merely disproves one of the bases for invoking the presumption. *See* Peabody Coal Co. v. Lowis, 708 F.2d 266, 274 (7th Cir. 1983) ("Although negative

Even with the use of the interim presumption, most claims come down to a weighing of a wide variety of medical evidence; although there is a relatively narrow focus of evidence in invoking the presumption, a very broad range of evidence can be presented on rebuttal. This does not mean that Black Lung disability adjudications are particularly complex from a medical point of view. Indeed, most claims are thought to involve relatively simple balancing of conflicting medical opinions, not unlike a typical personal injury case.[355] Still, the flow of medical evidence into the disability adjudication is restricted by the fact that medical issues are so intertwined with legal issues. Thus, a physician asked to submit a medical report may be convinced that the claimant does not have pneumoconiosis but at the same time be unable to provide findings necessary to rebut the interim presumption.[356]

d. Medical Equivalence of Specified Medical Conditions

Disability evaluations can make use of standards based on specified medical conditions even in cases where the evidence does not match the criteria listed for those specified conditions. Thus, disability can be established on the basis of an impairment, or combination of impairments, that is the "medical equivalent" of an impairment that would qualify for disability under the Social Security Administration's Listing of Impairments, and ratings for purposes of Veterans Disability Benefits can be made by analogy to, yet outside of, the Veterans Administration's Schedule for Rating Disabilities.[357] In both cases, an attempt is made to use specific criteria identified in the Listing or the Schedule as indicators of disability for claims where those indicators are not present, but where the argument can be made that the claimant's condition is essentially of the same medical severity as the condition of an individual who would be determined to be disabled according to those criteria. These types of evaluations are particularly important where the specified criteria constitute the disability standard, as opposed to one of a number of alternative methods of proof. For this reason, the ability to prove disability on the basis of the medical equivalence to a listed impairment can be crucial in Social Security disabled surviving spouse's benefits and child's Supplemental Security Income cases.[358]

A determination of medical equivalence to a listed impairment is part of the third step of the Social Security Administration's sequential evaluation process, and therefore it is an evaluation based on medical evidence alone, without consideration of a claimant's age, education, or work experience.[359] Medical equivalence is evaluated according to the disabling effect of an impairment, or combination of impairments, and requires "medical findings . . . at least equal in severity and duration to the listed findings."[360] A

---

x-ray results *alone* are not sufficient to rebut the presumption . . . [they] are highly probative and must be given great weight . . . when corroborated by other medical evidence"). *See also* Welch v. Benefits Review Board, 808 F.2d 443, 446 (6th Cir. 1986).

355. OALJ interview, *supra* note 287. This is one reason why medical advisors are considered unnecessary in Black Lung appeals. This view is shared at the Benefits Review Board. Interview with Roy P. Smith, Administrative Appeals Judge, and Deborah Morris, Senior Division Attorney, Benefits Review Board, Department of Labor (October 13, 1988) [hereinafter BRB interview].

356. As stated by one Department of Labor administrative law judge, medical questions have meaning in Black Lung cases only in a legal context. OALJ interview, *supra* note 287.

357. The Listing of Impairments and the Schedule for Rating Disabilities are discussed at text accompanying notes 314-41, *supra*.

358. *See* text accompanying notes 60-76, *supra*.

359. 20 C.F.R. §§ 404.1520(d), .1526, 416.920(d), .926. The sequential evaluation process is discussed generally at text accompanying notes 25-46, *supra*.

360. 20 C.F.R. §§ 404.1526(a), 926(a).

comparison is made between the symptoms, signs, and laboratory findings in the claimant's medical record and the medical criteria for the appropriate listing.[361] Medical equivalence determinations are meant by the Social Security Administration to be tied directly to the published criteria in the Listing, not to a broader notion of disability.[362] For any particular listing, a medical equivalence determination must be based on a sufficient showing of comparable severity using different evidence than would be required to meet the listing.[363]

There are relatively few cases where a claimant attempts to show that a single impairment identified in the Listing that does not meet the listed requirements is the medical equivalent of a listed impairment, and even fewer cases in which a single, unlisted impairment is alleged to be the equivalent of a listed impairment. By far the most common determinations of medical equivalency involve a combination of impairments. It is difficult, however, to state precisely the criteria used to determine medical equivalence, particularly when based on a combination of impairments and when subjective symptoms, including pain, are present.[364] Recently, there has been some movement toward expanding the notion of medical equivalence, in part as a recognition of the difficulty in determining medical equivalence and in part because of the importance of the medical equivalency determination in certain types of claims.[365]

Administration regulations provide that medical equivalence decisions are based on medical evidence only, and there must be an opinion in the file on medical equivalence from an Administration-designated physician -- usually a medical consultant -- before an equivalence determination can be made.[366] Policy statements applicable to Disability Determination Services go farther and require that medical consultants decide the issue of medical equivalence.[367] As implemented in practice, however, medical equivalence determinations at the Disability Determination Services are usually made first by the

---

361. The listing used will be the listing for the claimant's dominant impairment or, if that impairment is not included in the listing, the listing of the impairment most like the claimant's impairment. *See* 20 C.F.R. §§ 404.1526(a), 416.926(a).

362. *See* S.S.R. 83-19 106 (Cum. Ed. 1983) ("As in determining whether the listing is met, it is incorrect to consider whether the listing is equaled on the basis of an assessment of overall functional impairment").

363. *See, e.g.*, Myers v. Bowen, CCH Unempl. Ins. Rep. 14,208A (S.D.N.Y. 1988) ("Where weight is insufficient to meet the Listing requirements [for obesity], medical equivalence . . . can still be found if additional impairments, in combination with each other and a significantly overweight condition, present a disability equal in severity to the Listing").

364. *See, e.g., Thompson v. Schweiker*, 555 F.Supp. 1282, 1289-90 (W.D. Mo. 1983) (must look at a claimant's "total physiological well-being"). *See also* Doustou v. Bowen, 640 F.Supp. 217, 219 (D. Me. 1986) (administrative judge's standard upheld where "*symptoms, signs*, and *laboratory findings*" are compared to the most closely related impairment in the listings) (emphasis in original). Subjective symptoms alone are insufficient to find that a claimant's condition equals the listings, absent an "equivalent underlying medical condition which ordinarily produces symptoms which would prevent gainful employment." *Id.* at 219, n.3. Although pain can be considered in a medical equivalence determination, it cannot substitute for a required sign or finding. *See* S.S.R. 88-13 92 (Cum. Ed. 1988) ("For example, a history of severe, persistent joint pain cannot be substituted for the required x-ray evidence in Listing 1.04 [arthritis of one major joint in each upper extremity]"). Pain as a basis for disability is discussed generally at text accompanying notes 436-55, *infra*.

365. Most recently, this issue was reconsidered in the context of child's Supplemental Security Income benefits. *See* Zebley v. Bowen, 855 F.2d 67 (3d Cir. 1988), *cert. granted*, ____ U.S. ____ (1989); text accompanying notes 75-76, *supra*. Questions have also been raised about the failure to consider Residual Functional Capacity in medical equivalence determinations in spouse's disability claims. *See* Tolany v. Heckler, 756 F.2d 268, 271-72 (2d Cir. 1985); text accompanying notes 67-71, *supra*.

366. 20 C.F.R. §§ 404.1526(b), 416.926(a). The roles of disability examiners and medical consultants in making disability decisions are discussed in greater detail at text accompanying notes 611-18, *infra*.

367. POMS DI 24505.15A, 24501.010B.1. *See also* S.S.R. 83-19 105 (Cum. Ed. 1983).

disability examiner, and then reviewed and approved by the medical consultant.[368] At the Railroad Retirement Board, medical consultants must participate in medical equivalence determinations.[369]

According to the Office of Hearings and Appeals, a determination of medical equivalence is considered a "clinical" judgment, as opposed to a "program" judgment, requiring complex decisions involving considerable medical judgment.[370] However, a medical advisor is not needed at hearings where the issue is medical equivalence, so long as the required medical opinions on the issue are in the record.[371] On the other hand, administrative law judges are required to obtain a new medical opinion on equivalence before reversing a finding to the contrary by the Disability Determination Service; however, after obtaining the new evidence the judge is not bound to follow any particular opinion.[372] Some judges feel that medical advisors are needed in all medical equivalence cases, which has led, in the opinion of the Chief Administrative Law Judge, to a "peculiar type of abdication" by administrative law judges in favor of medical experts on this question.[373] Some advocates argue that medical advisors are not helpful on medical equivalence issues for two reasons: they are unfamiliar and uncomfortable with the applicable regulations, and they are not effective in assessing claims involving multiple impairments, as occurs commonly in equivalence cases.[374]

Disability can be established for veterans benefits also through a substitute standard, based on the Veterans Administration's Schedule for Rating Disabilities. Administration regulations provide for ratings by analogy to a disability included in the Schedule, through a process similar to a determination of medical equivalence to the Social Security Administration Listing of Impairments. Thus, an unlisted condition can be rated "under a closely related disease or injury [in the Schedule] in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous."[375] Also, under limited conditions a 100 percent disability rating can be

---

368. OHA interview, *supra* note 32; Interview with Fran Krator, Director, Nancy Schweiker, Chief Medical Consultant, Cedric Short, Supervisor for Continuing Disability Reviews and Hearings, J.D. Reed, Coordinator of Policy and Procedures, Ray Lamberth, Supervisor for Medical Unit, and Larry Raye, Supervisor of Operations, Disability Determination Services, Tennessee Department of Human Services (November 16, 1988) [hereinafter Tennessee DDS interview]; Interview with Lloyd D. Moses, Associate Commissioner for the Office of Disability Determinations, New York Department of Social Services (November 16, 1988) (hereinafter New York DDS interview]. In the opinion of the Deputy Director of the Illinois Disability Determination Service, a doctor's opinion on equivalence is not so important; rather, the disability examiner can make the determination based on medical evidence and consultations, if necessary, with a medical consultant. Illinois DDS interview, *supra* note 322. In Florida, on the other hand, medical equivalence determinations are done almost always by the medical consultant. Interview with Jeffrey B. Kessler, M.D., Medical Executive Director, Office of Disability, Florida Department of Health and Rehabilitative Services (November 17, 1988) [hereinafter Florida DDS interview].

369. RRB interview, *supra* note 176.

370. OHA interview, *supra* note 32.

371. *Id.*

372. *See* S.S.R. 83-19 (Cum. Ed. 1983). Although the Social Security Administration recognizes that administrative law judges are responsible for making the final decision on medical equivalence, they are cautioned to give "appropriate weight" to the opinions of the Administration's medical consultants. *Id.*

373. OHA interview, *supra* note 32. In the Downtown Chicago Office of Hearings and Appeals, medical equivalence cases are among the type of cases where medical advisors are most commonly used. Chicago OHA interviews, *supra* note 157. As stated by the Hearing Office Chief Administrative Law Judge, doctors should decide medical equivalence cases because it is "such a fuzzy area, I don't understand it." *Id.*

374. Interview with Joseph A. Antolin, Director, SSI Advocacy Project, Thomas Yates, Staff Attorney and Health Specialist, and Julian Henriques, Staff Attorney, Legal Assistance Foundation of Chicago (June 17, 1988) [hereinafter LAF interview].

375. 38 C.F.R. § 4.20. The Schedule is discussed at text accompanying notes 326-41, *supra*.

given for service-connected impairments which require hospital treatment or observation for more than 21 days.[376]

2. Medically-Based Functional Limitations

Disability is never a purely medical phenomenon in the sense that the existence of a medical condition necessarily produces disability. A person is always disabled from doing something. Ultimately, therefore, eligibility for disability benefits is based on a claimant's inability to perform at a designated capacity, usually defined in terms of the capacity to work.[377] The focus is specifically functional: what it is that the claimant can and cannot do, or, more particularly, what the limits are to his or her ability to function physically and mentally. Thus, a key issue in determining disability can be the claimant's capacity to stand, sit, push, pull or lift, or to respond to supervision, tolerate work stresses or get along with coworkers. There must be a medical basis for any limitations, but the measure is the effect of the condition or conditions, not the existence or degree of severity of the condition itself.

Functional capacity can be evaluated without reference to any particular standard other than basic activities such as standing, pushing and lifting.[378] Such is the case with Residual Functional Capacity assessments in the Social Security program. Residual Functional Capacity assessments consider only the impact of claimants' impairments and are used only as a component part of the process; they do not address fully the ability of claimants to function as contemplated in the disability standard. Thus, the fact that a claimant is unable to lift more than twenty pounds as the result of arthritis and hypertension will not in itself establish disability. It can, however, be an important and even critical finding, depending on other, related evidence in the record.

As mentioned earlier in the context of disability determinations based on specified conditions, starting the process with a search for the existence of a particular medical condition runs counter to the usual medical clinical practice of first finding out what a patient can and cannot do.[379] The inquiry proceeds more along conventional lines when the issue is the extent of a claimant's functional limitations. A record is compiled with a goal of focusing on the effects of the claimant's impairments, based to a considerable degree on the claimant's statements of his or her limitations. The process does, however, still require the identification of a medical condition, or combination of conditions, to which the stated functional limitations can be attributed.[380]

a. Social Security: Residual Functional Capacity

376. *See id.* § 4.29. Disability can be based on the veteran's hospitalization only if a rating cannot be assigned otherwise under the schedule, and it is effective only for a certain period following discharge from the hospital. The outer limit is usually the last day of the month the veteran was discharged from the hospital. *Id.* § 4.29(a).

377. In some programs, however, the existence of a particular medical condition can prove disability. See generally text accompanying notes 305-13, supra.

378. Functional limitations can also be evaluated with more or less direct reference to the appropriate disability standard, which usually includes a vocational component and therefore requires an assessment framed in terms of a claimant's ability to perform general or specific work activity. These medical-vocational functional limitations are discussed at text accompanying notes 392-434, infra.

379. See text accompanying notes 312-13, supra.

380. Cf. Statement of Vert Mooney, M.D., to the Disability Advisory Council (June 19, 1988), at 2 (physical limitations as such can be less important factors in assessing the ability to work than vocational or medical-vocational factors and the individual's commitment to work).

Residual Functional Capacity is a measure of a claimant's physical and mental limitations and how they affect his or her ability to work.[381] It is used in the Social Security Administrations "sequential evaluation process" for determining disability as part of the medical-vocational assessment whether a claimant can perform work he or she has done in the past, or any other work.[382]

Regulations set out specific requirements for sedentary, light, medium, heavy and very heavy work. The physical abilities assessed include the ability to stand, lift, carry, push, pull and reach; mental abilities include understanding, carrying out and remembering instructions, as well as responding appropriately to supervision, work pressures and coworkers in a work setting.[383] Residual Functional Capacity assessments based on physical abilities, which are used regularly in the application of the Administration's Medical-Vocational Guidelines,[384] are defined quite specifically. Thus, a capacity for sedentary work means the ability to lift a maximum of 10 pounds, lift or carry occasionally light objects such as files or small tools, and walk or stand up a certain amount during the work day.[385]

Residual Functional Capacity assessments must be based on all relevant evidence, including a claimant's statement of subjective symptoms such as pain. As stated in recently proposed regulations, "[r]esidual functional capacity is an assessment based upon all of the relevant evidence. It may include descriptions (even [the claimant's] own) of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of your medical condition."[386] Residual Functional Capacity assessments for claimant's with mental impairments require a full evaluation of all evidence relating to the claimant's ability to cope with the pressures of a work setting.[387]

There is a difference of opinion between the Social Security Administration and some Disability Determination Services concerning the appropriate role for medical consultants in making Residual Functional Capacity determinations. Regulations and Administration rulings and policy statements provide that they are to be made by the medical consultants, a view reinforced in a 1988 letter from the Associate Commissioner

---

381. See 20 C.F.R. §§ 404.1545(a), 416.945(a). Residual functional capacity is sometimes described as "physical and mental capabilities." See e.g., Berry v. Schweiker, 675 F.2d 464, 467 (2nd Cir. 1982). See also 20 C.F.R. §§ 404.1545, 416.945; S.S.R. 86-8 (Cum. Ed. 1986). When used in conjunction with the Medical-Vocational Guidelines, the specific levels of Residual Functional Capacity are defined in terms of "physical exertion requirements." 20 C.F.R. § 404.1567.

382. The use of Residual Functional Capacity assessments in the sequential evaluation process and how that process is used to implement the Social Security disability standard are discussed at text accompanying notes 25-59, supra.

383. See 20 C.F.R. §§ 404.1545(b), (c), 416.945(b), (c).

384. See text accompanying notes 47-59, supra.

385. 20 C.F.R. §§ 404.1567(a), 416.967(a). A claimant must also be able to sit for most of the work day. Ferraris v. Heckler, 728 F.2d 582, 587 (2d Cir. 1984); S.S.R. 83-10 (Cum. Ed. 1983). *See also* Wages v. Secretary, 755 F.2d 495, 499 (6th Cir. 1985) (need to alternate between sitting and standing precludes finding of Residual Functional Capacity for sedentary work). *But see* Bradley v. Secretary, 862 F.2d 1224, 1227 (6th Cir. 1988) (the need to alternate between sitting and standing does not necessarily preclude sedentary work, but instead all evidence must be evaluated to establish ability to do the sedentary work). *See also* Hall v. Bowen, 837 F.2d 272 (6th Cir. 1988) (claimant not disabled simply based on a need to alternate between sitting, standing, and walking, if a vocational expert can identify jobs that can be performed within the claimant's limitations).

386. 53 Fed. Reg. 35,516, 35,520-21 (1988) (proposed 20 C.F.R. § 404.1545(a)). *See* also S.S.R. 88-13 4 (1988). Disability based on pain is discussed generally at text accompanying notes 436-55, *infra.*

387. Disability based on mental impairments is discussed generally at text accompanying notes 456-69, *infra.*

for Disability to directors of state Disability Determination Services.[388] Some state offices are in compliance with this requirement; however, others are only reluctantly moving in the direction of giving the full responsibility for Residual Functional Capacity determinations to medical consultants.[389] Residual Functional Capacity assessments in cases involving mental impairments are completed by a psychiatrist or psychologist at most Disability Determination Services.[390] Even at the Railroad Retirement Board, where there is no requirement of medical consultant participation in the determination of any issue, the highest percentage use of medical consultants is with respect to Residual Functional Capacity determinations.[391] One reason for the resistance found in some Disability Determination Services to precluding disability examiners from making Residual Functional Capacity determinations is the strong program content of the determination; although invariably medically-based, it is difficult to separate the evaluation from its program context.

3. Medical-Vocational Functional Limitations

Ultimately, all disability programs are aimed at addressing the financial consequences of being unable to perform in the work place as the result of medical conditions. Payments are authorized when an individual suffers from one or more medical conditions that preclude satisfactory performance at a particular job or category of jobs. It would seem to follow that most, if not all, disability evaluations would be based on the most direct finding available: a claimant's medical-vocational functional limitations. Instead, the issue of medical-vocational functional limitations is reached usually, if at all, only as a last resort. In the Social Security program, for example, the disability determination process is structured to reach the question of a claimant's medical-vocational limitations only after applying a purely medical standard -- contained in the Listing of Impairments -- substituting as a shorthand definition of disability.[392]

When the issue of a claimant's functional capacity to perform a job or range of jobs is reached, there is an uneasiness brought about perhaps by the hybrid nature of the inquiry. Does the issue involve essentially a medical evaluation presented in a vocational context, or is it essentially a vocational evaluation based on medical evidence? For some programs, depending on the disability standard applied and the process (including

---

388. *See* 20 C.F.R. §§ 404.1546, 416.946; S.S.R. 82-30 (Cum. Ed. 1982); POMS §§ DI 24501.010, DI 24510.005A, DI 39518.010B.1.a. The summer, 1988 letter from the Associate Commissioner was phrased in terms of an endorsement of current policy. DDS interviews, *supra* notes 322, 368, *infra* note 389.

389. In New Mexico, for example, the Administrator of Disability Determination Services believes that it is unnecessary for doctors to complete the Residual Functional Capacity forms themselves. Interview with Richard L. Fairbanks, Administrator, Disability Determination Services, Division of Vocational Rehabilitation, New Mexico Department of Education (November 23, 1988) [hereinafter New Mexico DDS interview]. On the other hand, the most intensive use of doctors in New York is on Residual Functional Capacity assessments, and more would be hired for this purpose if funds were available. New York DDS interview, *supra* note 368. The roles of disability examiners and medical consultants in making Residual Functional Capacity assessments are discussed in more detail at text accompanying notes 612-15, infra.

390. Illinois DDS interview, *supra* note 322. The Disability Determination Services must make "[e]very reasonable effort" to use a psychiatrist or psychologist when issuing an unfavorable decision and mental impairments are involved. *See* 20 C.F.R. §§ 404.1503(e), .1615(d), 416.903(e), .1015(d); POMS DI 24501.010B2. *See generally* text accompanying notes 456-69, *infra*.

391. RRB interview, *supra* note 176.

392. For two categories of benefits in the Social Security program -- disabled spouse's benefits and Supplemental Security Income benefits for children -- the inability to perform any gainful activity can be shown only by medical proof directed at the requirements of the Listing of Impairments. *See* text accompanying notes 60-76, *supra*.

personnel) used to make disability determinations, the issue, when reached, turns mostly on the medical basis for identified functional limitations. As a result, the issue of medical-vocational functional limitations can be approached in essentially the same manner as is the issue of purely medically-based functional limitations. This tends to be the case, to a greater or lesser degree, in most programs; it is true particularly with respect to the Social Security program, which uses Residual Functional Capacity assessments as part of its process for resolving the medical-vocational issues of whether a claimant can perform work he or she has held in the past, or can perform any other substantial gainful activity.[393] On the other hand, in a program such as Civil Service Disability Retirement, where the disability determination process moves relatively quickly to the ultimate question of the ability of the claimant to perform a particular job, the resolution of medical-vocational issues is approached more like a personnel decision based on medical evidence.[394]

a. Social Security: Ability to Perform Past Work or Other Substantial Gainful Activity.

Medical-vocational functional limitations are considered specifically twice in Social Security disability determinations. A finding of non-disability can be made at the fourth step of the sequential evaluation process for claimants who are able to perform "past relevant work."[395] If a claimant can no longer perform past relevant work, the disability determination reaches the fifth and final step of the sequential evaluation process at which the issue is whether the claimant can perform any other work given his or her age, education and past work experience.[396] These two issues address, in effect, the ultimate disability standard for Disability Insurance Benefits and Supplemental Security Income.[397]

The determination of whether a claimant can perform past relevant work or other substantial gainful activity involves -- other than a residual functional capacity assessment -- mostly vocational considerations. Thus, many of the contested issues with respect to the ability to perform past relevant work focus on the general nature and requirements of prior jobs, how far back into the claimant's work history is the relevant past, and how long the claimant must have worked at a particular job to be considered past work for these purposes.[398] Of course, once a claimant's prior relevant work has been identified, a determination must be made whether the claimant has the physical or mental ability to perform that work in light of his or her alleged impairments. In most cases, medical evidence of the claimant's ability to perform the requirements of prior

---

393. These issues are raised in the last two steps of the sequential evaluation process. *See* text accompanying notes 48-51, supra.

394. OPM interview, *supra* note 191. See text accompanying notes 92-94, *supra*. *A similar view is taken by the Veterans Benefits Administration when it decides claims on the basis of total disability due to unemployability. See text accompanying notes 425-34, infra.*

395. 20 C.F.R. § 404.1520(e). Past relevant work is defined simply as "work [the claimant] ha[s] done in the past." *Id.*

396. *Id.* § 404.1520(f).

397. The general disability standard is discussed at text accompanying notes 19-59, *supra*. Disability determinations for Spouse's Insurance Benefits and Child's Supplemental Security Income Benefits are made according to a stricter standard that does not reach the fourth and fifth steps of the sequential evaluation process. *See* text accompanying notes 60-76, *supra*.

398. *See, e.g.*, Jock v. Harris, 651 F.2d 133, 135 (2nd Cir. 1981) (prior relevant work defined by general type of work, not a particular past job); Carter v. Heckler, 712 F.2d 137, 141 (5th Cir. 1983) (time limit for vocationally relevant past work must be decided on a case-by-case basis); Lashley v. Secretary, 708 F.2d 1048, 1053 (6th Cir. 1983) (work lasting only a few days not relevant).

relevant work is tied closely to vocational evidence concerning the actual requirements of the job.[399]

Similarly, most of the contested issues are vocational when the question is whether a claimant can perform other substantial gainful activity. This question is reached, of course, only if the claimant cannot perform past relevant work; if a claimant cannot perform past relevant work, the burden shifts to the Social Security Administration to prove that the claimant can perform other substantial gainful activity.[400] The Administration can meet this burden either through the use of its Medical-Vocational Guidelines or by providing vocational evidence that the claimant can perform a particular job.[401]

The medical evaluation required by the Medical-Vocational Guidelines is limited to a determination of the claimant's Residual Functional Capacity.[402] Otherwise, the Guidelines take into account only vocational factors: the claimant's age, education and prior work experience.[403] There are cases, however, where the Guidelines cannot be used, usually because the claimant's impairments include "nonexertional" limitations that are not considered in a Residual Functional Capacity assessment. In order to show that the Guidelines are not applicable, medical proof of the existence of nonexertional impairments is needed.[404] Nonexertional impairments include mental, sensory or skin impairments, and postural, manipulative or environmental restrictions.[405] When the Guidelines cannot be used and proof of the claimant's ability to perform a particular job is required, again most of the evidence is vocational in nature, going to the nature and existence of the work. As with determinations of claimants' ability to perform past relevant work, the medical and vocational issues on the question of a claimant's ability to perform other substantial gainful activity tend to merge. Thus, it has been stated that the Social Security Administration must, in identifying suitable other work, show that the claimant has the functional capacity to perform the work "taking into consideration the requirements of the job as well as the claimant's age, education, and [vocational] background."[406]

Proof of a claimant's physical and mental capacity to perform either past relevant work or other substantial gainful activity must be based on competent medical evidence. Medical evidence is compiled and evaluated for these purposes in the same manner as is medical evidence relating to other medical-legal issues that arise in the Social Security

---

399. *See, e.g.*, Abshire v. Bowen, 848 F.2d 638 (5th Cir. 1988); Smith v. Heckler, 782 F.2d 1176 (4th Cir. 1986); McGhee v. Harris, 683 F.2d 256, 257-58 (8th Cir. 1982). Other important evidence on this issue, such as efforts by the claimant to return to a former job, is purely vocational. *See* Butler v. Secretary, 850 F.2d 425, 428-29 (8th Cir. 1988); Watson v. Bowen, 671 F.Supp. 580, 584-86 (N.D. Ind. 1987); Lanes v. Harris, 656 F.2d 285, 287 (8th Cir. 1981).

400. *See* Torres v. Schweiker, 682 F.2d 109, 112 (3rd Cir. 1982), *cert. denied*, 459 U.S. 1174 (1983). *See also* Smith v. Bowen, 826 F.2d 1120, 1122 (D.C. Cir. 1987); Butler v. Secretary, 850 F.2d 425, 426 (8th Cir. 1988).

401. The proposed job must exist in significant numbers in the national economy, as required by the general disability standard. See text accompanying notes 49-59, *supra*.

402. The guidelines are written to encompass broad classes of potential claimants based on their Residual Functional Capacity. *See* 20 C.F.R. § 404, Subpart P, App. 2. Residual Functional Capacity assessments are discussed at text accompanying notes 381-91, *supra*.

403. 20 C.F.R. § 404, Subpart P, App. 2.

404. *See, e.g.*, Johnson v. Bowen, 851 F.2d 748 (5th Cir. 1988) (speculation about a possible psychiatric, nonexertional impairment could not overturn use of the Guidelines); Murray v. Heckler, 737 F.2d 934, 935 (11th Cir. 1984).

405. *See* 20 C.F.R. Subpart P, Appendix 2, § 200.00(e) (1988). *See generally* S.S.R. 85-15 (Cum. Ed. 1985). *See also* Asher v. Bowen, 837 F.2d 825, 827 n.2 (8th Cir. 1988); Thomas v. Schweiker, 666 F.2d 999, 1004 (5th Cir. 1982).

406. Hall v. Secretary, 602 F.2d 1372, 1377 (9th Cir. 1979).

disability determination process, including residual functional capacity assessments. There is continuing debate, on the other hand, about whether a vocational expert is required to establish the necessary vocational facts to make these determinations. Although the Social Security Administration's regulations leave it to the Administration to decide whether a vocational expert is required,[407] some courts have imposed this requirement on the Administration.[408]

b.Civil Service: Ability to Perform Useful and Efficient Service

There are two separate but related issues raised by the general disability standard for Civil Service disability benefits. First, it must be determined whether the employee is able to provide "useful and efficient service" in his or her current position. This determination raises issues much like those involved in the evaluation of a Social Security claimant's ability to perform past relevant work, except that the only relevant job is the federal employee's current position. Second, it must be determined whether the employee is qualified for reassignment to a vacant position within the agency.[409] This is a much more limited version of the search for other substantial gainful activity incorporated into the final step of the Social Security Administration's sequential evaluation process; only limited types of positions are considered, as opposed to all those possibly existing in the national economy.[410]

Of course, there must also be a causal link between an alleged medical impairment and the inability to perform useful and efficient service.[411] The nature or origin of the disease, however, is irrelevant.[412] Moreover, an organic cause need not be found if there is sufficient evidence of a disabling medical condition.[413] The effect of pain, which can be based on subjective evidence of pain and discomfort, must be

---

407. 20 C.F.R. §§ 404.1566(e), 416.966(e). *See also* S.S.R. 83-10, 83-11, 83-12, 83-14 (Cum. Ed. 1983), S.S.R. 85-15 (Cum. Ed. 1985).

408. *See, e.g.*, Mackinaw v. Bowen, 866 F.2d 1023, 1024 (8th Cir. 1989) (requiring "expert vocational testimony or other similar evidence" when Guidelines are held inapplicable). *See also* Ferguson v. Schweiker, 641 F.2d 243, 247-48 (5th Cir. 1981) (vocational expert testimony required except for "exceptional cases . . . when the claimant can clearly do unlimited types of . . . work"). *Cf.* McLamore v. Weinberger, 538 F.2d 572, 575 (4th Cir. 1976) (vocational expert not needed where claimant had only limited restriction in physical capacity).

409. 5 U.S.C. § 8337 (Supp. V 1987). The Civil Service disability standard is discussed generally at text accompanying notes 92-94, *supra*. Although the statute contains no minimum duration requirement for disability, regulations have added the requirement that the claimant's condition "in all probability will continue for at least a year." *See* 5 C.F.R. § 831.502(b)(4). *See also* Federal Personnel Manual § S10-3(a)(2).

410. *See* text accompanying notes 46-59, *supra*.

411. Thus, where a claimant lacked any real motivation to continue his job, benefits were denied despite his medical problems because there was no evidence indicating that his poor physical condition was the immediate cause of his inability to perform at the level expected of him. Reese v. Office of Personnel Management, 8 M.S.P.R. 10, 12 n.3 (1981). *See also* Goodall v. Office of Personnel Management, 14 M.S.P.R. 588, 590 (1983). Causation can mean "either that the medical condition causes the service to be less than useful and efficient or that the medical condition itself warrants restriction from the essential or critical tasks or duties of the position occupied or from employment altogether." Federal Personnel Manual § S10-3(a)(1).

412. Parodi v. Merit Systems Protection Board, 690 F.2d 731, 739 (9th Cir. 1982). *See also* Federal Personnel Manual § S10-3(a).

413. *See* Pugh v. Office of Personnel Management, 38 M.S.P.R. 184, 188 (1988) ("[claimant's] failure to submit objective medical evidence showing the cause of his medical condition cannot be the only reason to deny disability retirement"); Cabe v. Office of Personnel Management, 34 M.S.P.R. 60, 64 (1987) ("the fact that the cause of the [claimant's] condition was unknown does not vitiate his claim"); Hill v. Office of Personnel Management, 10 M.S.P.R. 622, 624-25 (1982) ("while no organic cause had been found, that did not establish that there was no organic basis for [the claimant's] condition").

considered.[414] A disability must be total, as opposed to partial, to qualify for benefits; even if a condition is more than intermittent, it will not be considered totally disabling unless the condition interferes with the claimant's ability to perform his or her job.[415] The same standard is used for the Federal Employees Retirement System.[416]

The evaluation of a claimant's ability to perform "useful and efficient service" begins with a medical-vocational determination of the claimant's ability to perform the tasks required at his or her last position in federal employment. The first issue is whether the claimant's medical condition precludes performance of required work activities continually throughout the required work day.[417] A finding of total disability does not necessitate, therefore, a showing that the applicant is completely helpless or unable to perform any of the functions of his or her position.[418]

Once a claimant has shown his or her inability to perform the relevant current position, the government must come forward with an offer for a comparable position, if there is an appropriate position vacant within the claimant's "commuting area."[419] If no position is offered, eligibility is clear. If a position is offered but refused, there are two issues remaining: the comparability of the vacant position in question, and whether the claimant can perform useful and efficient service at that position. Comparability of the vacant position is a vocational, and even technical, issue. Determining whether a claimant's condition prevents performance of a comparable vacant position in a useful and efficient manner involves essentially the same type of medical-vocational issues

---

414. *See* Chavez v. Office of Personnel Management, 6 M.S.P.R. 404, 421 (1981). *See also* Behar v. Office of Personnel Management, 28 M.S.P.R. 183, 184 (1985) ("Objective clinical findings, medical diagnoses, subjective evidence of pain and other evidence showing work restrictions are the factors to be assessed in determining one's entitlement to disability retirement benefits"); Sweat v. Office of Personnel Management, 40 M.S.P.R. 84, 87 (1989) (quoting *Chavez*). Disability based on pain is discussed at text accompanying notes 435-55, *infra*.

415. *See* Meighen v. Office of Personnel Management, 7 M.S.P.R. 164, 165-66 (1981). *See also* Bingham v. Office of Personnel Management, 38 M.S.P.R. 197, 200 (1988) (claimant suffered pain from diabetic neuropathy and migraine headaches intermittently and therefore was denied disability retirement); de Matteo v. Office of Personnel Management, 7 M.S.P.R. 334, 337 (1981) (denial of claim based on diagnosis of diverticulosis and colitis resulting in intermittent diarrhea and abdominal pain upheld because "there are no provisions in the disability retirement regulations for partial disability"). *Cf.* Gonyer v. Office of Personnel Management, 38 M.S.P.R. 560, 562 (1988) (despite the fact that the claimant "is able to work in an outstanding manner for part of the day, the unpredictability of his attacks [from nystagmus] and the constant risk of injury to him . . . show a relationship between the service deficiency and the medical condition").

416. 5 U.S.C. § 8451(a)(1)(B). The legislative history of the supplemental program reveals no indication that Congress considered restricting the disability standards for the Federal Employees Retirement System disability program. *See generally Civil Service Pension Reform Act of 1985: Hearings on S.1527 before the Senate Comm. on Governmental Affairs*, 99th Cong., 1st Sess. (1985); H.R. Rep. No. 606, 99th Cong., 2d Sess. (1986).

417. *See* Gonyer v. Office of Personnel Management, 38 M.S.P.R. 560, 562 (1988) (even though claimant could "work in an outstanding manner for part of the day", the fact that his disability did not allow him to work safely for a full day made him eligible for benefits). Battle v. Office of Personnel Management, 7 M.S.P.R. 422 (1981) (cook could no longer walk, stand, and lift heavy pots for an eight-hour shift).

418. *See* Hillis v. Office of Personnel Management, 40 M.S.P.R. 592, 598 (1989) ("Complete disability for purposes of entitlement to disability annuity does not mean a condition of total helplessness or inability to perform any functions of a particular position"); McCoy v. Office of Personnel Management, 28 M.S.P.R. 185, 187 (1985) (presiding official reversed for requiring a showing of "total" disability); Bigelow v. Office of Personnel Management, 8 M.S.P.R. 190, 193 (1981) (postal clerk disabled because could not lift or stand for extended periods of time although could perform sedentary aspects of job). On the other hand, a claimant able to perform some duties and unable to perform others, must show that the precluded activities "comprise a major, or even substantial, portion of the claimant's overall duties." French v. Office of Personnel Management, 7 M.S.P.R. 249, 251 (1981).

419. 5 C.F.R. § 831.502(b)(7). The agency is not required to create or vacate a position. Prior to 1981, federal employees had to show only that they were unable to perform their last job. *See* 5 U.S.C. § 8331(6) (1976). An employee was considered disabled if he or she was "unable, because of disability, to perform useful and efficient service in the specific position he [or she] occupie[d]." Cerrano v. Fleishman, 339 F.2d 929, 931 (2nd Cir. 1964), *cert. denied*, 382 U.S. 855 (1965).

involved in determining whether the claimant is able to perform his or her last job, except that the specific job requirements would be different.

At the Office of Personnel Management, medical consultants participate in most determinations of disability together with claims examiners. The usual pattern is for the consultant to review the file before it is submitted to an examiner.[420] Medical consultants have no separate or special responsibilities; however, they are expected to comment on the medical basis for any functional limitations alleged as the basis for the claimant not being able to perform his or her job.[421] The Office of Personnel Management presumes that in the past the employee's health was good and that his or her work performance was satisfactory; therefore, ordinarily, medical records must show either a deterioration in medical condition or a deterioration in work performance.[422] Medical issues as such are not separated out in the decisionmaking process, in part because there are no criteria for establishing disability on the basis of medical evidence alone.[423] There are also no specific guidelines for evaluating and establishing work place restrictions; the medical evidence is simply measured as a whole against the vocational requirements of the employee's job.[424]

c. Veterans Benefits: Unemployability

Disability determinations are made in the Veterans disability program on the basis of a broad, medical-vocational finding of "unemployability" when a 100% disability cannot be established through use of the Schedule for Rating Disabilities. The unemployability standard is used in pension cases, where a showing of total disability is required, and in compensation cases when the veteran is seeking a 100% disability payment but does not have an impairment or combination of impairments that would rate 100% disability on the Schedule.[425]

In most cases where disability is based on unemployability the veteran must also establish a threshold showing of partial disability under the Schedule for Rating Disabilities.[426] Thus, for compensation benefits proof of unemployability must include one disability rated at 60 percent, or more than one disability rated together at 70 percent.[427] The same minimum percentages are used for pension benefits when the veteran is under 55 years of age; the percentages are reduced to 60 percent for one or more disabilities at ages 55 to 59, and to 50 percent at ages 60 to 64.[428] Unemployability is used only rarely in compensation cases to raise a rating to 100 percent when a total disability rating would not be justified otherwise under the

---

420. *See generally* text accompanying notes 196-99, *supra*.

421. OPM interview, *supra* note 191.

422. Federal Personnel Manual § S10-3(g).

423. Thus, the absence of a listing of disabling impairments or standards for medically-based functional limitations, such as are used by the Social Security Administration, is seen at the Office of Personnel Management as making the decisionmaking process more difficult. OPM interview, *supra* note 191.

424. As a result, it is felt at the Office of Personnel Management that doctors tend to present only conclusionary statements about work place restrictions when submitting reports in support of a claim. *Id.*

425. The Veterans disability standards for compensation and pension benefits are discussed at text accompanying notes 95-109, *supra*.

426. *See* 38 C.F.R. §§ 4.16, .17. Unemployability can also be used in special circumstances even when the minimum percentage rating requirement cannot be met. *Id.*

427. *Id.* § 4.16. If more than one partial disability is claimed, one must be rated at at least 40 percent. *Id.*

428. *Id.* § 4.17. At age 65 or over a veteran is "conclusively presumed" to be totally disabled for pension purposes, which in effect establishes eligibility on the basis of age. *Id.*

Schedule. Even in pension cases, where a finding of total disability is critical, most evaluations are based directly on the Schedule.[429]

The "unemployability" standard is essentially the same for both compensation and pension benefits, except that the veteran's age is considered only in pension cases.[430] However, unemployability determinations are more rigorous for purposes of compensation benefits. There is a full medical-vocational evaluation of the record directed at whether the veteran's service-connected disabilities prevent employment.[431] The rating board looks at "the nature and character of the disability as it relates to the individual's vocational and educational achievements, potentialities and residual abilities."[432]

Unemployability is defined more broadly in pension cases as the inability to secure employment "of the type [that one is] capable of performing in the area of [one's] residence."[433] For purposes of pension benefits, a finding of unemployability will be presumed, in effect, when the veteran is over 55 years of age and meets the reduced minimum percentage requirements from the Schedule. In such cases, a determination of unemployability can be based on proof that the veteran is not working.[434]

4. Special Issues

The medical issues discussed above arise in disability adjudications as a result of the legal framework -- statutory and regulatory -- in which the various programs are administered. Thus, whether a Social Security claimant has a particular specified medical condition or has certain medical-vocational functional limitations is an issue because of the disability standards being applied and the process used by the Social Security Administration for making disability determinations. There are in addition a number of special medical issues that are of interest because they involve difficult medical problems that cannot or do not fit into clearly defined legal rules, or difficult legal issues that cannot be framed clearly because of the nature of the underlying medical facts involved. These issues can arise across programs and, within a program, across stages or components of the disability determination process. From among many that could be chosen, two of the most important -- disability based on pain and disability based on mental impairments -- are discussed below.

a. Disability Based on Pain

---

429. VA interview, *supra* note 5. The Schedule is discussed at text accompanying notes 326-41, *supra*.

430. *See* 38 C.F.R. §§ 4.17, .19. The standard for a finding of unemployability for both benefits is phrased in terms of the inability to work, and therefore, is similar to the general disability standards for both the Social Security and Civil Service Disability programs.

431. Winston-Salem VA interview, *supra* note 320.

432. Veterans Administration Manual PG 21-1 § 0-14-3.

433. Veterans Administration Manual M21-1 § 50.47(b).

434. VA interview, *supra* note 5. *See also* Veterans Administration Manual M21-1 § 50.47. In many cases all that is required is the veteran's statement of employment status; in other cases, corroborating evidence from former and prospective employers is required. *Id.* § 50.47b.

One of the most difficult aspects of disability evaluations is the assessment of pain.[435] One problem, as noted by the Commission on the Evaluation of Pain, is the lack of knowledge in the medical community about chronic pain and the resulting inadequate guidance given to disability decisionmakers, including medical consultants, with respect to the assessment of pain.[436] In addition, the medical basis for putting much emphasis on the objective proof of a source for pain has been questioned. Thus, in testimony before the Social Security Administration's Disability Advisory Council, a physician testified that "[p]erhaps only 10 to 15 percent of chronic back problems have an objectively definable anatomic source of pain. Thus speculation, opinion, bias, and many other subjective factors enter into the medical diagnosis."[437]

Pain can figure in a disability determination in a number of ways. In the Social Security program, for example, pain may be included among the requirements for a listed impairment[438] or, in appropriate cases, can be the sole basis for a claimant's inability to engage in substantial gainful activity.[439] When pain is included in the criteria of a listed impairment, it is necessary only to prove that the symptom is present: "It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of the symptom as long as all other findings required by the specific listing are met."[440] However pain figures into a disability evaluation, in most cases both the underlying medical basis for the pain and the degree of severity of the pain must be addressed.

For a number of years, courts differed in their approaches to the requirements of an underlying medical basis for pain in the Social Security disability programs.[441] In 1984, Congress sought to clarify this issue by establishing a statutory standard for disability based on pain. Disability determinations based on pain must include

> medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physio-logical, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all

---

435. There are other symptoms that are considered in determining disability, such as dizziness and shortness of breath, that present some of the same issues as disability based on pain. Pain is the most common, however, and is therefore discussed separately in this section.

436. Report of the Commission on the Evaluation of Pain, xix (1986) (Finding #8). The Commission was appointed by the Secretary of Health and Human Services pursuant to provisions of 1984 amendments to the Social Security Act. *See* note 305, *supra*. Since the report was issued, the Administration has proposed new regulations on pain and other syumptoms. *See* text accompanying notes 486, *infra*. *See also* S.S.R. 88-13 (Cum. Ed. 1988).

437. Statement of Vert Mooney, M.D., to the Disability Advisory Council (June 19, 1987), at 3.

438. The listing for arthritis of a major weight-bearing joint, for example, requires a "history of persistent joint pain" and limitations of motion affected, presumably, by the claimant's tolerance of pain. *See* 20 C.F.R. § 404, Subpart P, Appendix 1 § 1.03.

439. Thus, pain can be considered at all steps of the sequential evaluation process, including residual functional capacity assessments. It can also be considered in a more general medical-vocational context. *See generally* text accompanying notes 381-91, 395-408, *supra*.

440. *See* S.S.R. 88-13 (Cum. Ed. 1988); 53 Fed. Reg. 35,516, 35,519 (1988) (proposed 20 C.F.R. §§ 404.1525(f), 416.925(f)).

441. Most courts have always required some medical evidence of the existence of an underlying impairment. Differences arose as to the type or extent of evidence necessary. *See, e.g., Marcus v. Califano*, 615 F.2d 23, 28 (2nd Cir. 1979) (where an impairment was medically established, objective clinical evidence not necessary to prove pain resulted from the impairment); *Beavers v. Secretary*, 577 F.2d 383, 386 (6th Cir. 1978) (pain need not be the inevitable result of the underlying medical impairment).

> evidence required to be furnished . . . would lead to a conclusion that the individual is under a disability.[442]

As stated in introductory comments to recent proposed regulations, statements of pain "need not be fully corroborated by medical signs and laboratory findings" to establish disability; however, "the evidence as a whole must be sufficient to clearly indicate that the symptoms alleged are compatible with the physical or mental medical signs and laboratory findings and could reasonably contribute to a conclusion of disability."[443]

Although there remains some controversy as to the strictness of the requirement of proof of an underlying impairment, current law still depends heavily on claimants' subjective evidence of pain.[444] Thus, "[s]ymptoms which are real to the claimant, although unaccompanied by objective medical data, may support a claim for disability benefits, providing, of course, the claimant satisfies the requisite burden of proof."[445] The Administration has been consistent in the view that the evaluation of pain must be made on the basis of all relevant evidence, including testimony from claimants and lay witnesses. At the same time, recent proposed regulations can be seen as strengthing the role of objective medical evidence in disability determinations based on pain: "Objective medical evidence is usually a reliable indicator from which [the Social Security Administration] can make reasonable conclusions about the intensity and persistence of [a claimant's] symptoms and the effect of those symptoms, such as pain, may have on [a claimant's] ability to work."[446] The regulations also look to medication, treatment and restrictions prescribed for pain, including "[a]ny measures [claimants] use or have used to relieve [their] pain or other symptoms (e.g., lying flat on [their] back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.)"[447]

The evaluation of subjective complaints of pain is the central issue in a large number of Social Security disability claims, particularly at the administrative hearing

---

442. Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460 § 3(a)(1), 98 Stat. 1794 (1984). This language was included as part of an interim pain standard to remain in effect until January 1, 1987. 42 U.S.C.A. § 423(d)(5) (Supp. 1989). The interim standard, which has remained effectively in place until permanent standards are developed, has been accepted by the Social Security Administration as an accurate statement of the law and has been written into recent proposed regulations. *See* 53 Fed. Reg. 35,516, 35,519 (1988) (proposed 20 C.F.R. §§ 404.1529(b), 416.929(b)) ("Medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptom alleged"). The Administration considers the lapsed statutory provision to be a codification of its policy on pain. *See* 53 Fed. Reg. at 35,516. *See also* 20 C.F.R. §§ 404.1529, 416.929; S.S.R. 88-13 (Cum. Ed. 1988); POMS DI 24515.060.

443. 53 Fed. Reg. 35,517 (1988).

444. A number of the courts that were critical of pain evaluations before the amendments have held that the new provision is consistent with their view of the law, and apparently the Social Security Administration feels the same way. *See, e.g.*, Polaski v. Heckler, 751 F.2d 943, 950 (8th Cir. 1984), *cert. denied*, 476 U.S. 1167 (1986); Hollis v. Bowen, 837 F.2d 1378, 1383 (5th Cir. 1988); Gatson v. Bowen, 838 F.2d 442, 447 (10th Cir. 1988). *Cf.* Hand v. Heckler, 761 F.2d 1545, 1548 n. 4 (11th Cir. 1985) (1984 amendments "effectively obsoletes" prior decisions on subjective evidence of pain).

445. *Green v. Schweiker*, 749 F.2d 1066, 1070 (3rd Cir. 1984). The court also noted that "subjective symptomatology, such as pain, must be considered, and can *support* a finding of disability. This is in keeping with the caveat that subjective complaints of pain, without more, do not themselves *constitute* disability." *Id.* (emphasis in original). *See also* Rainey v. Bowen, 814 F.2d 1279, 1281 (8th Cir. 1987) ("A subjective complaint of pain may not be disregarded on the sole basis that there is no supporting objective evidence").

446. 53 Fed. Reg. 35,516, 35,519-20 (1988) (proposed 20 C.F.R. § 404.1529(c)(2)). The proposed regulation goes on to describe objective medical evidence as "evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, and sensory and motory disruption." *Id.*

447. *Id.* (proposed 20 C.F.R. § 404.1529(c)(3)(vi)).

level.[448] There are no special procedures for processing pain cases at the Disability Determination Services; medical consultants review pain-related medical evidence and pain-based medical determinations routinely. There is disagreement, however, as to whether medical advisors can assist in evaluating pain cases at administrative hearings. Some advocates feel that doctors should be used at hearings more than they are currently because they have a greater understanding of medical issues relating to pain than administrative law judges, and can be more objective.[449] On the other hand, some administrative law judges find that medical advisors are not helpful in pain cases since the most important determination is the claimant's credibility.[450]

Pain can be an important factor in establishing disability in other programs as well.[451] Pain is included, for example, among the criteria for some impairments in the Veterans Administration's Schedule for Rating Disabilities.[452] However, pain and other subjective symptoms tend to be evaluated in the context of resulting functional loss without special rules for assuring a legitimate underlying medical basis. Thus, the concern in the Civil Service program is that the claimant show that pain alleged precludes the performance of useful and efficient service.[453] A medical report will not be sufficient to establish disability if it "fail[s] to answer the logical question of whether it is the pain alone which is disabling, whether the pain can be controlled to the extent that the [employee] can continue working, or whether the [employee] may be disabled by pain on some occasions but able to work on others."[454] In assessing functional loss resulting from a musculoskeletal impairment under the Schedule, pain is to be considered if "supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion."[455]

b. Disability Based on Mental Impairment

Although in many cases mental disabilities are evaluated in the same manner and with no greater difficulty than physical disabilities, problems have arisen in this area which have produced a great deal of controversy. This was true particularly with respect to the Social Security program in the early 1980s, when large numbers of claimants with mental impairments that did not satisfy the criteria in the Listing of Impairments were being denied or terminated on the basis of a general, unsupported presumption that they could perform unskilled work.[456] The Veterans Administration has also been criticized with respect to the evaluation of post traumatic stress disorder

---

448. In Nashville, for example, such cases are the "overwhelming majority." Nashville OHA interview, *supra* note 159.

449. LAF interview, *supra* note 374.

450. Chicago OHA interviews, *supra* note 157; Nashville OHA interview, *supra* note 159.

451. One exception would be the Black Lung program, where proof of disability usually focuses on other evidence. *See* text accompanying notes 110-32, *supra*.

452. *See, e.g.*, 38 C.F.R. § 4.40 (musculoskeletal impairments).

453. *See* Chavez v. Office of Personnel Management, 6 M.S.P.R. 404 (1981). Sweat v. Office of Personnel Management, 40 M.S.P.R. 84, 87 (1989) (quoting *Chavez*).

454. Wagoner v. Office of Personnel Management, 7 M.S.P.R. 277, 279 (1981). *See also*, Boss v. Office of Personnel Management, 23 M.S.P.R. 234 (1984) (quoting *Wagoner*); Komarek v. Office of Personnel Management, 11 M.S.P.R. 118 (1982) (benefits denied because pain did not preclude performance of job).

455. 38 C.F.R. § 4.40.

456. *See* Mental Health Association of Minnesota v. Schweiker, 554 F.Supp. 157 (D. Minn. 1982), *aff'd in part, modified in part*, 720 F.2d 965 (8th Cir. 1983).

claims, notwithstanding the fact that there has been a relatively high allowance rate for those claims.[457]

In 1984 amendments to the Social Security Act, the Social Security Administration was directed to "make every reasonable effort" to have psychiatrists or psychologists evaluate disability claims when issuing an unfavorable decision and mental impairments are involved.[458] This directive has been implemented at the Disability Determination Services.[459] On the other hand, the Veterans Administration does not use psychiatrists or psychologists specially on either Rating Boards or the Board of Veterans Appeals.[460]

All programs recognize, of course, that a medical basis for disability must include mental as well as physical impairments, except for a physical disease-based program such as the Black Lung program. Mental impairments are included in both the Social Security Administration's Listing of Impairments and the Veterans Administration's Schedule for Rating Disabilities.[461] They are also recognized generally as causing both medically-based and medical-vocational functional limitations.

There are special problems with identifying certain mental impairments as a basis for disability brought about by difficulties in diagnosing and assessing severity in this branch of medicine. In response to a specific congressional directive that the Social Security Administration revise its Listing "to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment," entirely new adult listings for mental impairments were published in 1985.[462] The revised listings attempt to address more clearly functional limitations related to a work setting, and to bring the signs and symptoms included in the listings criteria in line with current medical knowledge.[463] The new listings were to expire in 1988 after they had been reviewed in operation and revised again; the Administration has extended the new listings for two more years because its review has not been completed.[464] There has been less controversy over the Veterans Administration's Schedule, except for claims based on post traumatic stress disorder. The main difficulty in adjudicating those claims, from the Administration's point of view, is that a proper diagnosis could well point to another condition, such as schizophrenia, in which case there would be no service connection.[465]

The Social Security Administration has published separate general regulations covering disability adjudications in cases involving mental impairments, also prompted

---

457. *See* Operation of the Board of Veterans Appeals: Hearings before the Subcomm. on Compensation, Pension and Insurance of the House Comm. on Veterans Affairs, 100th Cong., 1st Sess. 25 (1987) (statement of Phillip R. Wilkerson, Assistant Director, National Veterans Affairs and Rehabilitation Commission, American Legion).

458. 1984 Amendments, *supra* note 305, § 8(a).

459. DDS interviews, *supra* note 322, 368, 389. *See also* text accompanying notes 576-79, *supra*.

460. VA interview, *supra* note 5; BVA interviews, *supra* note 5.

461. *See* 20 C.F.R. § 404, Subpart P, Appendix 1, Sections 12 and 112; 38 C.F.R. §§ 4.123-.132. The Listing and the Schedule are discussed generally at text accompanying notes 314-41, *supra*.

462. *See* Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460 § 5(a), 98 Stat. 1794; 50 Fed. Reg. 4,948, 35,038 (1985). Other parts of the Listing were revised also in 1985, in unrelated action. *See* 50 Fed. Reg. 55,068 (1985).

463. The revised listings, written with the assistance of the American Psychiatric Association and other professional groups, are based on the third edition of the Diagnostic and Statistical Manual published by the Association. In recent testimony before the Disability Advisory Council, the Association stated that its participation in this process was "very positive." Statement of American Psychiatric Association to Disability Advisory Council (March 20, 1987), at 6.

464. 53 Fed. Reg. 29,878 (1988).

465. VA interview, *supra* note 5.

by the 1984 Social Security amendments.[466] They restate the Administration's policy that mental impairments are to be evaluated according to the same process as other impairments, but provide for some special, additional procedures for recording evidence and for determining degree of functional loss.[467] Four areas of focus are specified in mental impairment cases: activities of daily living; social functioning; concentration, persistence or pace; and deterioration or decompensation in work or work-like settings.[468] The determination of functional loss is particularly important in Residual Functional Capacity assessments, for which a separate Residual Functional Capacity assessment form is used and a special effort is made to have the form completed by a psychiatrist or psychologist medical consultant.[469]

B. Nature of Medical Evidence Required

Medical proof of disability is approached in one of two ways, depending in part on the program and disability standard involved and in part on the nature of the claimant's disability. One approach is to look for specific information, either in the form of a particular impairment and level of severity or in the form of a certain degree of functional limitation. Thus, proof of a particular impairment and level of severity is required for the adjudication of claims based on the Social Security Administration's Listing of Impairments or the Veterans Administration's Schedule for Rating Disabilities.[470] Proof of functional limitations is required to make the critical Residual Functional Capacity assessment used in many Social Security adjudications, and to resolve the ultimate issue of disability in Civil Service disability claims.[471]

The other approach is to look for any and all information related to the claimant's medical condition and how that condition affects his or her ability to work. There is an element of this approach in all disability adjudications, to the extent that agencies and administrative appellate bodies are required to make disability determinations on the basis of all available evidence.[472] It is used more directly when disability is based on complaints of symptoms, such as pain, or when a very broadly stated standard is used, such as unemployability in the Veterans Administration pension program.[473]

Regardless of whether medical information is to be directed to proof of a particular impairment, a certain level of functional limitation or a claimant's general medical condition, disability adjudicators usually look for two things: a diagnosis and an evaluation of severity.[474] With respect to evidence of both diagnosis and severity, the component parts necessary to prove disability include the claimant's medical history, symptoms reported by the claimant, clinical findings obtained by the physician, and the

---

466. *See* note 305, *supra*; 50 Fed. Reg. 35,065, 35,070 (1985).

467. *See* 20 C.F.R. §§ 404.1520a, 416.920a. These rules apply for appeals as well. *Id.* §§ 404.1520a(d), 416.920a(d).

468. *Id.* §§ 404.1520a(b), 416.920a(b).

469. DDS interviews, *supra* notes 322, 368, 389. *See also* POMS DI 24501.010B.1.2, DI 24510.005A. Residual Functional Capacity assessments are discussed generally at text accompanying notes 381-91, *supra*.

470. *See generally* text accompanying notes 314-41, *supra*.

471. *See generally* text accompanying notes 381-91, *supra*.

472. The Veterans Administration, for example, will consider "[a]ny evidence . . . offered by a claimant in support of a claim." 38 C.F.R. § 3.103(b). *See also* 20 C.F.R. § 404.1512(a) (Social Security Administration "will consider all information [it] gets from [the claimant] and others about [the claimant's] impairments").

473. *See generally* text accompanying notes 425-34, *supra*.

474. *See, e.g.*, S.S.R. 83-19 2 (1983) ("A finding that an impairment meets the [requirements of the Social Security Administration Listing of Impairments] will not be justified on the basis of a diagnosis alone").

results of laboratory tests or studies.[475] A family medical history, which can be important to a presumptive diagnosis and in determining prognosis, may also be included. This information can be obtained from a single source, or a source may be able to provide only a part of the information needed, such as the results of a particular test. Although most disability evaluations require both a diagnosis and an assessment of severity, depending on the impairment and disability standard involved one or the other can be far more difficult to establish.[476]

The weight given to a medical report on diagnosis and severity usually will turn on the thoroughness and consistency of the report, both internally and with respect to other evidence in the record, and the extent to which the concluding opinions of diagnosis and severity are supported by evidence in the form of signs, symptoms, clinical findings and test results.[477] All of this information is not treated equally, however. Thus, in order to show that impairments are medically determinable for purposes of establishing eligibility for Social Security benefits, they must "manifest themselves as signs or laboratory findings apart from symptoms. Abnormalities which manifest themselves only as symptoms are not medically determinable."[478]

Another factor considered is the capability of the physician to provide the particular evidence required.[479] In the Black Lung program, for example, the relative qualifications of x-ray readers can be a critical issue in a disability claim.[480] For certain types of impairments, such as mental impairments, the use of specialists may be preferred.[481]

---

475. These component parts, together with a general assessment of the claimants condition and what the claimant can do, are expected to be included in medical reports. *See, e.g.*, 20 C.F.R. §§ 404.1513(b), 416.913(b) (Social Security Administration); 5 C.F.R. § 831.502(a) (Office of Personnel Management). Sometimes signs observable to the physician are called for separately from clinical findings. *See, e.g.*, 20 C.F.R. §§ 404.1528, 416.928.

476. For example, most of the disagreements between veterans and the Veterans Administration in psychiatric cases are on diagnosis; in other cases the disagreements are usually on assessment of severity. DAV Interview, *supra* note 245.

477. The status and credentials of the reporting physician are also taken into account. Criteria used to weigh medical evidence are discussed generally at text accompanying notes 588-610, *infra*.

478. Social Security Administration, Disability Evaluation Under Social Security 2 (1986). *See also* 42 U.S.C. §§ 423(d)(3), 1382c(a)(3)(C). The symptom of pain is discussed in detail at text accompanying notes 435-55, *supra*.

479. *See generally* text accompanying notes 588-610, *infra*.

480. *See, e.g.*, Sexton v. Director, 752 F.2d 213, 215-16 (6th Cir. 1985); Giffith v. Jewell Ridge Coal Co., 4 BLR 1-355, 1-358 (1981).

481. Following litigation challenging the quality of mental disability assessments by the Social Security Administration, Congress required that every reasonable effort be made to use a psychologist or psychiatrist to evaluate claims based on mental impairments before issuing an unfavorable decision; the Veterans Administration, on the other hand, has chosen not to place psychiatrists on boards evaluating mental disabilities. *See* text accompanying notes 458-60, *supra*.

IV. MODELS FOR THE USE OF MEDICAL PERSONNEL

Each of the disability programs in this study makes use of medical personnel in the disability determination process. Medical personnel in this context includes medical staff employed by the agency on a full-time or part-time basis, as well as outside medical personnel typically hired to examine a claimant and report on the examination. There is a greater participation by medical staff and outside medical consultants at the initial decision level in all programs, except at the Department of Veterans Affairs where doctors are used on decision-making panels at both Rating Boards and the Board of Veterans Appeals. In the Social Security program, for example, medical staff play their most important role at the Disability Determination Services, where initial disability decisions are made, both as decisionmakers and as consultants to disability examiners. In other programs, medical consultants are relied upon to assist examiners at the initial decision level, without participating as decisionmakers.

Medical personnel are used only sporadically on appeal; when medical and lay personnel do their jobs fully and effectively at the initial decision level, there is little need for medical participation on appeal. This is seen in practice at the Social Security administrative hearing level, where much of the need for medical personnel arises because of poor development and evaluation of the claim at the Disability Determination Services. In other programs, medical advisors are not available at hearings, largely because of the assumption that the difficult medical issues have already been framed below.

Despite the many specific differences in procedures for adjudicating disability claims found in federal disability programs, three common functions for medical personnel are found in current practice: developing the medical records on which disability decisions are based, providing medical findings and opinions to be used as evidence in the record, and making disability decisions based on the record. The first two roles -- developing medical records and providing medical findings and opinions -- might be thought of as something other than decisionmaking. Thus, it can be argued that a doctor acts as a decisionmaker only after reviewing the record and evaluating the findings and opinions supplied by other medical sources. This is certainly not true in disability practice, however, nor is such a narrow view of decisionmaking valuable when considering disability policy. Accordingly, each of these three roles will be examined below in the context of current practice as background and data for the construction of possible models for the use of medical decisionmakers in Social Security disability determinations.

These roles will be discussed in the context of three models for using medical decisionmakers which are set out along slightly different lines. The first model incorporates fully the role of developing the medical record. The second model incorporates the role of providing medical findings and opinions and part of the actual decisionmaking role in a model directed at deciding specified medical issues, which are often component parts of the ultimate disability decision. The third model encompasses the actual decisionmaking role in the final disability decision. A common underlying assumption is that uniform and complete processing of claims initially, including obtaining outside, independent medical examinations when needed and careful consideration of all claims by competent and dedicated examiners and physicians, will not only improve initial decisions but will reduce greatly the need for medical personnel on appeal.

A. To Develop Medical Record

One of the most fundamental principles of administrative fairness applied consistently to the adjudication of disability claims is that all decisions must be based on

the evidence in the record.[482] As is the case generally in administrative law, records can be developed in disability claims using evidence, including hearsay medical reports, that would not be admissible under the formal rules of evidence.[483] Accordingly, the compilation of the evidence to be included in the administrative record in a disability case is a critical, yet loosely-defined and open-ended function. There must be a full and complete presentation of all arguably competent and relevant medical information; records are deficient only because someone did not try to get the missing evidence from the appropriate source, or because the source was unwilling or unable to submit the evidence.

In a sense, the most important role for medical staff in the disability determination process is in the development of the medical record. In most cases the medical issues are relatively simple and certainly within the grasp of experienced disability examiners and administrative law judges, so long as all of the relevant medical evidence has been compiled and presented clearly. Even in the few cases presenting novel or complex medical issues, most difficulties that arise in decisionmaking stem from inadequacies in the medical record. This is true both at the initial decision level and on appeal. Thus, one of the most consistent and persistent frustrations expressed by appeals level personnel is that disability claims presented to them for review were decided on the basis of an inadequate medical record.[484]

From the point of view of claimant representation, there is no more important function than identifying, compiling and submitting relevant medical evidence.[485] Agency personnel share this view of the importance of factual development, and are concerned that not enough is being done to assure the development of full and complete medical records. Virtually all disability examiners put factual development at the top of their list of responsibilities, and at the top of their list of priorities for greater resource allocation.[486]

1. Current Use: Development of Medical Record

Medical personnel are used presently to help develop the medical record on which disability decision is to be based. Factual development is usually an ongoing process,

---

482. *See, e.g.*, Kertesz v. Crescent Hills Coal Co., 788 F.2d 158, 163 (3d Cir. 1986); Wiginton v. Secretary, 470 F.Supp. 235, 237 (E.D. Wis. 1979); Kenny v. Weinberger, 417 F.Supp. 393, 399 (E.D.N.Y. 1976). *See also* 20 C.F.R. §§ 404.953(a), 416.1453(a). *See generally* Mashaw, *The Management Side of Due Process: Some Theoretical and Litigation Notes on the Assurance of Accuracy, Fairness and Timeliness in the Adjudication of Social Welfare Claims*, 59 Cornell L. Rev. 772 (1974).

483. This practice was upheld by the Supreme Court specifically with respect to the use of written medical records in Social Security disability cases. *See* Richardson v. Perales, 402 U.S. 389, 402 (1971).

484. Social Security administrative law judges, for example, complain that poor factual development often puts them in a bind. First, in many cases they, together with claimants and their representatives, are forced to compile significant amounts of new medical evidence overlooked at the initial stages of the process which results in an entirely different record on appeal from that used by the agency. Then, they are criticized by the agency for their high reversal rates. OHA interview; Chicago OHA interview. This is consistent with Popkin's findings with respect to the role of representatives in Social Security hearings. *See* Popkin, *The Effect of Representation in Nonadversary Proceedings - A Study of Three Disability Programs*, 62 Cornell L. Rev. 989 (1977). Administrative law judges are criticized in turn, most often when the claimant was unrepresented, for failing to oversee necessary development at the administrative hearing stage. *See, e.g.*, Poulin v. Bowen, 817 F.2d 865, 870 (D.C. Cir. 1987). Mimms v. Heckler, 750 F.2d 180, 185 (2d Cir. 1984). *See generally*, Bloch, *supra* note 160.

485. It has been argued that developing and submitting additional medical evidence into the record is the most important function of representatives in Social Security disability appeals. *See* Popkin, *supra* note 484.

486. DDS interviews, *supra* notes 322, 368, 389. The Social Security Administration published proposed regulations in 1987 which were intended, in part, to cure deficiencies in the development of medical evidence. *See* 52 Fed. Reg. 13,014 (1987). However, these regulations have not yet been published in final form.

with a concentration of activity at the initial decision stage, when a claim is first evaluated by agency personnel, followed often by significant additional development when a claim moves its way through levels of administrative appeal.[487] Depending on the program and the administrative stage involved, doctors have from little to essentially full control over the ultimate content of the medical record.

Considering the importance of full factual development in disability claims, a careful review of current practice is warranted. A key question is how and to what extent are medically-trained personnel used to develop medical records. If the record in this area is less than optimal, the option of allocating greater amounts of medical resources to this aspect of the disability determination process must be considered seriously.

a. Initial Development and Allocation of Responsibility

Under most circumstances, agencies expect claimants to participate, at least initially, in the development of their own medical records.[488] The bounds of this expectation vary, depending to some extent on the agency's view of the reliability of the claimants' evidence. Thus, at the Office of Personnel Management, where federal agency personnel put together claims files for fellow federal employees seeking Civil Service disability benefits, disability examiners rely initially almost exclusively on the claimants.[489] The Veterans Administration, on the other hand, assumes that it is responsible for providing virtually all medical evidence, usually from its own sources.[490] Another factor considered by agencies such as the Veterans Administration and the Social Security Administration is the claimant's ability to locate and obtain necessary medical information.[491] Although Social Security claimants are expected to identify all existing sources of evidence, the actual documentation is obtained for the most part by the Disability Determination Services.[492] The amount of time available for this task is limited, however, and in many cases the initial compilation of existing evidence is far from complete.[493]

Obviously, it is helpful for a claimant to provide as much supporting medical evidence as possible, and to do so early in the process. When it comes time to make a decision on disability, however, most agencies consider themselves responsible for

---

487. Some have argued that development is permitted to go on over too long a period. This has been a source of great controversy in the Social Security program, particularly at the administrative hearing level and between the administrative hearing and the Appeals Council. *See generally* text accompanying notes 156-72, *supra*; Koplow & Koch, *supra* note 135, at 108-10.

488. This report deals only with the development of evidence relating to the issue of disability. There are similar issues and concerns with respect to the development of evidence relating to non-disability issues. *See, e.g.*, F. Bloch, *supra* note 15, at § 2.3 (insured status for Social Security benefits); *id.* §§ 9.5-9.6 (years of coal mine employment for Black Lung benefits).

489. OPM interview, *supra* note 191. *See generally* text accompanying notes 193-99, *supra*. Special forms are used to identify to claimants just what additional evidence, if any, is needed to complete the determination.

490. The Veterans Administration is experimenting with the merger of regional offices and medical centers, in part to facilitate the exchange of information within the Administration while processing benefit claims. VA interview, *supra* note 5. *See generally* text accompanying notes 226-41, *supra*.

491. Thus, the Railroad Retirement Board sees itself as more trusting of its claimants' evidence than the Social Security Administration, partly because of the relatively greater access of Railroad Retirement claimants to qualified medical sources. RRB interview, *supra* note 176. The smaller size of the Board and its pool of claimants probably contributes as well.

492. DDS interviews, *supra* notes 322, 368, 389.

493. Some of this deficiency is corrected later in the development process. *See generally* text accompanying notes 505-47, *infra*.

assuring a full and complete record; the agency may be able to put reasonable demands on a claimant, but the agency must make the request before it can blame a claimant for a gap in the record.[494] In order to meet this responsibility, agencies turn, to one degree or another, to medical professionals.[495]

In some programs, medical professionals are involved in the initial development of medical records as part of their general responsibility in decisionmaking. Usually this occurs when doctors are included in decisionmaking teams, as is the case with the Social Security and Veterans programs.[496] The bulk of the responsibility for development falls on the non-medical members of these teams. This is not because development of medical evidence is seen as a function best left to non-medical disability specialists, although it is a function thought to be well within the competence of disability examiners. Rather, the primary responsibility for developing medical evidence is left to the non-medical members because they are more available; they are the ones who receive the file first and who are expected to make the preliminary evaluation of the claim.[497] Another approach is to have medical consultants or advisors assist examiners in developing records when requested to do so, as part of their general consulting responsibilities. This type of access to doctors for purposes of developing medical evidence is available at the Railroad Retirement Board and the Office of Personnel Management; however, current practice with respect to their use varies considerably from program to program, and within programs from office to office and even within an office. The development process usually begins at the Railroad Retirement Board with a review of the file by the examiner and a general work-up based on information provided by the claimant, before any request for assistance is made to a medical consultant.[498] Consultants at the Office of Personnel Management sometimes initiate development requests on their own, as they generally view the file before the examiners.[499]

Thus, when doctors are asked to assist in the development function, they do so not as development specialists but rather as part of their overall responsibility to the particular agency involved. As a result, there is little difference in the way physicians are used to develop medical records when the physician is available as a member of a team responsible for the final decision and when the physician is available as a consultant. Access may be easier when the doctor is either a member of the team or an in-house consultant, although this depends on the program, the level of staffing, and even the personalities of the people involved. Veterans Administration personnel are convinced that doctors' membership on the Rating Board contributes not only to their

---

494. Even administrative law judges are held responsible for developing a full and complete record. *See, e.g.*, Heckler v. Campbell, 461 U.S. 458, 471-72 (1983) (concurring opinion); Sears v. Bowen, 840 F.2d 394, 402 (7th Cir. 1988); Vaughn v. Heckler, 741 F.2d 177, 179 (8th Cir. 1984). *See also* 20 C.F.R. § 404.944 (1988). This is particularly true when the claimant is unrepresented. *See, e.g.*, Ransom v. Bowen, 844 F.2d 1326, 1330 n.4 (7th Cir. 1988), *cert. denied* 109 S.Ct. 499 (1988). *See generally* Bloch, *supra* note 160.

495. The claimant, of course, has the burden of proof on the merits of the claim. *See, e.g.*, 20 C.F.R. § 404.1512(a) (1988) (Social Security); Chavez v. Office of Personnel Management, 6 M.S.P.B. 404, 414-17 (1981) (Civil Service).

496. *See generally* text accompanying notes 137-55, *supra*. There are no programs where a doctor alone is charged with making initial decisions. At the Office of Personnel Management, where disability examiners are responsible for initial disability determinations, over the years a few registered nurses have been hired as examiners. OPM interview, *supra* note 191. *See generally* text accompanying notes 190-99, *supra*.

497. These functions also are not allocated as they are because of any special faith in the non-medical members of the team. It is more a function of the relatively small number of physicians used as compared to non-medical examiners. *See* text accompanying notes 502-04, *infra*.

498. RRB interview, *supra* note 176.

499. OPM interview, *supra* note 191. They are also available to consult on development issues raised subsequently by the examiners.

effectiveness in the process, including record development, but also enhances the ability of non-medical members over time to address medical issues.[500]

Most development is done without the involvement of a physician. This is accepted practice in many routine cases where the medical problems are obvious and the appropriate sources are clearly identified. There are also some more complex cases where the examiner, based on his or her particular training and level of experience, can and is expected to proceed with development without the assistance of the physician.[501] The problem is where to draw the line and how to deal with examiners who should consult with doctors about development matters yet either cannot or simply choose not to do so.

There is no doubt that doctors are involved in the development function to a less than optimal degree. One reason is simply resource allocation. In the Social Security program, the ratio of physicians to non-physicians is so low that physician members of decision-making teams can never be given serious, let alone primary, responsibility for the development of medical evidence. The problem is aggravated when part-time, non-decisionmaking consultants are used, for the development function is usually seen as a secondary role adding pressure to their already full schedule.[502] A second reason is that until recently little serious thought has been given to just what doctors can and should do to improve the development of medical records.[503] Even when a specific value of using doctors for development has been identified, such as the value of having a doctor speak directly to treating medical sources to steer them toward providing the most relevant information, uniform implementation through the system is absent.[504] Assuming that greater use of medically-trained personnel in the development process is desirable, there is no consensus that medical resources should be allocated to this function as a priority over other functions.

There is also the problem of when in the process efforts at full and complete development of medical records should be concentrated. Is it better to slow the process down somewhat and focus more time and resources on the development of the record for initial decisions, or should any greater effort be directed at a smaller number of difficult claims identified by the fact that they moved through the process to appeal or by some other means?

b. Special Development and Choice of Source

For some claims, the medical record can be developed with little or no special effort, either by the claimant or by the agency. This depends in part on the nature of the medical-legal issues involved. Thus, a veteran seeking compensation benefits based on the loss of a limb in combat is unlikely to present serious evidence-gathering

---

500. VA interview, *supra* note 5; San Francisco VA interview, *supra* note 230.

501. The examiner may or may not have formal authority to act alone outside of routine cases. Senior Veterans Administration rating specialists, for example, are encouraged to work on their own; Social Security Administration examiners, on the other hand, are given less autonomy, at least in theory. *See generally* text accompanying notes 640-62, *infra*.

502. At the Office of Personnel Management, for example, consultants are used for this purpose less than at the Social Security Administration and the Veterans Benefits Administration. OPM interview, usupra note 191.

503. The Social Security Administration has issued proposed regulations that deal in part with these matters. *See* note 486, *supra*. *See also* POMS DI 22510.001-.065.

504. Thus, the Office of Hearings and Appeals encourages this practice in the Social Security program, with mixed results at the Disability Determination Services. OHA interview, *supra* note 32; DDS interviews, *supra* notes 322, 368, 389.

problems. Even where the claim involves significant medical-legal issues, special development may still be unnecessary if the regular development process is reasonably comprehensive.[505] Nonetheless, there are circumstances where some unusual, claim-specific development of medical evidence is needed in order to decide whether a claimant meets the applicable disability standard. It is relevant, therefore, to examine how different agencies determine that special development is needed and how they carry through with this aspect of the disability determination process.

The line between routine and special development is not always clear. If an agency has been effective in tailoring its routine procedures for developing evidence to the factual requirements of the disability standards it uses, then common types of claims requiring special development will be developed specially as a matter of course. This is the theory behind the Department of Labor's practice of sending every claimant for a specialized medical examination directed at the major factual issues in Black Lung claims.[506] Also, there are important cost considerations that may counsel against too much specialized development too early in the process. The key is to identify the appropriate amount of quality, relevant medical evidence that should be accumulated initially as a matter of routine practice, and to put in place procedures for quick and thorough identification of those claims that require additional, special development.

The difficulty in implementing procedures for special development of medical evidence is twofold: establishing uniform yet intelligent guidelines for seeking additional information, and controlling the relevance and quality of the information received. Given the natural tendency to place special reliance on evidence produced by experts[507] and the fact that, by definition, this specially-produced evidence will be directed at critical issues, it is extremely important that this part of the disability determination process operate fairly and effectively. Encouraging the involvement of medical personnel in the decision to seek special development and in the choice of sources used can be a step in the right direction.

The extent to which agencies engage in special development varies considerably. This variation can be seen as a function of the differences in effort put in at the initial development stage and the complexity of the disability standards involved. Thus, the Social Security Administration, which invests a limited amount of resources in routine general development yet administers claims that could call for virtually any type of medical evidence imaginable, uses consultants for special examinations far more often than other agencies. On the other extreme is the Department of Labor's approach to Black Lung adjudications, where claims examiners rarely, if ever, order more detailed additional evidence after the routine independent medical examination directed at the existence of pneumoconiosis has been completed.[508]

At the agency level, the process of deciding whether additional medical development is needed begins usually as an assessment whether the record is sufficiently complete to proceed with making a decision. This is seen usually as an administrative decision, as opposed to a medical decision; therefore, in most cases, direct involvement by medical personnel is not required. Thus, claims examiners routinely decide that there is

---

505. As noted above, agencies have different views as to what is required for "normal" initial development. *See* text accompanying notes 488-504, *supra*.

506. *See* text accompanying notes 271-73, *supra*. In a broader sense the Veterans Administration has a similar view with respect to its practice of making liberal use of its medical facilities.

507. Rules to control this tendency and to direct the weighing of conflicting medical evidence in the disability determination process are discussed at text accompanying notes 588-610, *infra*.

508. The fact that adjudications become adversarial adds to the Department's reluctance to engage in special development. Interview with James DeMarce, Assistant Director, Division for Coal Mine Workers Compensation Programs, Department of Labor (October 14, 1988) [hereinafter DOL interview]; OALJ interview, *supra* note 287.

sufficient medical evidence in the file to make a disability decision and do so without seeking assistance from a medical expert concerning the state of the medical record. In a program such as Railroad Retirement, where claims examiners have the authority to make initial decisions without even consulting with a doctor, the examiner's decision to close the record can be final.[509] Similarly, Social Security claims examiners and non-medical members of Veterans Administration Rating Boards can decide that no further medical evidence is needed, at least for purposes of making their preliminary decisions.[510] Examiners are also free in most instances to obtain additional medical evidence on their own.[511]

This does not mean, however, that medical expertise is considered unimportant at this stage in the process. If a case is at all unusual medically or if the examiner is uncertain as to the quality or completeness of the medical evidence in the record, consultation with medical experts is available. This type of consultation is a common by-product resulting from the use of physicians in a formal decisionmaking role at the Social Security Administration and the Veterans Administration. At the Social Security Administration, the use of medical consultants to assist in special development, separate from their role as decisionmakers, is encouraged in some Disability Determination Service offices.[512] In practice, however, the extent to which medical consultants are used in this part of the process and their effectiveness in that role varies considerably from state to state.[513] Interaction takes place between non-medical and medical members of Veterans Administration Rating Boards on special development issues on a more regular basis, simply because they work together more closely throughout the process. As would be expected, it is less common at the Railroad Retirement Board, where medical consultants are used only at the option of the claims examiners.[514] At the Office of Personnel Management, medical consultants can order additional evidence as part of their review of the file, as they evaluate the claim in most cases before the examiner; however, any sort of special development, such as the ordering of consultative examinations, is unusual in these cases.[515]

Once it has been determined that the record is incomplete, with or without medical expert involvement, most agencies have some sort of procedure in place for doctors to at least approve a decision to order special examinations or tests. Thus, in theory requests

---

509. *See* text accompanying notes 177-79, *supra*. Claims examiners in the Black Lung program also make final decisions without the assistance of a doctor; however, they are required to have medical evidence evaluated for quality, as opposed to the completeness of the record as a whole, by medical consultants. DOL interview, *supra* note 508.

510. In both the Social Security and the Veterans programs, doctors participating the the initial decision are free to order additional evidence. Usually, however, if additional development is going to be done it is done before the claim comes to the doctor for decision. *See* text accompanying notes 641-49, *infra*.

511. A common exception is ordering specialized examinations. *See* text accompanying notes 566-87, *infra*.

512. In Florida, for example, consultants are expected to be available to respond to examiners' questions. Florida DDS interview, *supra* note 368. *See also* text accompanying notes 143-52, *infra*. Introductory comments to proposed Social Security Administration regulations on consultative examinations and medical evidence recognize expressly that "direct doctor-to-doctor contact is very productive." *See* 52 Fed. Reg. 13,014, 13, 017 (1987).

513. DDS interviews, *supra* notes 322, 368, 389.

514. There is no similar role for doctors in the Black Lung Program because medical advisors are not used generally by the Department of Labor at the Deputy Commissioner level.

515. OPM interview, *supra* note 191. The most common practice is to request the claimant to provide additional evidence. *Id*.

for special examinations at the Disability Determination Services are to be approved by the consultant; however, only the most unusual requests are actually discussed.[516]

Some pre-hearing factual development is undertaken by administrative appeal staff, including administrative law judges.[517] There is a wide variation in amount of involvement, both from program to program and from case to case. Generally there is less staff involvement than at the agency level, in part because of the expectation that claimants on appeal are better equiped to develop the medical evidence themselves.[518] When appellate staff or judges do get involved, their activity tends to fall into two categories: routine updating of information available only since the initial decision was made, and the special development to supplement the record compiled below.[519] This process can begin with the procedures for initiating an appeal, which provide, to one degree or another, for the identification of specific issues on appeal, including allegations of an inadequate record.[520] More typically, a need for further development is identified by a staff member or judge after reviewing the record sent up by the agency. Only at the Veterans Benefits Administration, where a doctor participates as a member of the Board of Veterans Appeals, is there regular use of a medical expert in this development work.[521] Special development is required in Veterans Benefits cases, however, only in rare cases; when needed, outside consultations are ordered from independent medical experts, the Veterans Benefits Administration Department of Medicine and Surgery, or the Armed Forces Institute of Pathology, with the concurrence of the medical member.[522] When a Social Security Administration administrative law judge decides to order a special examination, the decision is made by the judge alone based on his or her reading of the record.[523]

Unfortunately, the process for using medical professionals to assist in developing special medical evidence tends to break down at the point where it can be most critical. Beyond these very general guidelines for drawing (or not drawing) on medical expertise to assess the completeness of medical records and to decide when to order additional evidence, there is very little specific direction given with respect to the content required

---

516. DDS interviews, *supra* notes 322, 368, 389; SSA interview, *supra* note 27. A similar practice is followed by other agencies.

517. Obviously, this is done only when supplementation of the record is otherwise allowed, which is the case at all first-level appeals and, to a lesser extent, at second-level appeals before the Social Security Administration Appeals Council and the Veterans Administration Board of Veterans Appeals.

518. The reality will vary, of course, from claimant to claimant. Black Lung administrative law judges remove themselves from this process entirely based on their belief that the adversarial system used in that program leaves the responsibility to the parties and their representatives. OALJ interview, *supra* note 287. By contrast, Social Security Administration administrative law judges have been held to be under a duty to supplement the medical record when claimants are unable to do so themselves. *See* note 160, *supra*.

519. There are instances where general information, such as hospital records, that should have been obtained by the agency were simply overlooked and the appellate staff locates the information and puts it into the record. At the Social Security Administration Office of Hearings and Appeals this is less uncommon than one would hope. *See* Nashville OHA interview, *supra* note 159; Chicago OHA interviews, *supra* note 157.

520. The specifity of issue identification depends in part on the procedures in place and on the quality of legal representation, if any. Issue identification ranges from answering a simple, general question on a Social Security Administration form to an elaborate series of statements of the issues by veterans and the Veterans Administration. *See generally*, text accompanying notes 133-299, *supra*.

521. BVA interviews, *supra* note 5. Until recently, Rating Boards held hearings; at these hearings, doctor members consulted on record development in much the same manner as they do when making initial decisions. VA interview, *supra* note 5. *See generally* text accompanying notes 242-45, *supra*.

522. BVA interviews, *supra* note 5.

523. In rare instances, the judge may use a medical advisor to assist in this decision. Chicago OHA interviews, *supra* note 157; OHA interview, *supra* note 32.

for such evidence, and supervision over the selection and quality of the sources of the evidence is at best lax.[524]

There are some examples where agencies identify clearly the information requested from medical sources when supplementing a record.[525] In most instances, however, information is sought with little or no directions given to the source supplying the additional evidence. When detailed instructions are given it is usually the result of individual effort by the lay or medical personnel involved, rather than the result of any rules or procedures reflecting coherent policy. Some greater care is taken when a claimant is sent out for a special medical examination or test in order to assess disability on the basis of a specified medical condition, as with claims under the Veterans Administration Schedule for Rating Disabilities.[526]

The issues involved in choice and control of medical sources depend on whether existing or new information is sought. When existing information is sought, usually in the form of a clarification or expansion upon evidence already in the file, the choice is whether to make use of an identified source. Most agencies feel that they make every reasonable effort to obtain apparently available relevant information, from whatever source. Claimants sometimes see it otherwise, particularly when it comes to seeking supplemental information from treating sources.[527] At Social Security Administration Disability Determination Service offices, some reluctance to follow up with treating sources is attributable to a perception that treating sources do not cooperate.[528] There are also convenience factors which favor more comprehensive development from certain sources, as is the case, for example, with the Veterans Administration's preference for records and reports from personnel at its own medical facilities.[529] The choice of physicians to provide new evidence, usually in the form of reports of consultative examinations, is discussed later in this section.[530]

c. Explanation and Clarification of Evidence

Doctors on staff, whether part-time or full-time, are usually available to answer questions about medical evidence in the record. Accordingly, this type of consultation is common at the Disability Determination Services, Rating Boards and the Board of Veterans Appeals, where doctors are on site and fully integrated into the decisionmaking process. It also takes place between examiners and medical consultants at the Railroad Retirement Board and at the Office of Personnel Management, where consultants do not have a decisionmaking role. Thus, except for medical advisors engaged by some Social Security Administration administrative law judges, doctors are rarely called upon to explain or clarify evidence if they are not used otherwise in the disability determination process.

---

524. Regulations proposed in 1987 would address some of these concerns. *See* note 486, *supra*.

525. Thus, at the Office of Personnel Management, special forms are used to notify claimants of the need for certain specific additional evidence. OPM interview, *supra* note 191.

526. Specific requests of this type are usually directed to doctors at Veterans Administration medical facilities. VA interview, *supra* note 5.

527. LAF interview, *supra* note 374. Failure to obtain clearly relevant additional evidence from existing sources, including treating physicians, is a common basis for court-ordered remands in Social Security cases. *See, e.g.*, Sears v. Bowen, 840 F.2d 394, 399 (7th Cir. 1988); Lawson v. Secretary, 688 F.2d 436, 440 (6th Cir. 1982).

528. DDS interviews, *supra* notes 322, 368, 389. This view is more pronounced with respect to the use of treating sources for consultative examinations. *See* text accompanying notes 581-95, *infra*.

529. VA interview, *supra* note 5.

530. *See* text accompanying notes 566-87, *infra*.

Doctors are used most consistently for these purposes at Veterans Benefits Administration Rating Boards and the Board of Veterans Appeals. It occurs quite naturally, as non-medical specialists work on a daily basis and in close physical proximity with their usually full-time medical counterparts.[531] This ready access to a doctor, and the resulting regular exchange on medical and medical-legal matters that occurs among the members of Rating Boards and the Board of Veterans Appeals, is cited often by Veterans Administration personnel in support of retaining doctor members on those boards.[532] The amount of consultation varies, of course, depending on the difficulty of the claim, the experience of the non-medical member, and the responsiveness of the medical member. Most claims are not very complex medically; accordingly, although the medical members are available for consultation, they are consulted for these purposes only rarely.[533] When they are consulted, medical members can answer most questions from their own knowledge and experience with little difficulty.[534] Nonetheless, virtually all personnel in the process believe that they and their colleagues benefit from the medical knowledge accumulated over time through these exchanges.[535]

The use of medical consultants at Disability Determination Services to explain and clarify evidence is less consistent. At some offices, consultants work independently from examiners and communicate with them mostly on paper; they tend to be separated physically, sometimes working on different floors.[536] On the other hand, in other states, medical consultants are encouraged to be available to answer questions from examiners. In Florida, for example, the Disability Determination Service maintains an "open door" policy for this purpose, and consultants are expected to credit as much as twenty-five to thirty-five percent of their time to responding to examiners' questions. The goal is to assure that they perform a "true" consulting function so that the consultants support the examiners, rather than vice versa.[537]

Medical advisors play a similar role for Social Security Administration administrative law judges who choose to use them.[538] They are used, for example, to explain how evidence in the record does or does not match medical criteria specified in regulations applicable to the particular claim, such as the Listing of Impairments. They are also used to explain how certain evidence could or could not support a finding of medical equivalence to a listed impairment.[539] In fact, a medical advisor's opinion on medical equivalence is required before an administrative law judge can make a finding of medical equivalence, although the judge is not bound by the advisor's opinion.[540] Most judges recognize that this type of information can come close to an opinion on the merits of the claim and therefore take pains to keep the role as one of a neutral, technical advisor. However, as stated by one judge who uses advisors relatively

---

531. *See generally* text accompanying notes 226-66, *supra*.

532. VA interviews, *supra* notes 5, 230, 333, 533; BVA interviews, *supra* note 5.

533. Thus, an experienced specialist -- who may have gained much of his or her experience through earlier discussions with doctor members -- will ask questions only in extremely difficult or unusual cases. Montgomery VA interview, *supra* note 533.

534. BVA interviews, *supra* note 5.

535. VA interviews, *supra* notes 5, 230, 333, 533; BVA interviews, *supra* note 5.

536. Tennessee DDS interview, *supra* note 368.

537. Florida DDS interview, *supra* note 368. The time is credited so that this type of consulting is included in medical consultants' workload for purposes of efficiency ratings.

538. Judges are free to call advisors if they wish; the rate of use varies considerably from judge to judge. *See generally* text accompanying notes 158-60, *supra*.

539. Chicago OHA interviews, *supra* note 157.

540. *See* S.S.R. 83-19 (Cum. Ed. 1983).

frequently, it is difficult to solicit the views of your own expert and then rule otherwise.[541]

Medical advisors are not used at administrative hearings in other programs.[542] Thus, administrative judges at the Merit Systems Protection Board view disability appeals as essentially legal cases usually turning on the vocational issue of the nature of the employee's job. In this respect, disability cases are not that different from other cases involving vocational issues that are brought to the Board, such as removal actions.[543] An appeal can involve a conflict as to the extent of the claimant's functional limitations; however, Board judges find that they can resolve any conflicts by weighing conflicting medical evidence just as they weigh and evaluate other evidence.[544]

This type of consulting with medical personnel is an extremely valuable aspect of the development process, particularly at the initial decision level, as it helps focus the evaluation on the truly difficult and contested medical issues. One problem is that these opinions often are not included formally in the record. Some justify this omission on the ground that a consultation with a medical colleague is indistinguishable from purely internal thought about a claim; however, most agree that critical explanations or clarifications should be in the record. The problem then becomes one of drawing the line between case-specific, substantive inquiries and a general sharing of knowledge. There has been some controversy recently over a related practice at the Board of Veterans Appeals, where doctor members of other sections of the Board are sometimes consulted about a particular case without including information about the consultation in the record. In response to substantial criticism that such consultations were no different from consultations with an outside specialist which would certainly have to be memoralized in the record and presented to a claimant for rebuttal, the Chair of the Board argued that they were merely part of the internal decisionmaking process. A similar practice involving medical advisors at Social Security administrative hearings was discontinued following severe criticism in the late 1950s.

2. Model: To Develop Medical Record

There should be a formal mechanism to assure that the development of medical records in disability claims is supervised by medical personnel at the initial decision level. There is a more limited need for medical expertise in development on appeal, particularly if the initial development is done effectively. In extraordinary cases, a medical consultant could be called upon to assist with development on appeal.

---

541. Chicago OHA interviews, *supra* note 157.

542. Most feel that they are not needed, even if funds were available. Even at the Railroad Retirement Board's Office of Hearings and Appeals, where referees hear essentially the same claims as Social Security administrative law judges, medical advisors are thought to be unnecessary. RRB interview, *supra* note 176.

543. In the opinion of some judges, disability cases are among the easier cases at the Board. Chicago MSPB interview, *supra* note 209.

544. Disputes over the extent of functional limitations are the most common medical issues presented to the Board. *Id.*

545. In Florida, for example, all contacts between the examiner and consultant are expected to be included in the record. Florida DDS interview, *supra* note 368. However, in the vast majority of instances where such consultations take place, only a cursory notation of all but the most important contacts is made, if any notation is made at all.

546. See *Operation of the Board of Veterans Appeals: Hearing Before the Subcomm. on Compensation, Pension, and Insurance of the House Comm. on Veterans' Affairs*, 100th Cong., 1st Sess. 507 (1987).

547. *See* C. Horsky & A. Mahin, The Operation of the Social Security Administrative Hearing and Decisional Machinery, 170-71 (1960).

Ordinarily, however, the appellate staff should be able to order supplemental information or remand the claim to the agency if the medical record is seriously deficient.

At agencies with doctors already deciding claims or with medical staff available regularly for other purposes, such as the Social Security Administration, existing medical staff could be given this responsibility, with the assistance of appropriate support staff. Otherwise, a separate staff for development, including some doctors or nurses, would have to be used. A model for utilizing medical staff to develop medical records would include the following elements.

Staff

There would be both medical and non-medical staff involved in developing medical records. If existing doctors are not used as the medical staff in charge of development, nurses could be used instead. Nurses could perform most of the development tasks assigned to the medical staff; they could also have access to doctors on staff or serving as consultants when needed in particularly difficult cases.[548]

Compilation of Existing Evidence

Agencies would accept responsibility for the compilation of all relevant medical evidence, subject to appropriate requests for assistance from claimants.[549] Most of the responsibility for compiling existing medical evidence, particularly information from institutional sources such as hospital records and test results, can rest with non-medical staff.[550] A distinction would be drawn, however, between this material and reports from treating physicians. Medical staff would be responsible for evaluating the adequacy of reports from treating physicians and for following up with requests for clarification or additional information from these sources.[551]

Evaluation for Completeness

A member of the medical staff would be responsible for evaluating the record from existing sources to determine whether development is complete. Because a finding of "completeness" will depend on the nature of the disabilities alleged and the particular disability standard being used, significant legal or program expertise is required as well. Accordingly, it would be preferable to combine this responsibility with other decisionmaking functions.[552] If no further development is needed, the claim would be submitted for decision, subject to requests for additional development that could be made later in the process. If additional evidence is needed, the medical staff would have the authority to obtain that information from appropriate sources. This information could be additional data about the claimant's condition, including reports

548. Instances where nurses have been used for development have been, by and large, very successful. *See* note 496, *supra*.

549. Obviously, some claimants will be in a better position to assist than others. In current practice, the extent to which claimants are relied upon to produce their own medical evidence varies considerably from program to program. *See* text accompanying notes 488-504, *supra*.

550. This process could be carried out with standardized procedures, forms and check lists monitored by the medical staff.

551. Experience demonstrates that doctors and nurses are far more successful at obtaining supplemental information from practicing physicians. *See* text accompanying notes 502-04, *supra*.

552. *See* text accompanying notes 624-28, 663-73, *infra*.

from treating sources and reports of consultative examinations, or an explanation or clarification of evidence already in the record.

There would be an independent review of the completeness of the record at the agency level whenever a final decision is appealed. If the record is deficient, those deficiencies would be noted and the medical staff would be authorized to obtain any necessary additional evidence; the claim would then be evaluated again on the merits rather than submitted for a hearing. Once submitted for a hearing, decisions about further development should be left to the administrative law judge, who would have the authority to obtain additional information or remand the claim to the agency for further development.[553]

Ordering Additional Data

Much ordering of additional data can be done routinely, with only minimal participation by medical staff. Requests for standard examinations or tests, for example, can be processed initially by non-medical staff. Medical staff must be available, however, to monitor carefully the substance of routine requests made to treating and consulting sources and to participate actively when special requests are made. Medical staff would also review all reports returned, conduct any necessary follow-up, and determine when sufficient additional data has been received to submit the claim for decision. Finally, medical staff would be encouraged to meet personally with claimants, if necessary, to decide whether additional data is needed and how it should be obtained.

In extraordinary cases, the medical staff would be able to consult with specialists before ordering a special examination or test. This could be done internally, if there were appropriate specialists on the medical staff, including doctors otherwise involved in decisionmaking. If not, independent consultants could be made available for these purposes.

Explaining or Clarifying Evidence in the Record

Medical staff would also assure that the record is clear and understandable to those persons making the initial disability determination. Even if the same medical staff is used for development and disability determination, the record must be clear and correct medically so that the medical issues can be understood by non-medical decisionmakers, including administrative law judges.[554] If an explanation or clarification is needed, it could be provided by the staff itself or from outside sources. It is extremely important, of course, that the full content of any explanation or clarification offered be included in the record. Therefore, when this type of information is obtained from outside sources, it would be solicited whenever possible in writing.

Medical consultants would be available to provide explanations and clarifications on appeal as well. Presumably they would be needed only rarely, since a separate certification of completeness of the record for appeal will have been made. If consultants are used for this purpose, their comments would be obtained usually in writing, and introduced into the record prior to a hearing. In extraordinary cases a

---

553. Any remands for development would be on a high-priority basis, to avoid delay; frequency of remands would be monitored to guard against any temptation by the agencies to pass development responsibilities on to the appellate level.

554. Simple lack of clarity of medical evidence is one of the greatest liabilities cited by non-medical decisionmakers. *See* text accompanying notes 482-547, *supra*.

judge could call a consultant to testify at a hearing, but special care would have to be taken to avoid allowing the consultant to slip into a decisionmaking role.[555]

Communicating with the Claimant

Claimants would be brought into the process of development whenever it appears that the record is deficient with respect to particular conditions alleged by the claimant, or any other medical information critical to the disability determination. A formal mechanism for communicating this deficiency to claimants would be established, providing claimants both with notice and an opportunity to respond. This notice would be sent on behalf of the medical staff and would be expressed clearly in medical terms. The purpose of the notice would be to communicate to claimants, or their representatives or doctors, that the sufficiency of proof with respect to an important medical issue in their claim is being questioned, and that they are being given the opportunity to correct that deficiency.[556]

B. To Decide Specified Medical Issues

A particular disability decision can be based, at least in part, on the resolution of a relatively narrow medical-legal issue. The issue can be more medical than legal, as is the case when a claim is being measured against a standard based on a specified medical condition. In such instances, a decision must be made whether the claimant has a particular impairment and whether the impairment is sufficiently severe.[557] More often, however, there is a significant legal dimension as well. The distinguishing feature of these types of issues, as opposed to final disability decisions, is that they are framed only in terms of medical information that could be relevant in the disability determination. It is true, of course, that as a practical matter the resolution of a medical issue in aparticular case can amount to a resolution of the claim itself.

Medical personnel can be used in a limited decisionmaking role with respect to these specified medical issues. One approach is to use medical sources for supplying medical data and opinions on which disability decisions can be based. Information from medical sources can be obtained at any time as needed, including at or even after an administrative hearing.[558] Obviously, only doctors or psychologists can perform this particular role; the variables are the extent to which they are called upon to provide this information, who they are and how they are chosen, and the weight given to their opinions. A second approach is to identify certain issues to be evaluated and resolved by medical personnel, usually as a component part of the final disability decision. Both

---

555. This is a real concern. Thus, some personnel at the Social Security Administration Office of Hearings and Appeals are skeptical about the use of medical advisors because they believe some administrative law judges have let this happen. OHA interview, *supra* note 32. *See generally* text accompanying notes 156-62, *supra*.

556. The claimant would be expected to respond appropriately. Depending on the circumstances, the claimant could be asked to provide additional information about missing evidence, to meet personally with medical staff to discuss the state of the record, or to submit to requested examinations or tests. In some cases, the claimant could be asked simply to explain the deficiency.

557. This type of issue is raised, for example, in claims based on the Social Security Administration's Listing of Impairments and the Veteran's Benefits Administration's Schedule for Rating Disabilities. *See generally* text accompanying notes 313-40, *supra*.

558. Unnecessary delay in consulting with an appropriate medical source, which is inefficient and often unfair to claimants who give up early in the process, is a common problem. Administrative law judges complain that it is often left to them to obtain clearly necessary medical examinations and opinions from known treating sources. Chicago OHA interviews, *supra* note 157; Nashville OHA interview, *supra* note 159. *See generally* text accompanying notes 156-60, *supra*.

approaches are found in current practice and offer useful insights for a model for the use of medical personnel to decide specified medical issues.

1. Current Use: Medical Findings and Opinions as Evidence

Any disability evaluation must necessarily make use of medical findings and opinions as evidence. If this evidence is given no special consideration over other evidence in a record, such as statements from claimants and other lay witnesses, then there would be no meaning in including the preparation and submission of medical reports and opinions as a decisionmaking function of doctors. In fact, doctors' reports often are given special consideration in the disability determination process, depending on the program involved, the quality of the report and the status of the doctor; in writing a report on a particular medical condition a doctor can be, in effect, deciding an important medical issue.

Doctors can supply these findings and opinions as an unintended by-product of treatment, when reports from previously existing medical sources are used. Usually, however, doctors are solicited expressly for the purpose of conducting special examinations, or preparing a medical opinion evaluating a particular medical aspect of a claim. In both instances there are, at least in theory, guidelines for determining the weight to be given these findings and opinions. These guidelines tend to focus on the completeness of the report and the status of the source rather than any prescribed content for findings or opinions.

a. Use of Existing Sources

All programs use medical evidence from existing sources to help resolve medical issues, although the purposes for which they are used and the extent to which they are relied upon vary considerably. At one extreme is the Civil Service program, where reports and opinions of treating physicians are often the only medical evidence in the record. The assumption is that the best evidence to resolve the underlying medical issues -- whether the claimant has any medical impairments, and if so, whether there are any resulting functional limitations -- will come from the medical professional providing treatment. Usually this information is provided on a standardized form, supplemented with relevant records.[559] On the other extreme, the Veterans Administration approaches private treating sources with almost total distrust.[560] Even reports from treating doctors at Veterans Administration facilities are often considered insufficient; instead, special examinations are requested to support the claim under consideration.[561]

The range of problems associated with the use of existing medical sources to provide medical findings and opinions is reflected in current Social Security Administration practice. Claimants are encouraged to submit all available medical evidence relating to their medical condition, from every possible source. Moreover, the Administration assumes the responsibility for requesting hospital reports, office records and any other

---

559. OPM interview, *supra* note 191. The Office of Personnel Management also sets out certain criteria for medical reports in its regulations. *See* Federal Personnel Manual Supplement 831-1 § S10-7.

560. Thus, a claim for compensation cannot be granted on the basis of private source evidence; evidence from private sources can support a claim for pension benefits, but reports from Veterans Administration personnel are preferred. VA interview, *supra* note 5.

561. *See generally* text accompanying notes 505-30, *supra*.

information available from all sources listed on the claimant's application.[562] This does not mean, however, that evidence compiled from existing sources is given significant weight when it comes time to resolve particular medical issues.[563] In many cases, consultative examinations are ordered to supplement the record from existing sources.[564] Concern over the use of existing source evidence is heightened with respect to certain critical types of medical issues such as medical equivalence, and therefore regulations provide that a listed impairment can be made only when the record includes evidence on that issue from a physician designated by the Administration.[565]

b. Special Medical Examinations and Opinions

Far greater use is made of medical findings and opinions as evidence to resolve a particular medical issue when the findings and opinions are based on special medical examinations ordered as part of the disability determination process. This preference is seen in all programs other than Civil Service, which, as noted earlier, tends to rely whenever possible on the evidence submitted by the claimant. In the Black Lung program, special examinations are ordered as a matter of course.[566] In most programs, however, the decision whether to order a consultative examination is made on a case-by-case basis, depending on the nature of the medical issues involved and the quality of the information already in the record.[567]

Procedures for choosing a physician to perform a special examination and the quality of physicians chosen to perform these examinations range from fair to poor. At best, there are some agencies willing to commit the time and expense necessary to make it possible for conscientious examiners, medical staff or appellate staff to identify and contract with reasonably competent doctors to perform and report on special examinations of claimants. At the high end of the spectrum, at least in terms of formal structure, is the program for use of independent medical examiners at the Veterans Administration's Board of Veterans Appeals.[568] Experts are identified by hospitals or medical schools; if an expert opinion is obtained by the Board, the appellant is sent a copy of the report and given an opportunity to respond.[569] In practice, however, these experts are used only rarely. Most consultative examinations are ordered from Veterans Administration medical facilities.[570]

Consultative examinations are ordered most frequently in the Social Security program. Although the percentages vary from office to office, Disability Determination

---

562. This obligation to develop the record -- and the Administration's efforts to meet that obligation -- is discussed at text accompanying notes 157-60, *supra*.,

563. According to some claimant advocates, evidence compiled from existing sources is often discounted simply because it comes from a treating source; when it is considered, it may be given very little weight in comparison to a special examination conducted by an outside medical source. LAF interview, *supra* note 374. The allocation of weight to conflicting reports is discussed generally at text accompanying notes 588-610, *infra*.

564. SSA interview, *supra* note 27; DDS interviews, *supra* notes 322, 368, 389. There is a similar reluctance to use treating sources to conduct special medical examinations. *See* text accompanying notes 576-83, *infra*.

565. *See* 20 C.F.R. §§ 404.1526(b), 416.926(b). Medical equivalence determinations are discussed in detail at text accompanying notes 357-76, *supra*.

566. *See* text accompanying notes 271-73, *supra*.

567. *See generally* text accompanying notes 505-30, *supra*.

568. *See* 38 U.S.C. § 4009(a) (1982).

569. *See* 38 C.F.R. § 19.179 (1988).

570. VA interviews, *supra* notes 5, 230, 333, 533.

Services order consultative examination in up to forty percent of disability cases.[571] In some instances, consultative examinations are ordered to fill a particular vacuum in the record. If it appears, for example, that a Social Security claimant suffers, or may suffer from an impairment included in the Listing of Impairments and a particular finding is needed to complete an evaluation under the Listing, an examination to address that finding may be ordered.[572] When specific examinations such as these are ordered, they tend to be given great weight in resolving the particular medical issue involved. Consultative examinations are also ordered frequently by some administrative law judges.[573] In many cases the judge does so because the record on appeal is generally inadequate, because either there was insufficient development at the Disability Determination Services or a significant change occurred in the claimant's condition.

The Social Security Administration has been criticized for relying too heavily on consultative examinations, mainly because of the poor quality of many of the examinations and the reports submitted by consulting physicians.[574] This results in part from the fact that there are no clear guidelines governing the use of consultative examinations, at the Disability Determination Services and on appeal, and therefore no consistent pattern of use.[575] Another reason for the poor quality of many reports and the overall inconsistency of the consultative examination process stems from the methods for selecting examining physicians and the small number of physicians available to perform these examinations.

Debate over the selection of physicians to perform consultative examinations has centered on whether independent or treating sources should be used. The practice at the Disability Determination Services has been, at least until lately, to rely almost exclusively on independent consultants.[576] This has been a consistent preference notwithstanding clear statements from the courts that under most circumstances opinions of treating physicians are to be given greater weight than opinions of physicians who have performed only consultative examinations.[577] 1984 amendments to the Social Security Act specifically directed the Social Security Administration to "make every reasonable effort" to use treating physicians in this process before relying on evaluations by outside consultants.[578] In the past year or two, as the result of litigation seeking to enforce the preference for the use of treating sources and specific directions to that effect from the

---

571. Tennessee DDS interview, *supra* note 368. In Illinois, the current percentage is approximately thirty-five percent, down from forty percent a few years ago. Illinois DDS interview, *supra* note 322.

572. DDS interviews, *supra* notes 322, 368, 389. A similar approach is used by Veterans Administration Rating Boards when there is a good possibility that a finding required by the Schedule for Rating Disabilities could be developed.

573. The percentage of use varies greatly from judge to judge. One judge estimated that he orders consultative examinations in twenty to thirty percent of all cases. Chicago OHA interviews, *supra* note 157.

574. In the early 1980s, complaints about the poor quality of examination and reports by high-volume providers of consultative examinations resulted in congressional hearings on the subject. *See Volume Providers of Medical Examinations for the Social Security Disability Program: Hearing Before the Subcomm. on Social Security and Oversight of the House Comm. on Ways and Means*, 97th Cong., 1st Sess. (1981); *Social Security Disability Insurance: Hearing Before the Subcomm. on Social Security of the House Comm. on Ways and Means*, 98th Cong., 1st Sess. (1983).

575. More often than not, the combination of time pressures, limited funds and a plain lack of initiative and motivation result in a poor choice of a consulting physician or no choice at all.

576. DDS interviews, *supra* notes 322, 368, 389.

577. The case law on the weight to be given medical evidence is discussed at text accompanying notes 588-610, *infra*.

578. 42 U.S.C. §§ 423(d)(5)(B), 1382c(a)(3)(G). *See* Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 9(b)(1), 98 Stat. 1794 (1984).

Social Security Administration, Disability Determination Services have begun shifting towards greater use of treating physicians for consultative examinations.[579]

The assumption, implicit in the Administration's own regulations and stated directly by claimants and their advocates, is that a treating source is in a far better position to provide evidence about and to assess the disabling effects of a condition than a doctor who has performed a single consultative examination. Moreover, this position has been strengthened -- particularly in the early 1980s -- by the poor quality of examinations and reports produced by many consulting physicians.[580] The Administration personnel who evaluate this evidence see the issue differently, however. At the Disability Determination Services, for example, there is a general feeling that treating sources are usually both unwilling and unable to conduct competent examinations.[581] The unwillingness is thought to stem from inadequate funding for these examinations, as well as a professional disinclination to spend the time necessary to respond to a request directed at a disability determination, as opposed to treatment.[582] Even if willing, most treating sources are thought to be ineffective as consultative physicians. As stated by one administrator, thousands of treating physicians across a state cannot be trained to provide the information needed to evaluate a disability claim; chasing after them individually to get the information is an unacceptably time-consuming task.[583]

Another related problem is that medical sources have been given little, if any, guidance as to the type of information needed for a disability determination and the form in which it should be transmitted.[584] In addition, many treating sources, particularly in small towns and rural areas, do not have the facilities to perform all examinations or tests required. Some effort is being made to address these problems, although the pace is slow and most Disability Determination Services remain frustrated on this point.[585] By and large, they prefer to use the services of contract independent examiners, even though they recognize that the system is not funded at a level to provide optimal independent consultative examination services. Administrative law judges also continue to prefer independent consultants for these purposes, rarely, if ever, requesting that a treating source be used to provide special evidence on a medical issue in dispute.

Special examinations and opinions are sought less frequently in other programs. This is true even at the Railroad Retirement Board, where a disability determination process essentially the same as that used by the Social Security Administration is

---

579. Samuels v. Heckler, 668 F.Supp. 656 (W.D. Tenn. 1986). *See also*, Schisler v. Bowen, 851 F.2d 43 (2d Cir. 1988); Schisler v. Heckler, 787 F.2d 76 (2d Cir. 1986). This policy is also reflected in POMS DI 22510.030 and in proposed regulations published in 1987, but as yet not adopted in final form. *See* 52 Fed. Reg. 13,014 (1987); note 486, *supra*.

580. *See* note 574, *supra*.

581. There is also some skepticism about the objectivity of treating physicians' reports; for most, however, this is not the main concern. *Cf.* Stephens v. Heckler, 766 F.2d 284, 289 (1985) ("[t]he patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability"); Cummins v. Schweiker, 670 F.2d 81, 84 (7th Cir. 1982) ("[the treating physician] might have been leaning over backwards to support the application for disability benefits"). *But see* Whitson v. Finch, 437 F.2d 728 (6th Cir. 1971) (treating physicians no more biased toward claimants than consulting physicians biased toward Administration).

582. DDS interviews, *supra* notes 322, 368, 389.

583. Tennessee DDS interview, *supra* note 368.

584. *See*, General Accounting Office, *Disability Programs: SSA Consultative Medical Examination Process Improved; Some Problems Remain*, 26-43 (1985).

585. In Tennessee, the Disability Determination Service and the plaintiffs' lawyers in Samuels v. Heckler, 668 F.Supp. 656 (W.D. Tenn. 1986) are conducting a survey in cooperation with the Tennessee Medical Association to attempt to uncover the extent and source of this reluctance.

followed to implement a virtually identical disability standard. At the hearings level referees do make an effort to use treating sources for consultative examinations, at least in some cases.[586]

As a practical matter, reports of special examinations often provide the only evidence with respect to certain medical issues, in which case the substance of the reports tends to be accepted as a basis for decision. Of course, examiners and judges alike reserve the right to disagree with the content of any medical reports in the record; when reports from special examinations are contradicted by other evidence in the record, it becomes a question of weighing the various items of evidence to reach a conclusion. If the persons responsible for making that evaluation believe that the record is sufficiently complete to weigh the evidence, they are free to do so; if there is a need for additional clarification or even yet another examination and report, usually this can be done before the conflicting evidence is weighed. In practice, however, this authority is rarely used. In part because of the press of business and in part because of a sense that records with conflicting evidence will always be in conflict, most examiners simply go ahead. Theoretically, an uncontradicted report might not be followed, either because the examiner or judge believes the report is insufficient or is simply wrong. This is an extremely rare occurrence, however, even though there would seem to be a basis for the rejection of a significant number of reports for incompleteness.[587]

c. Allocation of Weight

There has been a great deal of controversy over the question of the relative weight to be given to conflicting medical evidence in federal disability adjudications. Claimants argue regularly on appeal that insufficient weight was given to evidence favorable to their position; agencies also promulgate rules on weighing evidence, sometimes in response to litigation.[588] In a sense, this issue symbolizes the intersection of law, administration and medicine in federal disability programs. Depending on the program and level of administration involved, agency regulations, administrative hearing decisions or court opinions can be instructing doctors, judges or other administrative personnel on how to evaluate and measure one piece of medical evidence against another.

This issue has been aired most fully with respect to Social Security disability programs.[589] Most conflicts arise between the claimant's treating physician and one of two other physicians whose reports and opinions may be included in the record: a consulting physician hired by the Social Security Administration to conduct and report on a consultative examination, and the medical consultant at the Disability Determination Services who evaluates evidence in the record as part of the decisionmaking process without actually observing the claimant. Case law distinguishes these three sources in two ways. First of all, treating physicians are given a special status by virtue of their close association with the claimant and the fact that the motivation for the relationship -

---

586. RRB interview, *supra* note 176.

587. Administrative law judges feel this way about reports used by examiners; federal judges see the same deficiencies in administrative law judges, and claimant advocates cite instances of unwarranted reliance on incomplete reports throughout the process.

588. At the Social Security Administration, for example, some agency rulings supported claimants' arguments for greater weight for treating physicians; the litigation in turn led to new and more comprehensive rulings. *See* Schisler v. Bowen, 851 F.2d 43 (2d Cir. 1988). A broad set of regulations was proposed in 1987 which included guidelines for the use of treating physicians, but have not been adopted in final form. *See* note 486, *supra*.

589. The approach developed for Social Security adjudications has been followed directly in two other programs, Railroad Retirement and Civil Service. *See* text accompanying notes 600-02, *infra*.

- and information transmitted between them -- is treatment.[590] Their well-supported opinions must be accepted in the absence of evidence to the contrary; when contradicted by other evidence, a treating physician's opinion must be accepted unless the other evidence is "substantial."[591]

A second line of distinction is drawn between reports and opinions of treating physicians and consulting physicians who have performed consultative examinations, and medical consultants or advisors who have had no personal contact with the claimant. Reports and opinions based on complete consultative examinations can be considered as important as those provided by treating physicians, depending on the medical issue involved and the relative quality and detail of the reports.[592] Reports of non-examining physicians, on the other hand, are viewed as far less important than those of treating or consulting physicians, even though on certain technical issues a personal observation of the claimant may be all but irrelevant. Their opinions are usually considered not sufficient to contradict those of treating physicians, for example, unless there is other evidence supporting the contradicting opinion.[593] In addition, administrative law judges must be careful not to substitute their own opinions based on observations of the claimant at a hearing.[594]

These guidelines apply at both the initial decision level and on appeal. As noted earlier, there is general resistance to the use of treating sources for special medical development.[595] Even when treating source evidence is received at the Disability Determination Services, the guidelines for weighing that evidence are often ignored.[596] Similarly, although administrative law judges are aware of their responsibility to weigh medical reports and opinions, many are criticized on appeal for failing to do so according to established guidelines.[597] Instead, they will take into account their own

---

590. To be given this status the physician must, of course, have a real treating relationship with the claimant. "The nature of the physician's relationship with the plaintiff, rather than its duration or its coincidence with a claim for benefits, is determinative." Schisler v. Bowen, 851 F.2d 43, 46 (2d Cir. 1988). *Cf.* Hernandez v. Heckler, 704 F.2d 857, 861 (5th Cir. 1983) (physician who saw claimant only twice not a treating physician).

591. *See e.g.*, Embrey v. Bowen, 849 F.2d 418, 421-22 (9th Cir. 1988) ("ultimate conclusions of [treating] physician must be given substantial weight; they cannot be disregarded unless clear and convincing reasons for doing so exist and are set out in proper detail"); Mitchel v. Schweiker, 699 F.2d 185, 187 (4th Cir. 1983); Smith v. Schweiker, 646 F.2d 1075 (5th Cir. 1981). Well-supported means, at a minimum, something more than a simple statement that the claimant is "disabled" or "unable to work." *See* 20 C.F.R. § 404.1527; Bernal v. Bowen, 851 F.2d 297, 301 (10th Cir. 1988) ("treating physicians report may be rejected if it is brief, conclusory, and unsupported by medical evidence"); Laffoon v. Califano, 558 F.2d 253, 255 (5th Cir. 1977).

592. *See, e.g.*, Broadbent v. Harris, 698 F.2d 407, 414 (10th Cir. 1983). *See also* Richardson v. Perales, 402 U.S. 389, 403 (1971) ("We cannot, and do not, ascribe bias to the work of these independent physicians, or any interest on their part in the outcome of the administrative proceeding beyond the professional curiosity a dedicated medical man possesses").

593. *See, e.g.*, Sharfarz v. Bowen, 825 F.2d 278, 280 (11th Cir. 1987) ("opinions of nonexamining, reviewing physicians, . . . when contrary to those of the examining physicians, are entitled to little weight"). Millner v. Schweiker, 725 F.2d 243, 245 (4th Cir. 1984); Davis v. Schweiker, 671 F.2d 1187, 1189 (8th Cir. 1982).

594. Thus, it is improper for a judge to use the so-called "sit and squirm index." *See* McRoberts v. Bowen, 941 F.2d 1077, 1081 (11th Cir. 1988); Lewis v. Bowen, 823 F.2d 813, 816 (4th Cir. 1987); Perminler v. Heckler, 765 F.2d 870, 872 (2d. Cir. 1985); Kelly v. Railroad Retirement Board, 625 F.2d 486, 495 (3d Cir. 1980).

595. *See* text accompanying notes 527-30, *supra*.

596. LAF interview, *supra* note 374; Chicago OHA interviews, *supra* note 157.

597. *See, e.g.*, Wiggins v. Schweiker, 679 F.2d 1387, 1389 (11th Cir. 1982).

experience with the particular doctor, as well as the quality of the report submitted.[598] When they do follow the guidelines, they can feel frustrated and constrained.[599]

Courts have approached the question of how much weight should be given to different types of medical evidence in Railroad Retirement Disability cases in a manner similar to that used in Social Security cases. Thus, although examiners and referees are expected to weigh all of the evidence in the record and to assess and evaluate all medical reports, reports from treating physicians are treated with greater deference than reports from physicians who performed only a consultative examination.[600] They are free, of course, to disagree with opinions of treating physicians when there is other medical evidence supporting the referee's contrary conclusion.[601] The Social Security approach has been followed generally by the Merit Systems Protection Board for Civil Service disability claims as well.[602]

The Department of Veterans Affairs, on the other hand, has rejected suggestions that medical opinions provided by examining or treating physicians not affiliated with the Veterans Administration should be given more weight than those of doctors affiliated with the Administration.[603] Ordinarily, evidence submitted from sources other than the claimant, including reports from physicians, is accepted as competent and true unless there is a sound basis for doubt.[604] As noted earlier, there is a strong preference for medical evidence from Veterans Administration medical facilities, as opposed to private sources, particularly in compensation claims involving a service-connection issue.[605]

In the Black Lung Program, the most important guidelines for weighing evidence relate to the reading of x-rays. The main factor to be considered, other than the quality of the report itself, is the rating given the reader by the National Institute of Occupational Safety and Health. Most fully-qualified readers are given a "B" rating.[606] Generally, opinions of "B" readers are given greater weight; however, when there are conflicting readings by "B" readers, all readings regardless of the rating of the reader can be considered.[607] A single negative reading by a "B" reader may not be sufficient, however, even if uncontradicted by any other "B" reader, if there is strong evidence supporting positive readings by other, unrated readers.[608]

---

598. Chicago OHA interviews, *supra* note 157.

599. For example, they may be bound to accept a treating physician's opinion about which they have doubts, because the source of those doubts is the opinion of a non-examining physician. Nashville OHA interview, *supra* 368.

600. Sometimes the rule is stated more softly in Railroad Retirement cases. *See, e.g.*, Freels v. Railroad Retirement Board, ____ F.2d ____, 1989 W.L. 73920 (8th Cir. 1989); Chandler v. United States Railroad Retirement Board, 713 F.2d 188, 189-90 (6th Cir. 1983). *Cf.* Peppers v. Railroad Retirement Board, 728 F.2d 404, 406 (7th Cir. 1983) (conclusion not supported by objective findings).

601. *See* Krinshaw v. Railroad Retirement Board, 815 F.2d 1066, 1068 (6th Cir. 1987). The Referee is expected to evaluate the quality of a doctor's statement based on how well the doctor's opinion is supported by specific clinical findings. Elzy v. Railroad Retirement Board, 782 F.2d 1223, 1225 (5th Cir. 1986).

602. *See* Chavez v. Office of Personnel Management, 6 M.S.P.R. 404, 422-23 (1981).

603. *See* 48 Fed. Reg. 6962 (1983).

604. Veterans Administration Manual M21-1 § 7.02a. The Board recognizes a claimant's statement that he or she is disabled as evidence, but distinguishes such statements from "objective evidence" and "medical evidence." Veterans Administration Manual MBVA-1 § 9.22f.

605. *See* text accompanying notes 331-33, *supra*.

606. *See generally* 42 C.F.R. § 37.51 (1988).

607. *See* Back v. Director, 796 F.2d 169, 172 (6th Cir. 1986); Yeager v. Bethlehem Mines Corp., 6 BLR 1-307, 1-309 (1983).

608. *See* Sexton v. Director, 752 F.2d 213, 215-16 (1985).

General medical reports can be discounted in the Black Lung Program if a claimant can show that the physician is "hostile" to the Black Lung Act because he or she does not believe that pneumoconiosis is a totally disabling disease.[609] This notion comes from the general uncertainty in medical science about the source of coal miners' disabilities and the social and economic components of the Black Lung disability standard.[610]

2. Current Use: Determination of Component Parts of Disability Decision

Doctors are used more directly in some programs to decide specified medical issues at certain stages of the disability determination process. Instead of being asked to provide evidence about to a particular medical issue -- admittedly often with the expectation that the evidence returned will resolve the issue -- doctors are in these instances entrusted with evaluating and resolving any conflicts in the evidence, and then deciding the issue. This role is to be contrasted as well with the role of final decisionmaker on the ultimate issue of disability.[611]

The Social Security Administration follows this approach formally with respect to Residual Functional Capacity assessments.[612] Once the relevant evidence has been compiled, the medical consultant is required to follow through the evaluation form and establish the claimant's Residual Functional Capacity. For some time the consultant had been responsible for at least approving an assessment recommended by the examiner, after the examiner had completed the appropriate form. Under Administration policy, however, the consultant must actually complete the form.[613] This requirement has produced some conflict with respect to the allocation of responsibility and resources. Most Disability Determination Services administrators question whether it is necessary to focus limited medical resources on these assessments to this extent. As a result, some states are moving toward this practice more slowly than others.[614] Few disagree, however, with the proposition that the consultant should be responsible for the final assessment.[615]

Another decision delegated to medical consultants is the determination that an impairment or combination of impairments is the "medical equivalent" of an impairment in the Listing of Impairments.[616] Regulations state expressly that medical equivalence decisions are based "on medical evidence only, . . . [the Administration] will also consider the opinion given by one or more medical or psychological consultants

---

609. *See* Wetherill v. Director, 812 F.2d 376, 382 (7th Cir. 1987) ("The hostility to the Act rule only comes into play when a physician's diagnosis is affected by his subjective opinions about pneumoconiosis that are contrary to the congressional determinations implicit in the provisions of the Act"). "Hostility" is a question of fact to be determined by the fact finder. Endrizzi v. Bethlehem Mines Corp., 4 BLR 1-252, 1-255-256 (1981).

610. The proper determination of whether a physician is hostile is "whether and to what extent those hostile opinions affected the medical diagnoses." *Id.* Pancake v. Amax Coal Co., 858 F.2d 1250, 1256 (7th Cir. 1988).

611. *See* text accompanying notes 630-62, *supra.*

612. *See generally* text accompanying notes 381-91, *supra.*

613. There is support for this policy in the regulations. *See* 20 C.F.R. §§ 404.1546, 416.946. In some states medical consultants are assigned specifically to complete Residual Functional Capacity assessments; however, most doctors are rotated so that they will participate in all aspects of the process at one time or another. Illinois DDS interview, *supra* note 322; Tennessee DDS interview, *supra* note 368.

614. Thus, in Florida, the shift to full responsibility with the consultant is being phased in over time. Florida DDS interview, *supra* note 368.

615. The view was expressed by some that an experienced examiner can do as good a job in almost all cases. *Id.*

616. *See generally* text accompanying notes 357-76, *supra.*

designated by the Administration."[617] This role is performed informally by medical consultants on other medical issues as well.[618]

The medical member's role in making rating decisions is not set out consistently at Veterans Administration Rating Boards. One view is that the initial rating of claims is an essentially clerical function dictated by regulations outside the special expertise of doctors and therefore better left to lay rating specialists. The medical members are thus freed from tying their medical judgment to the rating schedule.[619] However, when a difficult rating determination is required, the medical member's view is often solicited by the other members, and almost always prevails.[620] Medical members are also deferred to regularly on contested service connection issues.[621]

In no instances are doctors not otherwise in a decisionmaking role given the responsibility for deciding special medical issues. This role is performed only by medical consultants at the Social Security Administration and medical members of Veterans Administration Rating Boards, both of whom have final decisionmaking roles as well.[622] The only other doctors with a decisionmaking role -- medical members of the Board of Veterans Appeals -- are also deferred to sometimes in particularly difficult cases; however, it does not happen regularly enough to amount to a separate role from final decisionmaking.[623]

3. Model: To Decide Specified Medical Issues

Doctors are particularly well-suited to decide specified medical issues that can arise in disability adjudications. A separate procedure would be established within the disability determination process to assure careful consideration and evaluation by a doctor of any focused medical questions presented in a claim for disability benefits. This could be a required step in the general process in programs utilizing doctors as final decisionmakers; even if final decisions are to be made only by non-medical personnel, doctors would be used whenever specified medical issues critical to the disability determination can be identified. A model for utilizing medical staff to decide specified medical issues would include the following elements.

Staff

Determinations of specified medical issues would be made by medical doctors on the basis of medical evidence addressing those issues. In some instances, the questions presented will be sufficiently technical that a doctor alone should be given responsibility for making the necessary findings and conclusions. If the issue involved includes a legal

---

617. 20 C.F.R. § 404.1526(b). *See also* S.S.R. 83-19 106 (Cum. Ed. 1983) ("In most instances, the designated physician is a physician in the [Disability Determination Services]. A medical advisor at a hearing . . . may also make the physician's decision in the determination of medical equivalence").

618. For example, consultants may be relied upon to decide whether a particular criterion included in the Listing of Impairments has been satisfied.

619. Montgomery VA interview, *supra* note 533.

620. San Francisco VA interview, *supra* note 230.

621. VA interviews, *supra* notes 230, 333, 533.

622. In at least one related state program, the West Virginia workers compensation program, a board of physicians is given the responsibility for deciding whether a coal mine worker claimant suffers from pneumoconiosis. *See* W. Va. Code § 23-1-8 (1985 Replacement Volume); Parker v. Workers' Compensation Commissioner, 324 S.E.2d 142 (W. Va. 1984).

623. BVA interviews, *supra* note 5.

or program dimension, then coordination with a non-medical decisionmaker would be preferable.[624] With or without the assistance of other staff, doctors would have the primary role. The doctors would be regular members of the agency staff, hired on a full- or part-time basis. They could be the same doctors used to make final decisions, if doctors are used for that purpose; otherwise, separate staff positions would be created, or combined with existing positions for non-decisionmaking medical consultants.

Identification of Issues

Each agency would have to identify particular issues appropriate for special decision by medical staff and develop general guidelines for evaluation, taking into account the disability standard being implemented. Medical staff would then determine whether a particular claim presents a medical issue appropriate for separate evaluation.[625] This function would be integrated into the overall disability determination process as fully as possible, so that medical staff already in place to decide claims would be responsible for identifying any special medical issues as well. Otherwise, the examiner responsible for the claim would make a preliminary recommendation of appropriate medical issues for special evaluation, subject to confirmation by the medical staff that would actually evaluate and decide the issues.

Coordination with Development

Before any specified issue is decided, the medical staff would assess the sufficiency of the record with respect to that issue. Any deficiencies would be noted and resolved, either directly by the doctor responsible for deciding the issue or with the assistance of the medical record development staff. Much of this development would fall in the category of special development. With respect to both previously obtained and new evidence bearing on the particular issue under consideration, the medical staff would be responsible for assessing the weight of any conflicting evidence and for noting the basis for that assessment in the record. [626]

Determination

A doctor, either alone or together with an examiner, would resolve any identified special medical issues. This determination could be limited to an explanation and evaluation of special medical reports obtained to address the particular issue. In other instances, the doctor would have to draw from general evidence the specific information relevant to the determination of the issue in order to make a new and independent decision. The doctor would also be expected to identify and resolve conflicts in the evidence. As part of this process, the doctor would make an express finding that further development is not required notwithstanding conflicts, or would recommend additional

---

624. Doctors should always be paired with program specialists in making final disability determinations. *See* text accompanying notes 663-70, *infra*.

625. Thus, for some programs, such as the Black Lung program, almost every claim will involve a specified issue. In most programs, however, there will be only the possibility -- more or less likely -- that one of a number of specified issues will arise. This is the case, for example, in Social Security cases: a particular claim may or may not require an evaluation under the Listing of Impairments or a Residual Functional Capacity assessment.

626. One of the functions of a development unit is to follow up on special requests for supplementation. *See* text accompanying notes 531-47, *supra*.

development if needed. Any further development needed would be coordinated with the development unit.[627]

Decisions on special medical issues would be documented fully and placed in the record. Ordinarily, the decision would simply be incorporated into the final disability determination; however, there is no reason to preclude a review of any special decisions as part of the final decisionmaking process.

C. To Decide Disability

Disability decisions are considered program decisions, involving medical as well as medical-legal issues. As a result, professional program personnel, as opposed to medical staff, must be involved in final decisionmaking in all programs. At the same time, there is unquestionably a need for medical expertise in the decisionmaking process; to the extent that a final decision rests on underlying medical facts, there is great value in having medical personnel -- particularly doctors or, in appropriate cases, psychologists -- concur in a finding of disability.

For the most part, program-trained personnel, and at the appeals level legally-trained personnel, are responsible for final decisionmaking in federal disability programs. There is far more involvement by medical staff at the initial decision stages, which is the stage in the administrative process when medical expertise can be the most useful. Indeed, if medical staff is used effectively not only in final decisionmaking but also at other key points in the process, such as record development and resolving special medical issues,[629] there would be little need for medical staff on appeal. First of all, appeals from initial decisions raising medical issues as such would be relatively rare. Then, in those cases raising medical issues on appeal, the record on appeal would include a clear and complete compilation of medical evidence together with a full explanation and rationale for decision on all key medical issues. The problem with current practice is that even when doctors are present and active as decisionmakers, the full potential value of their expertise to the entire process is not realized.

1. Current Use: Medical Professionals as Final Decisionmakers

Two agencies -- the Social Security Administration and the Veterans Administration -- have established procedures in which doctors share the responsibility for final disability decisions. Doctors participate in the initial decision in both programs: Social Security disability decisions are made by teams of one disability examiner and one medical consultant; Veterans disability decisions are made by three-member Rating Boards, consisting of two lay specialists and one medical doctor. In addition, panels of the Board of Veterans Appeals also consist of two lay members and one medical member.[630] Other than at these three points -- Social Security and Veterans initial decisions and Veterans appeals -- final decisionmaking in federal disability programs rests exclusively with non-medical personnel.

No particular area of specialization is required. Medical consultants at the Disability Determination Services represent a broad range of specialties; they are hired

---

627. *See* text accompanying notes 548-56, *supra*.

628. Obviously, this would occur only if someone else was making the final decision, or, if the same person made the final decision, when new evidence was obtained.

629. *See* text accompanying notes 548-56, 624-28, *supra*.

630. *See generally* text accompanying notes 256-58, *supra*.

with no preference for one specialty over another.[631] Indeed, some administrators prefer general practitioners and internists as medical consultants.[632] The one exception is with respect to claims involving mental impairments. In 1984 amendments to the Social Security Act, Congress required the Social Security Administration to make "every reasonable effort" to use a psychiatrist or psychologist to assess these claims before finding a claimant is not disabled.[633] As a result, a substantial number of consultants at each Disability Determination Services office are trained in one of those specialties.[634] A similar range of specialists is represented on Veterans Administration boards.[635] The Board of Veterans Appeals does divide its sections to some extent by medical specialties; however, the Board has refused to require the use of psychiatrists for claims based on mental conditions.[636]

Although both the Social Security Administration and the Veterans Administration utilize a team approach for incorporating doctors into final decisionmaking, the two team approaches operate quite differently. Most importantly, the medical consultant's role at the Disability Determination Services is less clearly defined than the role of medical members of Rating Boards and the Board of Veterans Appeals. Medical consultants are integrated into the decisionmaking process formally only by the requirement that they approve all final disability decisions made by the Disability Determination Service.[637] How they actually function in the process and the extent to which they participate generally in the evaluation of claims varies considerably from state to state, despite some guidance from the Social Security Administration. By contrast, medical members of Rating Boards and the Board of Veterans Appeals function formally as full-fledged members of a decisionmaking tribunal.[638] Their roles are well established not only at the Board of Veterans Appeals, but also at Rating Boards in regional offices throughout the country.[639] The real differences between the two uses of medical doctors are in most respects less than these differences in formal structure would seem to indicate.

In all three instances, initial responsibility for evaluation of the evidence rests with the non-medical member of the team.[640] Thus, Social Security claims are evaluated first by the examiner, who then recommends a decision to the medical consultant.[641] This procedure is justified as most efficient for two reasons. First, disability examiners are less expensive than medical consultants, and therefore are expected to take on as much

---

631. DDS interviews, *supra* notes 322, 368, 389.

632. Florida DDS interview, *supra* note 368.

633. 42 U.S.C. §§ 421(h), 1382c(a)(3)(G); 1984 Amendments, *supra* note 578, at § 8(a).

634. In New Mexico, for example, three of nine consultants are psychologists. New Mexico DDS, *supra* note 389.

635. VA interviews, *supra* notes 230, 333, 533; BVA interviews, *supra* note 5.

636. *Id.* The Board has non-member psychiatrists on staff as consultants. *See generally* text accompanying notes 252-58, *supra*.

637. *See* 20 C.F.R. §§ 404.1615(c), 416.1015(c). Medical consultants participate also in the development of medical records and in deciding specified sub-issues. *See generally* text accompanying notes 488-547, 611-23, *supra*.

638. *See* 38 C.F.R. § 4.6 (1988) (Rating Board); *id.* § 19.161 (Board of Veterans Appeals).

639. Medical members' roles in other aspects of the disability determination process are discussed at text accompanying notes 488-547, 611-23, *supra*.

640. Non-medical members of these teams are also usually responsible for initial development work. *See* text accompanying notes 496-504, *supra*.

641. DDS interviews, *supra* note 322, 368, 389.

of the team's work as possible.[642] Because of cost constraints, consultants are hard to hire and can be hired usually only on a part-time basis.[643] The second justification is more positive: experienced disability examiners are considered capable of evaluating the medical evidence and reaching a correct decision in most cases; certainly they can review a file and reach a proposed decision that can, in turn, be reviewed and confirmed or questioned by a medical consultant. Examiners are prepared for this role through initial and ongoing training,[644] and supported in their work, when needed, by the medical consultants.[645]

Theoretically, the medical consultant reviews the file completely and reaches an independent conclusion. An independent decision does not mean, however, a completely *de novo* evaluation; the examiner's recommended decision is always there to be considered. The amount and form of direct communication between examiner and consultant in this process varies greatly from office to office. In most offices, they work in physically separate locations and communicate rarely; when they do communicate, it is often in writing.[646] Indeed, one view is that claims examiners are primarily responsible for making disability decisions at the Disability Determination Services, with assistance when needed from medical consultants, and that the medical consultant's role at the end of the process is only to confirm or disapprove the claims examiner's decision.[647]

Disability Determination Services administrators recognize that there are some doctors who sign off on a decision without reviewing the file. They believe, however, that by and large their medical consultants are serious professionals who realize that they are making important, critical decisions.[648] The amount of time the consultants spend reviewing a file can vary from as little as five minutes to more than one and one-half hours, depending on the complexity of the case.[649]

Claims are processed in the same general fashion by Veterans Administration Rating Boards and the Board of Veterans Appeals, even though the medical members usually work in close physical proximity with the non-medical members, and many members of those boards work on a full-time basis.[650] At the Rating Boards, however, one doctor

---

642. This cost factor can be seen in staffing patterns. For example, in New York there are over 400 full-time examiners and from 70 to 100 part-time consultants; there are over 200 full-time examiners, 34 full-time consultants and 8 part-time consultants in Florida. New York DDS interview, *supra* note 368; Florida DDS interview, *supra* note 368. Similar ratios of examiners to consultants exist in other states as well. DDS interviews, *supra* notes 322, 368, 389.

643. There are exceptions. In Florida, for example, the Disability Determination Office prefers full-time medical staff and is able to fill those positions. Florida DDS interview, *supra* note 368.

644. Typically, new examiners are given an introductory course in the medical and legal aspects of Social Security disability determinations, and then supervised closely in on-the-job training as they take their first cases. DDS interviews, *supra* notes 322, 368, 389.

645. *See generally* text accompanying notes 487-547, *supra*.

646. This arrangement usually follows from the way the office is set up generally for examiner-consultant interaction. *See* text accompanying notes 536-47, *supra*.

647. Illinois DDS interview, *supra* note 322.

648. New York DDS interview, *supra* note 368.

649. Florida DDS interview, *supra* note 368. The number of claims handled each day by doctors in Florida averages from 13 to 14. *Id.* In Tennessee, doctors handle an average of 1.5 cases per hour. Tennessee DDS interview, *supra* note 368.

650. All members of the Board of Veterans Appeals are full-time; many, but often less than half, of the medical members of Rating Boards are full-time. BVA interviews, *supra* note 5; VA interviews, *supra* notes 230, 333, 533.

will serve as the medical member for two or three three-member boards.[651] At both boards, claims are assigned first to one of the two non-medical members -- the chief member at the Board of Veterans Appeals -- who is responsible for evaluating the evidence and writing a recommended decision.[652] The file and recommended decision are then passed on for review and concurrence or objection, first by the other non-medical member -- the legal member at the Board of Veterans Appeals -- and then by the medical member.[653] As is the case at the Disability Determination Services, the amount of time and original thought the medical member puts into this review depends on the difficulty of the claim and the attitude and commitment of the doctor.[654] One view of the medical member's role on the Rating Board is that they are to review the work of the lay members and to approve, or disagree with, their resolution of the claim.[655] There are significant inefficiencies in using doctors on a full-time basis in the same capacity as other adjudicators. Thus, it is estimated that only about ten percent of any member's time, including medical members, is spent in decisionmaking at the Board of Veterans Appeals. The remainder of their time is spent on administrative responsibilities and crafting of decisions, tasks for which medical expertise offers no advantage.[656]

This process is designed to achieve consensus, and that is what happens in almost every case. In "easy" cases, which are estimated to make up as many as ninety-five percent of Veterans disability claims and ninety percent of Social Security claims at the initial decision level, there is virtually never disagreement; even with the remaining, more difficult cases, there are as few as one or two claims per year that a Rating Board cannot decide unanimously and as few as three or four disagreements per week at Disability Determination Services offices.[657] In both cases, there is a tendency to defer to the doctor on medical issues, thereby making a formal conflict on a medical issue extremely rare.[658] When there is a disagreement at a Disability Determination Section, it is resolved by the chief medical consultant or office director, whenever possible with the participation of the original team.[659] Disagreements among Rating Board members are resolved ultimately by the Adjudication Officer at the regional office.[660] Conflicts are somewhat more common at the Board of Veterans Appeals, although still quite rare. Even at that level, the vast majority of cases are considered easy or routine; when a difficult medical issue is presented, the members of the Board usually will have discussed the claim during the course of each member's evaluation so that the chances of building a consensus are even greater. As a result, very few split decisions are filed by

---

651. VA interviews, *supra* notes 5, 230, 333, 533.

652. This same member is responsible for the initial development work on the claim as well. *See generally* text accompanying notes 229-36, *supra*.

653. VA interviews, *supra* notes 230, 333, 533; BVA interviews, *supra* note 5.

654. The vast majority of claims require very little time from the doctor; as little as 5 percent of the claims require serious review from a medical standpoint. San Francisco VA interview, *supra* note 230.

655. Montgomery VA interview*supra* note 533. They are also available to answer questions and assist lay members when asked. *See generally* text accompanying notes 226-38, *supra*.

656. BVA interviews, *supra* note 5.

657. Montgomery VA interview, *supra* note 533; Illinois DDS interview, *supra* note 322.

658. DDS interviews, *supra* notes 322, 368, 389; VA interviews, *supra* notes 230, 333, 533.

659. DDS interviews, *supra* notes 322, 368, 389. In rare cases, help from the regional or central Social Security Administration office is requested. SSA interview, *supra* note 27.

660. VA interviews, *supra* notes 230, 333, 533. Assistance is available in extraordinary cases from the central Veterans Administration office. VA interview, *supra* note 5.

the Board.[661] When there is a dissenting opinion, the claim can be submitted to the Chair, who has authority to reconstitute the second with additional members.[662]

2. Model: To Determine Disability

Doctors should have a decisionmaking role with respect to the medical-legal issue of disability in federal disability adjudications. Doctor participation would be required at the initial decision level, where most fact development and framing of medical issues take place. Consistent use of competent and conscientious doctors in initial decisions, as outlined in this study, would obviate the need for medically-trained decisionmakers on appeal.

Separate roles for doctors in developing medical records and deciding specified medical issues have been set out already;[663] although they can be justified independently, the use of doctors in the disability determination process would be far more effective and efficient if those functions were combined with final decisionmaking in one medical staff position. In addition to the responsibilities for development and determination of specified medical issues already discussed, a model for using medical staff to decide the ultimate question of disability would include the following elements.

Staff and Training

The doctors would be regular employees, on a full- or part-time basis.[664] Because of the significant legal or program content of any final disability decision, the responsibility for decisionmaking would be shared with program-trained, non-medical personnel. They would work in two-member teams. In the absence of a specialty in disability medicine, no particular area of specialization would be required of medical staff; however, the use of specialists, particularly in mental impairment cases, would not be discouraged.[665] All staff, medical and non-medical, would be trained on both the legal and medical aspects of disability adjudication.[666]

Coordination with Development and Determination of Specified Issues

Before proceeding to final evaluation of a claim, the doctor would review the file to assure that the record is complete for decision. This review would cover all evidence relevant to the disability determination, including any determinations of specified

---

661. BVA interviews, *supra* note 5. Split decisions are more common with respect to the issue of service connection, although still rare. *Id.*

662. *See* 38 C.F.R. § 19.189(b). *See generally* text accompanying notes 264-65, *supra.*

663. *See* text accompanying notes 548-56, 624-28, *supra.*

664. There is no consensus on the advantages and disadvantages of using full-time or part-time medical staff. Most Social Security medical consultants and many medical members of Rating Boards work on a part-time basis; most medical members of the Board of Veterans Appeals work on a full-time basis. This staffing arrangement depends in part on the local medical market. Thus, at the Florida Disability Determination Service, there seems to be no difficulty in finding qualified full-time consultants. Florida DDS interview, *supra* note 368.

665. With appropriate development of medical evidence, there may not be a need for specialization even in mental impairment cases. This view is expressed even now by some in the field despite a statutory requirement that psychiatrists or psychologists be used to evaluate certain mental disability claims. *See* statement of Albert F. Vickers, Chief State Agency Medical Consultant, Texas Disability Determination Services, presented to the Disability Advisory Council (March 20, 1987).

666. Training for medical and non-medical staff would be separate but coordinated with medical staff concentrating on program material and non-medical staff on medical material.

medical issues already in the file. Most files would be complete and ready for decision at this point, particularly if the doctor participated in the original development of the record and the evaluation and determination of specified medical issues. If there are minor deficiencies, the doctor could take steps necessary to cure the problem; serious deficiencies might require routing the claim back through the appropriate stages of the process.

Determination

The doctor would undertake a full and independent review of the entire record, following a similar complete review by a non-medical disability examiner. Although the two reviews of the file would be independent, open exchange between the two decisionmakers would be encouraged. Ideally, they would work in close proximity to each other so that communication would be easy and regular.[667]

The process of interaction between the doctor and examiner should be designed to make the best use of both. Accordingly, the examiner would be expected to review the claim initially, consulting whenever necessary with the doctor about medical issues. The examiner would also be expected to recommend a final decision, supported by a written rationale for the decision based on both legal and medical considerations. The doctor would then review the file and the examiner's recommendation, paying particularly close attention to the resolution of the medical issues. If in full agreement with the decision and rationale of the examiner, the doctor would certify that agreement.[668] If the doctor disagreed in any respect, the two members of the team would consult and reach an agreement, if possible. If an agreement is reached, a memorandum covering the disagreement and resolution would be included in the file; a new decision and rationale consistent with the agreement would be drafted as well.

If there is a disagreement which cannot be resolved, every effort would be made to obtain additional evidence to resolve the conflict. This could include further contact with the claimant's medical sources, new examinations, consultations with specialists or a personal interview with the claimant. Any new evidence resulting from these contacts would, of course, be placed in the record. If disagreement continues, the claim would be certified to a senior team for an independent evaluation of the disagreement; if they cannot resolve the dispute, final decision would rest with a designated senior administrator.[669]

Communication with Claimants

Before a final decision is made to deny a claim, the preliminary decision and a complete statement of the rationale for the decision would be communicated to the claimant. The precise medical basis for the determination, including a discussion of the evidence relied upon, would be stated separately as part of the rationale. The claimant would be given the opportunity to address any medical deficiencies at that time, prior to the decision becoming final. If the claimant responds, the process would continue so as

---

667. Any substantial communications on the merits of a claim would have to be documented in the file. This type of consultation would be, in effect, an extension of the development function for medical staff relative to the explanation and clarification of medical evidence. *See generally* text accompanying notes 531-47, *supra*.

668. This certification should include a sufficient basis for agreement to indicate that the certification was made on the basis of an independent review.

669. As this would be a final program decision based on a particularly full record, this administrator would not have to be a doctor. Moreover, because of earlier reviews by doctors, further consultation with a medical expert would in most cases be unnecessary.

to incorporate any new information provided. Otherwise, the decision would become final, subject to review at an administrative hearing.[670]

Appeal

There would be no medical decisionmakers on appeal.[671] Accordingly, every effort should be made to address medical issues at the initial decision level. Although claimants would not be precluded from supplementing the record on appeal, or even from raising a new medical basis for disability, they would be strongly encouraged to submit all relevant evidence at the agency level. This would be accomplished first through the formal mechanism discussed above for communicating to claimants the basis for an unfavorable decision prior to the decision becoming final and providing them an opportunity to supplement the record.[672] Second, if a new basis for disability is raised on appeal or if a substantial amount of evidence available at the time the original decision was made is submitted on any medical issue, the administrative law judge would have the discretion to remand the claim for development and new decision by the agency.[673]

---

670. With such a complete process in place, there would be no need for a second agency evaluation on reconsideration.

671. Medical consultants would be available on appeal, although on a limited basis. *See* text accompanying notes 538-44, *supra*.

672. There would also be a review of the file by the medical staff at the agency before sending the file up on an appeal.

673. Guidelines would have to be developed for remands on this basis in order to avoid unnecessary delay.

V. RECOMMENDATIONS

A number of recommendations for more effective use of medically-trained personnel in Social Security disability determinations can be derived from the models outlined in Part IV of this report. The attempt here will be to present separately those recommendations with the broadest implications for the use of medical staff in the disability determination process. The models themselves can be referred to for details and related suggestions for implementation.

Recommendation #1: The Social Security Administration Should Enhance the Decision-Making Role of Permanent Medical Staff at the Initial Decision Level

The Social Security Administration should continue to require that medical staff be included on two-member teams for purposes of determining disability at the initial decision level.[674] The medical member should be a licensed physician or psychologist, working for the agency on a regular, full-time or part-time basis.[675] All medical staff must be fully trained on legal and program issues, and should work under the supervision of a chief medical officer with significant status and independence in the agency.

The medical member of the team should be given primary responsibility for developing the medical evidence and resolving certain specified medical issues.[676] The two members of the team should work together throughout the process; however, each should be responsible for an independent, albeit coordinated, review of the claim.

Recommendation #2: Medical Staff Should Be Responsible for Developing All Relevant Medical Evidence at a Single Initial Decision; Reconsideration Should be Eliminated

Additional staff and funds should be made available in order to assure that a complete record of all evidence relevant to a disability claim is obtained before an initial decision is made on the claim. The medical member of the team assigned to the claim should be responsible for the development of the medical evidence, including compiling existing evidence, obtaining supplemental evidence and providing necessary explanations of unusual or complex medical material.[677] Whenever possible, the medical members should be assigned direct responsibility for evaluating the adequacy of reports from physicians and for following up with requests for clarification or additional information from these sources. Specially trained support staff, including non-medical personnel and nurses, should be available to assist the medical member in performing these tasks.

Claimants should be informed specifically of any apparent deficiencies in the medical evidence that could lead to an adverse determination. This notice should be prepared by the medical member and should encourage the claimant to provide additional information and explanation, as needed. The notice should also state that the agency will assist claimants in obtaining this information when they are unable to do so on their own due to financial or other constraints. As part of this process, either the

---

674. A more limited recommendation for the use of medical staff on appeals is discussed separately as Recommendation #6.

675. There is no clear advantage to full-time or part-time medical staff; experience indicates that there are advantages and disadvantages -- including cost considerations -- to both. In any event, funds should be made available for programs to hire fully competent medical staff, whether full-time or part-time.

676. These responsibilities are discussed separately as Recommendations #2 and #3.

677. Suggestions for improvements in the quality of evidence are discussed separately as Recommendation #4.

claimant or the medical member should have the authority to require a face-to-face interview with the claimant.

Although reasonable time limits for this process can be imposed, a sufficient amount of time must be allocated in order to allow for complete development. Once a final decision is made on the basis of such a record, there would be no need for a second agency review of the initial decision; therefore, the separate reconsideration evaluation should be eliminated.

Recommendation #3: Certain Issues Should Be Set Aside for Special Decision by Medical Staff

The Social Security Administration should develop a list of discrete issues raised by the applicable disability standards that are appropriate for separate decision by medical staff. When an individual claim raises one of these issues, the medical member of the team assigned to the claim should develop all evidence relevant to the issue and decide the issue. This process would cover a sub-category of issues that may or may not be involved in any particular claim.

The Administration should consider carefully which issues are suited for special decision by medical staff. It is not clear, for example, that the present policy of requiring medical staff to make Residual Functional Capacity assessments should be continued. On the other hand, more technical issues, such as whether a claimant meets the criteria set out in the Listing of Impairments, probably should be left to the medical member alone.

Recommendation #4: Medical Sources Should Be Used More Effectively to Provide Evidence of Disability

The Social Security Administration should take advantage of every opportunity to use medical sources to provide evidence in disability adjudications. Guidelines should be established which identify priorities for the use of treating physicians, examining physicians and nonexamining physicians, including specialists, for these purposes.[678] These guidelines should take into account the nature of the various medical questions raised by the disability standard as well as the different qualities each type of medical source brings to the process.[679] All contacts with medical sources relating to the determination of disability for a particular claim should be documented routinely in writing and included in the record.

Implementation of these guidelines should be supported with adequate funds and training for the physicians asked to provide medical information. A system for quality control should be put in place, with respect to both selection of physicians and the reports submitted.[680] Selection and evaluation should be done by medical staff independent from the agency staff responsible for making disability decisions.

Recommendation #5: Medical Staff Should

678. Regulations were proposed in 1987 which would address many of these issues. *See* 52 Fed. Reg. 13,014 (1987). However, these regulations have not been published in final form.

679. Thus, certain types of medical information may be more suited for reports from treating physicians while other types may require reports from specialists.

680. Quality control should take into account a number of factors in addition to professional competence, including independence, thoroughness, responsiveness and timeliness.

Be Used to Resolve Conflicts on Medical Issues at the Initial Decision Level

Medical personnel should be used to resolve any conflicts on medical issues that arise in the course of team evaluations of disability at the initial decision level. Senior medical staff should have the authority to review claims where the team members are unable to agree and to recommend further action, including the development of additional medical evidence, in order to resolve the conflict. If the conflict persists, a designated senior medical staff member should have the authority to decide the medical issue in dispute. As part of this process, independent medical experts, or panels of experts, should be identified and retained for use as examining and non-examining consultants, as appropriate.

Recommendation #6: Medical Consultants Should be Available on Appeals

Administrative law judges should be encouraged to call on independent medical experts in appropriate cases to assess the need for any additional medical evidence and to explain or clarify medical evidence in the record. They should be used only rarely, in cases involving unusual or complex medical information.[681] Communication with medical experts can be through oral testimony at the hearing or in writing; however, if the communication is in writing, the judge must assure that the claimant's right to cross-examine the expert is not abridged. Also, all information and opinions provided by medical experts must be included in the record.

681. Implementation of the other recommendations in this report will reduce significantly the need for medical consultants on appeals.