OFFICE OF
THE INSPECTOR GENERAL

SOCIAL SECURITY ADMINISTRATION

DISABILITY IMPAIRMENTS ON CASES MOST FREQUENTLY DENIED BY DISABILITY DETERMINATION SERVICES AND SUBSEQUENTLY ALLOWED BY ADMINISTRATIVE LAW JUDGES

August 2010 **A-07-09-19083**

AUDIT REPORT

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SOCIAL SECURITY

MEMORANDUM

Date: August 20, 2010 Refer To:

To: The Commissioner

From: Inspector General

Subject: Disability Impairments on Cases Most Frequently Denied by Disability Determination Services and Subsequently Allowed by Administrative Law Judges (A-07-09-19083)

OBJECTIVE

The objective of our review was to identify the impairments of initial disability cases[1] most frequently allowed at the Office of Disability Adjudication and Review's (ODAR) hearing level and evaluate the characteristics of these cases.

BACKGROUND

The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Disability Insurance program under Title II of the *Social Security Act* (Act) and the Supplemental Security Income program under Title XVI of the Act. Disability claims are initially processed through a network of SSA field offices and State disability determination services (DDS). DDSs are responsible for developing medical evidence and making the initial determination on whether a claimant is legally disabled or blind.

A person who disagrees with an initial determination may request an appeal. The appeal consists of several levels of administrative review. The levels of review are reconsideration at the DDS and an administrative law judge (ALJ) hearing and Appeals Council review at ODAR.[2] If an individual is still dissatisfied, he or she may request judicial review by filing an action in Federal court.[3]

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[1] We use "initial disability cases" to refer to those cases being decided based on an initial disability application and not those cases being decided based on a continuing disability review.

[2] During our audit period, there were 10 prototype States where the reconsideration level of review was eliminated.

[3] SSA, POMS, GN 03101.001.

A large percentage of appealed denial determinations made by DDSs are subsequently allowed at the ALJ hearing level.[4] For our review, we identified the four impairments that were most often denied by DDSs in Calendar Years (CY) 2004 through 2006,[5] appealed to the hearing level, and subsequently allowed (see Table 1).[6]

Table 1
Four Impairments Most Frequently Denied by DDSs and Subsequently Allowed at the Hearing Level

Impairment	Number of DDS Denials	DDS Denial Rate	Number of Hearing Level Allowances	Hearing Level Allowance Rate
Disorders of Back	744,602	78%	238,903	70%
Osteoarthrosis and Allied Disorders	204,652	58%	61,118	70%
Diabetes Mellitus	165,411	81%	38,174	67%
Disorders of Muscle, Ligament, and Fascia	138,905	80%	34,693	65%

RESULTS OF REVIEW

We analyzed information available in SSA's systems to identify characteristics of cases with the four impairments most frequently denied by DDSs and, on appeal, subsequently allowed at the hearing level. Our analysis disclosed factors that impacted disability determinations at both the DDS and hearing levels.

- Claimant age impacted disability determinations at both the DDS and hearing levels.
- Determinations of claimants' ability to work resulted in differences at the DDS and hearing levels.
- Claimant representation was more prevalent in cases allowed at the hearing level than in cases decided at the DDS level.
- Cases were allowed at the hearing level based on a different impairment than that on which the DDS made its determination.
- States had both DDS denial rates and hearing level allowance rates above the national averages.

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[4] Hearing level allowance rates ranged from 61 to 62 percent in FYs 2006 through 2009.

[5] We identified the final denial decision made at the DDS level during CYs 2004 through 2006 for each impairment. Therefore, if a case was denied initially and at the reconsideration level during CYs 2004 through 2006, we included the case as a DDS denial. However, if a case was denied initially and allowed at the reconsideration level during CYs 2004 through 2006, we did not include the case in our analysis. Finally, if a case was denied initially, but the reconsideration determination was made after CY 2006, we included the case as a DDS denial. See Appendix B for the scope and methodology of our review.

[6] We identified hearing dispositions through the end of FY 2008. Therefore, we only analyzed the DDS denials that had a hearing decision by the end of FY 2008.

- ODAR regions, hearing offices, and ALJs had wide variations in allowance rates.[7]

We were not able to determine from our data analysis the extent to which these factors resulted in a large percentage of appealed DDS denials being allowed at the hearing level. We also acknowledge that some hearing level allowances may have been due to other factors. For example, according to SSA, the two main factors that can lead to an allowance at the hearing level are: (1) the claimant's condition worsens after the DDS determination or (2) the claimant obtains additional medical evidence following the DDS determination that supports the alleged disability at the hearing level.[8] For this review, we did not corroborate the impact of these factors on the hearing decision.

Since we could not draw definitive conclusions on all of the factors identified during our analysis, we plan to initiate an audit that will further evaluate the events that occur between the DDS determination and hearing decision. In that audit, we will perform a case review that will evaluate the impact the factors identified in this review had on disability determinations at both the DDS and hearing levels. The review will require the assistance of SSA staff with medical and technical expertise in evaluating the two main factors that SSA claims will lead to an allowance at the hearing level—worsening of the claimant's condition and procurement of additional medical evidence.

AGE OF CLAIMANT

For the four impairments we analyzed, we found claimants allowed at both the DDS and hearing levels were more likely to be age 50 or older.[9] At the DDS level, between 43 and 69 percent of claimants age 50 or older was denied while between 89 and 95 percent of claimants under age 50 was denied (see Table 2). Further, between 76 and 80 percent of all claimants age 50 or older who appealed was allowed at the hearing level for the four impairments we analyzed. However, between 49 and 63 percent of claimants under age 50 who appealed was allowed at the hearing level.

[7] We also performed analysis on additional factors but these factors did not appear to significantly impact hearing level decisions. See Appendix C for the results of our analysis of these factors for the four impairments we analyzed.

[8] When asked, SSA could not provide us with a study that would corroborate these two factors as the main factors leading to an allowance decision.

[9] Analysis is based on the claimant's age in the year of the DDS determination.

Table 2 DDS and Hearing Level Allowances by Age of Claimant					
Impairment	**Age of Claimant**	**Number of DDS Determinations**	**Number of DDS Denials (Denial Rate)**	**Number of Appeals (Appeal Rate)**	**Number of Hearing Level Allowances (Allowance Rate)**
Disorders of Back	Age 50 or Older	433,677	257,574 (59%)	138,617 (54%)	110,311 (80%)
	Under Age 50	516,125	487,028 (94%)	204,253 (42%)	128,592 (63%)
Osteoarthrosis and Allied Disorders	Age 50 or Older	237,566	101,695 (43%)	47,511 (47%)	37,254 (78%)
	Under Age 50	115,371	102,957 (89%)	39,646 (39%)	23,864 (49%)
Diabetes Mellitus	Age 50 or Older	107,771	74,189 (69%)	29,310 (40%)	22,176 (76%)
	Under Age 50	96,320	91,222 (95%)	27,341 (30%)	15,998 (59%)
Disorders of Muscle, Ligament, and Fascia	Age 50 or Older	75,293	46,488 (62%)	21,941 (44%)	16,708 (76%)
	Under Age 50	97,271	92,417 (95%)	31,405 (34%)	17,985 (57%)

SSA policy recognizes that as people get older, it becomes easier for them to meet SSA's disability requirements. Specifically, SSA's policy states that if an individual is age 50 to 54 (closely approaching "advanced age" of 55 or older), age may seriously affect the individual's ability to adjust to other work if the individual also has a severe impairment and limited work experience. Further, SSA considers an "advanced age" will significantly affect a person's ability to adjust to other work, giving special consideration to individuals who are closely approaching age 60.[10]

Although claimants age 50 or older were more likely to be allowed than claimants under age 50 at both the DDS and hearing levels, a large percentage of claimants age 50 or older who were denied by the DDS and appealed was subsequently allowed at the hearing level. We plan to initiate an audit that will further evaluate the impact claimant age has on disability determinations at the DDS and hearing levels. At that time, we will make recommendations, as appropriate.

[10] 20 C.F.R. §§ 404.1563 and 416.963. SSA, POMS, DI 25015.005.A.

DETERMINATIONS OF ABILITY TO WORK

For the four impairments we analyzed, we found that between 81 and 88 percent of claimants allowed at the hearing level was previously denied because the DDS determined the claimants could perform past or other work.[11] However, at the hearing level, it was determined that these claimants could not work.

Adjudicators at both the DDS and hearing levels follow the same regulations for determining claimants' residual functional capacity (RFC), which is used to determine whether the claimants can work.[12] However, at the DDS, disability examiners receive more formal vocational training than ALJs and thus independently determine claimants' RFCs and ability to work.[13] Conversely, at the hearing level, ALJs or attorneys typically obtain assistance from vocational experts when relating claimants' RFCs to available work.[14] In fact, for the four impairments we analyzed, we found 52 to 57 percent of cases allowed at the hearing level involved a vocational expert.

Adjudicators at each level can make differing assessments of a claimant's RFC, which can result in different determinations about the claimant's ability to work. In fact, a large percentage of hearing-level allowances was for claimants DDSs previously determined could work. The audit we plan to initiate will evaluate the reasons for differences in determinations of claimants' ability to work at the DDS and hearing levels. At that time, we will make recommendations, as appropriate.

CLAIMANT REPRESENTATION

SSA could not provide the number of claimants represented at the DDS level. However, according to SSA, claimant representation at the DDS level is infrequent. Conversely, we found that the majority of claimants was represented at the hearing level. In fact, for cases with the four impairments we analyzed, 91 to 94 percent of claimants allowed had representatives at the hearing level.

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[11] In determining whether an individual is disabled, SSA uses a sequential evaluation process where the following conditions are considered in the order listed: (1) current work activity, (2) any severe impairment(s), (3) any impairment(s) that meets or equals the medical listings, (4) ability to do past work, and (5) ability to do other work considering age, education, training, and work experience. 20 C.F.R. §§ 404.1520(a)(4) and 416.920(a)(4). SSA, POMS, DI 22001.001.A.1.

[12] 20 C.F.R. §§ 404.1545-1546 and 416.945-946. RFC is the most a claimant can do despite physical or mental limitations that may affect what individuals can do in a work setting.

[13] Disability examiners can obtain opinions from vocational specialists, but these are typically only used on more complicated cases. SSA does not have an estimate of the number of DDS determinations that involved the use of a vocational specialist.

[14] HALLEX I-2-5-50. The audit we plan to initiate will also evaluate the impact of the RFC on disability determinations at both the DDS and hearing levels.

Individuals claiming benefits under the Act may appoint an attorney or other qualified individual to represent them to SSA.[15] According to ODAR, claimant representation may correlate to hearing level allowances. This may occur because representatives

- assist claimants in developing medical evidence;
- pre-screen applicants to identify cases likely to receive allowance decisions;
- are skilled at noticing additional impairments, especially mental impairments, that may not have been alleged at the DDS level; and
- ensure claimants stay focused at hearings.

Many claimants find it necessary to secure representation at the hearing level to continue through SSA's complicated disability process. In fact, a recent Allsup survey found that 78 percent of claimants experienced barriers to handling the disability process on their own.[16] Those barriers included reading, understanding, and completing forms. However, 35 percent of claimants surveyed stated SSA did not inform them that claimant representation was available at the DDS level.

If claimants with the four impairments we analyzed had representatives earlier in the disability process, some of them may have received an allowance decision at the DDS level, saving them time and SSA money. First, the claimants may not have had to go to the hearing level if they had representatives to assist them with completing SSA's forms and providing the necessary evidence at the DDS level. This could have saved some claimants about 500 days in receiving an allowance decision.[17] In addition, a rightful allowance at the DDS level would save SSA costs at the hearing level.

According to SSA, approximately 70 percent of all claimants allowed disability benefits for all impairments was allowed at the DDS level, and the majority of those claimants was allowed without the assistance of representation. However, when analyzed individually, three of the four impairments we analyzed had between 46 and 50 percent of all allowances made at the DDS level.[18] Therefore, claimant representation may have been beneficial to these claimants earlier in the disability process.

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[15] HALLEX I-1-1-1, 20 C.F.R. §§ 404.1700 and 416.1500. SSA, POMS, GN 03910.010.

[16] Allsup is a nation-wide company that acts as a third-party representative to claimants applying for SSA benefits. Allsup's September 2009 survey was based on responses from 296 individuals who had been awarded disability benefits, with Allsup as their representative, after being denied benefits when applying without a representative (see http://www.allsup.com/portals/4/allsup-claimant-survey-results-final.pdf).

[17] Average processing time at the hearing level ranged from 483 to 514 days in FYs 2006 through 2009.

[18] Approximately 71 percent of all claimants allowed disability benefits for Osteoarthrosis and Allied Disorders was allowed at the DDS level.

While SSA is required to notify claimants about the options for attaining representation,[19] some claimants were not informed at the DDS level. In addition, SSA indicated obtaining claimant representation at the DDS level is difficult because the financial incentive for representatives who collect fees is less at the DDS level than at the hearing level.[20] Finally, since SSA does not maintain the number of claimants at the DDS level with representation, SSA cannot substantiate whether representation at the DDS level would result in earlier allowances. Therefore, we recommend SSA collect information related to claimant representation at the DDS level to determine whether representation results in earlier allowances. Based on the results of that assessment, SSA should determine whether additional efforts are needed to ensure claimants are made aware that claimant representation is available at the DDS level.

DIFFERENT IMPAIRMENT AT ODAR

We found many cases with the four impairments we analyzed were allowed at the hearing level based on a different impairment than the DDS made its determination on.

- Disorders of Back – 21 percent of hearing level allowances was based on a different impairment.[21]
- Osteoarthrosis and Allied Disorders – 50 percent of hearing level allowances was based on a different impairment.[22]
- Diabetes Mellitus – 47 percent of hearing level allowances was based on a different impairment.[23]
- Disorders of Muscle, Ligament, and Fascia – 64 percent of hearing level allowances was based on a different impairment.[24]

At the DDS level, the DDS identifies the claimant's primary and, in some cases, secondary impairment. In our analysis, we expected to see that the impairment may change from the primary impairment to the secondary impairment identified at the DDS

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[19] SSA, POMS, GN 03910.030. According to SSA, the requirement to notify claimants about representation is limited to field office employees. State DDS employees are under no legal requirement to inform claimants about representation.

[20] 20 C.F.R. § 404.1730(b). SSA pays representatives up to 25 percent of claimants' past-due benefits.

[21] Of the hearing level allowances based on an impairment other than Disorders of Back, 27 percent was allowed based on Affective/Mood Disorders.

[22] Of the hearing level allowances based on an impairment other than Osteoarthrosis and Allied Disorders, 38 percent was allowed based on Disorders of Back.

[23] Of the hearing level allowances based on an impairment other than Diabetes Mellitus, 16 percent was allowed based on Disorders of Back.

[24] Of the hearing level allowances based on an impairment other than Disorders of Muscle, Ligament, and Fascia, 28 percent was based on Disorders of Back.

level. However, for at least 70 percent of the cases allowed at the hearing level based on a different impairment, the impairment was not changed to the secondary impairment (see Table 3). For example, for cases with Osteoarthrosis and Allied Disorders allowed based on a different impairment, 79 percent of the hearing level allowances was based on impairments not identified at the DDS level as a primary or secondary impairment.

Table 3
Cases Allowed Based on Impairments Not Identified at the DDS Level

Impairment	Number Allowed Based on Different Impairment	Number Allowed Based on Impairment Not Identified at the DDS Level	Allowed Based on Impairment Not Identified at the DDS Level
Disorders of Back	50,237	35,249[25]	70%
Osteoarthrosis and Allied Disorders	30,827	24,275[26]	79%
Diabetes Mellitus	18,054	13,698[27]	76%
Disorders of Muscle, Ligament, and Fascia	22,281	17,459[28]	78%

For the cases where the impairment changed to an impairment that had not been identified at the DDS level, we identified cases where the impairment was changed from one of the four physical impairments to a mental impairment. For example, in at least 5 percent of the cases, the impairment changed to Affective/Mood Disorders (see Table 4).[29] According to SSA, there is a correlation between depression and chronic pain, which may be present in the impairments we identified. Further, SSA stated that multiple denials and a lengthy appeals process can cause or add to a person's depression.

[25] Of the 35,249 cases denied at the DDS level based on Disorders of Back but allowed at the hearing level based on an impairment not identified at the DDS level, 17 percent was allowed based on Osteoarthrosis and Allied Disorders.

[26] Of the 24,275 cases denied at the DDS level based on Osteoarthrosis and Allied Disorders but allowed at the hearing level based on an impairment not identified at the DDS level, 39 percent was allowed based on Disorders of Back.

[27] Of the 13,698 cases denied at the DDS level based on Diabetes Mellitus but allowed at the hearing level based on an impairment not identified at the DDS level, 16 percent was allowed based on Disorders of Back.

[28] Of the 17,459 cases denied at the DDS level based on Disorders of Muscle, Ligament, and Fascia but allowed at the hearing level based on an impairment not identified at the DDS level, 28 percent were allowed based on Disorders of Back.

[29] Affective/Mood Disorder is defined as an emotional disorder involving abnormal highs and/or lows in mood.

Table 4 Cases Allowed Based on Affective/Mood Disorders Not Identified at the DDS Level			
Impairment	**Number Allowed Based on Impairment Not Identified at the DDS Level**	**Number Allowed Based on Affective/Mood Disorders That Was Not Identified at the DDS Level**	**Allowed Based on Affective/Mood Disorders That Was Not Identified at the DDS Level**
Disorders of Back	35,249	4,247	12%
Osteoarthrosis and Allied Disorders	24,275	1,219	5%
Diabetes Mellitus	13,698	927	7%
Disorders of Muscle, Ligament, and Fascia	17,459	1,010	6%

According to SSA, the four impairments we analyzed are degenerative in nature, which can result in increased pain over time and can also affect the functioning of other body systems, resulting in a change in impairment at the hearing level. SSA offered the following additional reasons allowance decisions may be made at the hearing level based on different impairments.

- The impairments were not evident in the file when the DDS made the determination.
- The impairments may have been new or first alleged at the hearing level.
- The impairments were alleged at the DDS level, but may have worsened over time or more evidence became available.

This review did not determine why a large percentage of claimants denied at the DDS level was subsequently allowed at the hearing level based on a different impairment. However, our future audit will determine why hearing level decisions are being made based on different impairments than the DDS determinations. At that time, we will make recommendations, as appropriate.

STATE

We identified six States with DDS denial rates greater than the national averages and hearing level allowance rates greater than the national averages for all four impairments we analyzed (see Table 5).[30] For example, 80 percent of claimants in Tennessee alleging Osteoarthrosis and Allied Disorders was denied at the DDS level while DDSs nationwide denied on average 58 percent of the claimants with this impairment.[31] In

[30] Analysis was based on the State of the servicing field office. Although this may not be the same State as the claimant's residence or the DDS making the initial disability determination, we expect any differences to be immaterial.

[31] See Table 1 for the national average DDS denial rate and hearing level allowance rate for each impairment.

addition, of the claimants from Tennessee alleging this impairment who appealed, 81 percent was allowed at the hearing level while, on average, 70 percent of claimants with this impairment was allowed at the hearing level.

Table 5
States with DDS Denial Rates and Hearing Level Allowance Rates Greater Than the National Averages by Impairment

State	Disorders of Back		Osteoarthrosis and Allied Disorders		Diabetes Mellitus		Disorders of Muscle, Ligament, and Fascia	
	DDS Denial Rate	Hearing Level Allowance Rate	DDS Denial Rate	Hearing Level Allowance Rate	DDS Denial Rate	Hearing Level Allowance Rate	DDS Denial Rate	Hearing Level Allowance Rate
Alabama	85%	80%	65%	80%	92%	73%	87%	73%
Georgia	88%	74%	77%	76%	91%	74%	90%	69%
Illinois	82%	76%	62%	77%	82%	76%	84%	73%
North Carolina	87%	72%	71%	73%	90%	72%	92%	69%
South Carolina	90%	75%	76%	76%	91%	72%	91%	71%
Tennessee	92%	78%	80%	81%	92%	78%	90%	78%

According to SSA, the percent of claimants who appeal the DDS denial is also an important factor to consider. Of the six States with higher than average DDS denial rates and hearing level allowance rates, Alabama and Tennessee consistently had higher than average appeal rates for each of the four impairments.[32] For example, 54 percent of the claimants in Tennessee appealed the DDS denial for Osteoarthrosis and Allied Disorders. However, on average, 47 percent of claimants denied at the DDS level with this impairment appealed the denial. Although the remaining four States had appeal rates lower than average, we were unable to determine the impact appeal rates had on hearing level allowance rates.[33]

SSA stated it did not have a methodology to identify unique circumstances in these States that would explain higher than average DDS denial rates and subsequent higher than average hearing level allowance rates. However, according to an SSA study, variations in allowance rates may be related to economic and demographic differences

[32] Alabama is a prototype state where appeals are made directly to the hearing level and bypass the reconsideration step. According to SSA, prototype States have higher appeal rates than non-prototype States.

[33] Of the six States with higher than average DDS denial rates and hearing level allowance rates, five States are in the Atlanta Region. In FYs 2005 and 2006, DDS accuracy rates for initial DDS determinations in the Atlanta Region were 93.4 and 93.0 percent, respectively. The national averages for the same period were 93.5 and 93.4 percent, respectively. Accuracy rates for FY 2004 are no longer available by Region.

among States.[34] In addition, SSA stated that allowance rates may vary based on the rates of filing for Title II and Title XVI benefits since each program has varying allowance rates.[35] Finally, SSA stated it is reasonable that a higher denial rate at the DDS level resulted in higher allowance rates at the hearing level since the impairments we analyzed are degenerative in nature. Therefore, the record reviewed at the hearing level is often not the same record reviewed at the DDS level.

We recommend SSA consider conducting a targeted review of disability determinations made in these six States for the four impairments we analyzed. The review should determine whether circumstances exist that explain why DDSs in these six States denied a higher than average percent of claimants and, upon appeal, the hearing offices subsequently allowed a higher than average percent of the claimants.

LOCATION OF HEARING OFFICE AND ALJ

We identified the ODAR regions with the highest allowance rates for the four impairments we analyzed. Specifically, we found

- the Boston Region had the highest allowance rates for Disorders of Back and Disorders of Muscle, Ligament, and Fascia;
- the Atlanta Region had the highest allowance rate for Osteoarthrosis and Allied Disorders; and
- the Seattle Region had the highest allowance rate for Diabetes Mellitus.

In fact, these are the only 3 of ODAR's 10 regions with allowance rates greater than the national averages for all four of the impairments.[36] For example, hearing offices in the Seattle Region had an average allowance rate of 74 percent for cases with Diabetes Mellitus while hearing offices nationwide allowed an average of 67 percent of cases with this impairment.

In addition, we identified a wide variance in allowance rates among hearing offices (see Table 6). For example, one hearing office in the Chicago Region had an allowance rate of 83 percent for cases with Disorders of Back, but another hearing office in the Chicago Region had an allowance rate of 45 percent for cases with the same impairment.

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[34] SSA Office of Policy, Office of Research, Evaluation, and Statistics; *Social Security Disability Programs: Assessing the Variation in Allowance Rates* (ORES Working Paper Series Number 98) p. 18 August 2002. This report does not specify the economic or demographic differences that may have resulted in certain States having higher than average DDS denial rates and hearing level allowance rates (see http://ssa.gov/policy/docs/workingpapers/wp98.pdf).

[35] In the audit we plan to initiate, we will also evaluate the impact differences in filing rates for Title II and Title XVI impact disability determinations at both the DDS and hearing levels.

[36] See Appendix D for hearing office allowance rates by region for ODAR's 10 regions.

Table 6 Range of Hearing Office Allowance Rates by Region and Impairment[37]								
Region	Disorders of Back		Osteoarthrosis and Allied Disorders		Diabetes Mellitus		Disorders of Muscle, Ligament, and Fascia	
	High	Low	High	Low	High	Low	High	Low
Boston	84%	59%	83%	55%	84%	60%	80%	57%
New York	84%	51%	79%	51%	75%	48%	84%	51%
Philadelphia	83%	50%	87%	55%	88%	50%	83%	48%
Atlanta	87%	57%	85%	59%	85%	55%	83%	58%
Chicago	83%	45%	84%	53%	81%	58%	80%	57%
Dallas	78%	46%	80%	43%	79%	43%	75%	46%
Kansas City	81%	55%	82%	55%	76%	56%	74%	47%
Denver	76%	61%	80%	60%	81%	62%	65%	54%
San Francisco	82%	49%	81%	54%	84%	47%	78%	42%
Seattle	84%	66%	82%	66%	80%	66%	80%	61%

In addition to a wide variance in allowance rates by hearing office, there was an even greater variance in allowance rates by ALJ. For example, one ALJ allowed 97 percent of his cases with Disorders of Back while another ALJ only allowed 15 percent of his cases with the same impairment. In fact, for each impairment we analyzed, at least 27 percent of ALJs had allowance rates of 80 percent or higher while at least 9 percent of ALJs had allowance rates of 50 percent or lower (see Table 7).

Table 7 ALJ Allowance Rates by Impairment[38]			
Impairment	Number of ALJs	Percent of ALJs with Allowance Rates:	
		0 - 50%	80 - 100%
Disorders of Back	1,095	14%	27%
Osteoarthrosis and Allied Disorders	231	9%	37%
Diabetes Mellitus	55	16%	44%
Disorders of Muscle, Ligament, and Fascia	64	11%	33%

Such variances in allowance rates among hearing offices and ALJs do not appear to support other factors that SSA stated may contribute to hearing level allowances for these impairments, such as the worsening of the condition over time or increased medical evidence. Specifically, if these factors were prevalent, it is reasonable to expect to see more consistent allowance rates among all hearing offices and ALJs.

[37] The hearing offices in Table 6 processed at least 100 cases for each impairment. See Appendix D for the number of cases processed by hearing office for each impairment.

[38] For each impairment, we reviewed the ALJs who processed at least 100 cases to ensure the ALJs processed a sufficient number for accurate analysis.

According to SSA, there are too many competing factors to draw accurate conclusions about variances in allowance rates among hearing offices and ALJs. For example, SSA stated cases that involve the same impairment will never involve the same evidence, testimony, or findings. We are not suggesting that the variances in allowance rates among hearing offices and ALJs resulted in inaccurate hearing level decisions. Further, we recognize that cases are unique. However, we believe the variances in allowance rates among hearing offices and ALJs are significant enough to warrant a recommendation that SSA consider analyzing these variances to determine whether competing factors are present that support the variances.[39]

ADDITIONAL IMPAIRMENTS OFTEN ALLOWED AT HEARING LEVEL

To achieve the objective of our review, we identified the four impairments that were most often denied by DDSs in CYs 2004 through 2006 and, on appeal, subsequently allowed at the hearing level. However, in our analysis, we also identified 27 impairments where at least 80 percent of appealed cases was allowed at the hearing level (see Table 8). Approximately 2 percent of all cases appealed to the hearing level had 1 of these 27 impairments.

Table 8
Impairments with 80 Percent or Greater Hearing Level Allowance Rates

Impairment	Number of DDS Determinations	DDS Denial Rate	Hearing Level Allowance Rate
Salmonella Bacteremia	13	62%	100%
Pancreatitis	9	89%	100%
Strongyloidiasis	7	29%	100%
Cardiovascular Syphilis	105	50%	94%
Squamous Cell Carcinoma of the Anal Canal or Anal Margin	228	34%	92%
Malignant Neoplasm of Pleura	2,672	3%	91%
Parkinson's Disease	12,359	22%	89%
Multiple Myeloma	6,530	12%	88%
Malignant Neoplasm of Gallbladder and Extrahepatic Bile Ducts	1,240	3%	88%
Secondary Malignant Neoplasm	1,096	2%	88%
Malignant Neoplasm of Small Intestine	1,896	15%	87%
Liver Transplant	1,440	20%	86%
Malignant Neoplasm of Trachea, Bronchus, or Lung	60,516	5%	85%
Macroglobulinemia or Heavy Chain	156	58%	84%

[39] In December 2009, SSA's Office of Quality Performance implemented an ongoing review of ALJ decisions. This review consists of a national random sample of 600 allowances and 600 denials per year, and includes an analysis of the factors that contribute to allowances at the hearing level. However, the review is not limited to hearing offices or ALJs with exceptionally high or low allowance rates. In addition, the review is not limited to cases with the impairments most frequently denied by DDSs and allowed at the hearing level upon appeal.

Table 8 Impairments with 80 Percent or Greater Hearing Level Allowance Rates			
Impairment	**Number of DDS Determinations**	**DDS Denial Rate**	**Hearing Level Allowance Rate**
Disease			
Multiple Sclerosis	42,614	47%	84%
Neuroblastoma	1,527	10%	83%
Malignant Neoplasm of Colon, Rectum, or Anus	35,825	26%	82%
Malignant Neoplasm of Maxilla, Orbit, or Temporal Fossa	3,649	18%	82%
Kaposi's Sarcoma	142	17%	82%
Leukemia	17,959	13%	82%
Malignant Neoplasm of Skeletal System	1,502	19%	81%
Malignant Neoplasm of Prostate	10,174	41%	80%
Chronic Renal Failure	69,836	10%	80%
Malignant Neoplasm of Stomach	5,830	9%	80%
Anterior Horn Cell Disease (including Amyotrophic Lateral Sclerosis)	4,661	1%	80%
Malignant Neoplasm of Bladder	4,896	25%	80%
Peripheral Vascular (Arterial) Disease	28,325	29%	80%

The majority of these impairments involve Human Immunodeficiency Virus or cancer impairments, and the remaining impairments are neurological. According to SSA, the high hearing level allowance rates may have resulted because these types of impairments worsen over time, and medical evidence may not have been available at the time of the DDS' determination.

We did not evaluate the characteristics of cases with these 27 impairments as we did for cases with the 4 impairments most frequently denied by DDSs and allowed at the hearing level. Therefore, we are not making recommendations pertaining to these 27 impairments. However, given the high rate of allowances at the hearing level for these impairments, we are presenting this information for any action SSA deems appropriate.

CONCLUSIONS AND RECOMMENDATIONS

Of cases that were appealed to the hearing level, over 60 percent was allowed in recent years. We acknowledge that there are factors that could result in this scenario. For example, a claimant's condition can deteriorate such that it meets SSA's definition of a severe impairment at the hearing level when it did not at the DDS level.

The SSA components we interviewed stated that disability decisions at the DDS and hearing levels are made following the same policies. However, as outlined in this

report, there are differences in the way these levels apply the policies. For example, DDS adjudicators receive more formal vocational training than ALJs and thus typically make determinations of ability to work independently. However, ALJs at the hearing level often obtain the opinions of vocational experts to make determinations on claimants' ability to work.

In this review, we identified factors of the four impairments most frequently denied by DDSs and, on appeal, subsequently allowed at the hearing level that, either alone or in combination, may impact hearing level decisions. SSA also offered additional reasons for differences in disability decisions, such as worsening of the claimant's condition and procurement of additional medical evidence. However, SSA could not provide us with any studies that support these reasons.[40] Given the wide differences between the DDS and hearing level decisions, we plan to conduct additional work to identify the underlying causes for these differences.

Based on the results of our analysis in this review, we recommend SSA:

1. Collect information related to claimant representation at the DDS level to determine whether representation results in more allowances at the DDS level. Based on the results of that assessment, determine whether additional efforts are needed to ensure claimants are made aware of the availability of claimant representation at the DDS level.

2. Consider conducting a targeted review of disability determinations made in the six States we identified as having higher than average DDS denial rates and hearing level allowance rates for the four impairments we analyzed.

3. Consider analyzing variances between the hearing offices and ALJs with high and low allowance rates for the four impairments we analyzed to determine whether factors are present that support the variances.

AGENCY COMMENTS

SSA agreed with our recommendations. The Agency's comments are included in Appendix E.

Patrick P. O'Carroll, Jr.

[40] SSA has launched the Integrated Disability Process, the purpose of which is to identify differences and difficult areas of disability policy and procedures across adjudicatory components. However, the Integrated Disability Process does not address any of the factors we identified in this report.

Appendices

Acronyms

Act	*Social Security Act*
ALJ	Administrative Law Judge
C.F.R.	Code of Federal Regulations
CPMS	Case Processing and Management System
CY	Calendar Year
DDS	Disability Determination Services
HALLEX	Hearings, Appeals, and Litigation Law Manual
ODAR	Office of Disability Adjudication and Review
ODD	Office of Disability Determinations
POMS	Program Operations Manual System
RFC	Residual Functional Capacity
SSA	Social Security Administration

Scope and Methodology

To accomplish our audit objective, we:

- Reviewed applicable Federal laws and regulations; the Hearings, Appeals, and Litigation Law Manual; and Program Operations Manual System related to the disability determination process as executed by disability determination services (DDS) and administrative law judges (ALJ).

- Reviewed prior Office of the Inspector General, Government Accountability Office, and Social Security Advisory Board reports related to the disability determination process.

- Obtained data extracts of DDS determinations and hearing dispositions.

    - Obtained a data extract from the SSA-831 file of 7.7 million DDS determinations made during Calendar Years (CY) 2004 through 2006. This included all (1) initial allowance determinations; (2) reconsideration determinations; and (3) initial denial determinations not appealed to, and decided at, the reconsideration level during CYs 2004 through 2006.[1] For the purposes of this review, we use "initial disability determinations" to refer to determinations made on initial disability applications and not determinations made on continuing disability reviews.

    - Obtained a data extract from the Office of Disability Adjudication and Review's (ODAR) Case Processing and Management System (CPMS) of 3.3 million cases decided at the hearing level or pending a hearing decision between December 27, 2003[2] and September 24, 2008.[3]

- Identified the DDS denials appealed to ODAR.

    - Of the 7.7 million DDS determinations, identified 4.7 million denials (61 percent).

[1] These 7.7 million determinations were the final determination made on any case during CYs 2004 through 2006. For example, if a case was denied initially and a reconsideration decision was made during CYs 2004 through 2006, the case is included once in the 7.7 million determinations. Further, if a case was denied initially and a reconsideration decision was not made during CYs 2004 through 2006 or the reconsideration level was not applicable, the initial denial is included in the 7.7 million determinations.

[2] December 27, 2003 was the beginning of ODAR's January 2004 reporting cycle.

[3] September 24, 2008 was the date the data were extracted from CPMS.

- Matched the 4.7 million DDS denials to the 3.3 million CPMS cases and identified 1.6 million DDS denials appealed to ODAR (35 percent of DDS denials):[4]

  - 530,774 denials (32 percent) were either denied or dismissed at the hearing level;
  - 946,280 denials (58 percent) were allowed at the hearing level; and
  - 161,282 denials (10 percent) were pending a hearing decision.

- Identified the impairments on cases with (1) at least 1,000 DDS denials, (2) a DDS denial rate of at least 50 percent, and (3) an allowance rate at the hearing level of at least 60 percent. Of the impairments that met these criteria, we identified the top four impairments appealed to the hearing level (see Table B-1). There were 372,888 denials on cases with these 4 impairments allowed at the hearing level, which accounted for 39 percent of all 946,280 DDS denials allowed at the hearing level.

Table B-1
Four Impairments Most Frequently Denied by DDSs and Subsequently Allowed at the Hearing Level

Impairment	Number of DDS Denials	DDS Denial Rate	Number of Hearing Level Allowances	Hearing Level Allowance Rate
Disorders of Back	744,602	78%	238,903	70%
Osteoarthrosis and Allied Disorders	204,652	58%	61,118	70%
Diabetes Mellitus	165,411	81%	38,174	67%
Disorders of Muscle, Ligament, and Fascia	138,905	80%	34,693	65%

- Interviewed officials in ODAR and the Offices of Disability Determinations (ODD) and Disability Programs to obtain information on the factors related to high ODAR allowance rates.

- Analyzed cases with the four impairments we identified above to determine the impact certain factors had on hearing level decisions.

- Identified 27 impairments with allowance rates of 80 percent or higher at the hearing level.

[4] We identified hearing dispositions through the end of FY 2008. Therefore, we did not analyze cases denied at the DDS level that did not have a hearing decision by the end of FY 2008. Further, we did not analyze the outcome of any cases beyond the hearing level.

The entities reviewed were ODD and ODAR. Our work was conducted at the Office of Audit in Kansas City, Missouri, from February 2009 through January 2010. We determined the data used in this report were sufficiently reliable given the review objective and their intended use. We conducted our audit in accordance with generally accepted government auditing standards.

Additional Factors Analyzed

Based on our analysis, the factors below did not appear to significantly impact hearing level decisions for the four impairments we analyzed.[1] We acknowledge that these factors may have contributed to some allowances, but we did not identify apparent correlations between these factors and hearing level allowances.

- Number of days between the disability determination services (DDS) and hearing level determinations.
- Change in age category.
- Education level of the claimant.
- Determinations of disability onset.
- Number of years the claimant worked.
- Purchase of evidence at the DDS level.
- Consultative examination at the DDS level.
- Specialty of the reviewing physician at the DDS level.
- Medical expert at the hearing level.

Number of Days Between DDS and Hearing Level Determinations

We found that more time elapsing between the DDS and hearing level determinations did not contribute to an allowance at the hearing level. Specifically, for the four impairments we analyzed, the average number of days between the date of the DDS determination and the date of the hearing level decision was

- 502 to 515 days for claimants allowed at the hearing level and
- 571 to 581 days for claimants denied or dismissed at the hearing level.

Change in Age Category

According to the Social Security Administration (SSA), because of long wait times at the hearing level, claimants may reach an older age category that would enable them to meet the disability requirements. We found that claimants who were allowed at the hearing level were only slightly more likely to have moved to an older age category by

[1] The four impairments we analyzed were Disorders of Back; Osteoarthrosis and Allied Disorders; Diabetes Mellitus; and Disorders of Muscle, Ligament, and Fascia. See Appendix B for the Scope and Methodology of our review.

the date of the hearing level decision than claimants who were denied at the hearing level.[2] Specifically, for the four impairments we analyzed,

- 17 to 20 percent of claimants allowed at the hearing level reached an older age category by the date of the hearing level decision, and
- 13 to 16 percent of claimants denied at the hearing level reached an older age category by the date of the hearing level decision.

Education Level of Claimant

We found that claimants who were allowed at the hearing level and claimants who were denied or dismissed at the hearing level had similar education levels. Specifically, for the four impairments we analyzed,

- 58 to 65 percent of claimants allowed at the hearing level had 12 years of education or more, and
- 52 to 61 percent of claimants denied or dismissed at the hearing level had 12 years of education or more.

Determinations of Disability Onset

According to SSA, hearing level allowances may result when an administrative law judge determines the claimant became disabled after the date of the DDS denial. However, for the four impairments we analyzed, only 7 to 10 percent of cases allowed at the hearing level was determined to have become disabled after the DDS denial date.

Number of Years Claimant Worked

We found that claimants who were allowed at the hearing level and claimants who were denied or dismissed at the hearing level had comparable years of work activities.[3] Specifically, for the four impairments we analyzed,

- 26 to 29 percent of claimants allowed at the hearing level had worked 15 years or less, and
- 24 to 29 percent of claimants denied or dismissed at the hearing level had worked 15 years or less.

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[2] We identified claimants who turned ages 50, 55, or 60 during the appeals process. These are the minimum ages for the three age categories given special consideration in disability adjudications, according to 20 C.F.R. §§ 404.1563 and 416.963 and SSA, POMS, DI 25015.005.A.

[3] This analysis is based on limited data. Specifically, SSA did not record the number of years worked for over 64 percent of the claimants with the four impairments we analyzed.

Evidence Purchased at the DDS Level

We found that claimants who were allowed at the hearing level were slightly more likely to have had medical evidence purchased at the DDS level than claimants who were denied or dismissed at the hearing level. Specifically, for the four impairments we analyzed,

- 78 to 81 percent of claimants allowed at the hearing level had medical evidence purchased by the DDS, and
- 72 to 75 percent of claimants denied or dismissed at the hearing level had medical evidence purchased by the DDS.

Consultative Examination at the DDS Level

We found that claimants who were allowed at the hearing level and claimants who were denied or dismissed at the hearing level were equally likely to have had a consultative examination at the DDS level. Specifically, for the four impairments we analyzed,

- 29 to 34 percent of claimants allowed at the hearing level had a consultative examination at the DDS level, and
- 31 to 36 percent of claimants denied or dismissed at the hearing level had a consultative examination at the DDS level.

Specialty of Reviewing Physician at the DDS Level

We found that most cases we analyzed were reviewed by a physician who specialized in internal medicine. Further, we found cases that were allowed at the hearing level were slightly more likely to have been reviewed by a physician with this specialty than cases that were denied or dismissed at the hearing level. Specifically, for the four impairments we analyzed,

- 22 to 26 percent of cases allowed at the hearing level were reviewed by a physician with a specialty in internal medicine at the DDS level, and
- 20 to 23 percent of cases denied or dismissed at the hearing level were reviewed by a physician with a specialty in internal medicine at the DDS level.

Medical Expert at the Hearing Level

We found that cases allowed at the hearing level were slightly more likely to have a medical expert involved than cases denied or dismissed at the hearing level. Specifically, for the four impairments we analyzed,

- 10 to 12 percent of cases allowed at the hearing level involved a medical expert, and
- 8 to 10 percent of cases denied or dismissed at the hearing level involved a medical expert.

Hearing Office Allowance Rates by Region

For each of the 4 impairments we analyzed, we identified the hearing office allowance rates for the Office of Disability Adjudication and Review's 10 regions and 142 hearing offices.[1] For allowance rates by impairment, see:

- Disorders of Back – Table D-1
- Osteoarthrosis and Allied Disorders – Table D-2
- Diabetes Mellitus – Table D-3
- Disorders of Muscle, Ligament, and Fascia – Table D-4

Table D-1
Disorders of Back
National Average Allowance Rate – 70%

Location	Number of Dispositions	Number of Allowances	Allowance Rate
Boston Region	**12,436**	**9,489**	**76%**
Regional Office Staff	20	20	100%
Manchester, NH	1,699	1,419	84%
Portland, ME	1,807	1,506	83%
Boston, MA	3,135	2,497	80%
Hartford, CT	1,393	1,093	78%
Springfield, MA	1,731	1,306	75%
New Haven, CT	1,137	755	66%
Providence, RI	1,514	893	59%
New York Region	**30,209**	**21,846**	**72%**
Regional Office Staff	1	1	100%
Jericho, NY	3,127	2,638	84%
Voorhees, NJ	2,323	1,912	82%
Mayaguez, PR	612	487	80%
Brooklyn, NY	1,901	1,507	79%
San Juan, PR	3,322	2,611	79%
Ponce, PR	866	669	77%
Albany, NY	2,524	1,830	73%
Bronx, NY	1,324	929	70%
Newark, NJ	3,023	2,057	68%
Buffalo, NY	2,897	1,927	67%
White Plains, NY	1,784	1,180	66%
New York, NY	2,471	1,629	66%
Syracuse, NY	3,093	1,988	64%
Queens, NY	941	481	51%
Regional Office Staff	1	1	100%

[1] See Appendix B for our methodology for identifying the four impairments we analyzed and the national average allowance rates for each impairment.

Table D-1 Disorders of Back National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Philadelphia Region	**44,089**	**28,887**	**66%**
Charleston, WV	3,277	2,719	83%
Harrisburg, PA	2,718	2,081	77%
Baltimore, MD	3,030	2,289	76%
Huntington, WV	3,452	2,444	71%
Roanoke, VA	3,108	2,159	69%
Washington, D.C.	1,757	1,200	68%
Wilkes-Barre, PA	3,604	2,437	68%
Richmond, VA	1,418	944	67%
Pittsburgh, PA	3,370	2,214	66%
Elkins Park, PA	3,342	2,114	63%
Johnstown, PA	2,098	1,240	59%
Philadelphia, PA	1,988	1,157	58%
Cranberry, PA	312	181	58%
Charlottesville, VA	2,528	1,463	58%
Morgantown, WV	2,168	1,214	56%
Norfolk, VA	1,989	1,041	52%
Philadelphia-E, PA	2,369	1,204	51%
Dover, DE	1,561	786	50%
Atlanta Region	**95,172**	**69,399**	**73%**
Birmingham, AL	4,271	3,713	87%
Greenville, SC	4,050	3,392	84%
Montgomery, AL	1,843	1,511	82%
Kingsport, TN	4,966	4,039	81%
Nashville, TN	3,217	2,588	80%
Chattanooga, TN	3,919	3,138	80%
Macon, GA	2,303	1,811	79%
Atlanta-N, GA	2,637	2,003	76%
Louisville, KY	3,260	2,459	75%
Greensboro, NC	4,018	3,022	75%
Florence, AL	2,336	1,748	75%
Mobile, AL	3,392	2,537	75%
Tampa, FL	5,375	3,957	74%
Paducah, KY	2,246	1,644	73%
Memphis, TN	2,508	1,800	72%
Atlanta, GA	1,824	1,291	71%
Columbia, SC	2,722	1,920	71%
Knoxville, TN	3,476	2,447	70%
Charlotte, NC	3,354	2,351	70%
Raleigh, NC	3,611	2,531	70%
Charleston, SC	3,672	2,531	69%
Savannah, GA	2,702	1,849	68%
Orlando, FL	4,715	3,222	68%
Hattiesburg, MS	2,079	1,401	67%

Table D-1 Disorders of Back National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Tupelo, MS	1,806	1,215	67%
Jackson, MS	1,360	901	66%
Middlesboro, KY	1,912	1,231	64%
Jacksonville, FL	4,030	2,577	64%
Fort Lauderdale, FL	2,910	1,822	63%
Lexington, KY	3,801	2,260	59%
Miami, FL	857	488	57%
Chicago Region	**46,034**	**31,753**	**69%**
Evanston, IL	2,182	1,815	83%
Chicago, IL	1,438	1,167	81%
Regional Office Staff	51	40	78%
Orland Park, IL	3,001	2,281	76%
Detroit, MI	2,038	1,515	74%
Oak Brook, IL	2,328	1,716	74%
Milwaukee, WI	3,122	2,244	72%
Cincinnati, OH	3,212	2,303	72%
Flint, MI	1,934	1,357	70%
Cleveland, OH	2,722	1,904	70%
Fort Wayne, IN	2,237	1,546	69%
Grand Rapids, MI	2,287	1,572	69%
Minneapolis, MN	3,688	2,499	68%
Oak Park, MI	2,400	1,615	67%
Madison, WI (Satellite)	662	442	67%
Columbus, OH	2,603	1,677	64%
Indianapolis, IN	3,132	2,006	64%
Evansville, IN	1,595	1,012	63%
Lansing, MI	1,753	1,097	63%
Peoria, IL	1,699	1,063	63%
Dayton, OH	1,950	882	45%
Dallas Region	**43,778**	**29,379**	**67%**
Regional Office Staff	7	6	86%
Albuquerque, NM	3,882	3,031	78%
Little Rock, AR	4,086	3,182	78%
Fort Smith, AR	2,006	1,545	77%
Tulsa, OK	3,490	2,687	77%
Dallas-DT, TX	4,053	2,894	71%
Oklahoma City, OK	3,066	2,183	71%
Houston-DT, TX	2,114	1,473	70%
Alexandria, LA	2,909	1,925	66%
McAlester, OK	872	566	65%
Houston, TX	3,040	1,896	62%
Metairie, LA	1,335	829	62%
Dallas-N, TX	3,006	1,810	60%
San Antonio, TX	3,840	2,232	58%

Table D-1 Disorders of Back National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
New Orleans, LA	1,583	912	58%
Fort Worth, TX	2,864	1,457	51%
Shreveport, LA	1,625	751	46%
Kansas City Region	**14,630**	**9,565**	**65%**
St. Louis, MO	2,769	2,247	81%
Regional Office Staff	5	4	80%
Omaha, NE	1,454	1,003	69%
Wichita, KS	1,855	1,216	66%
Creve Coeur, MO	3,578	2,282	64%
Springfield, MO	1,503	885	59%
West Des Moines, IA	1,597	892	56%
Kansas City, MO	1,869	1,036	55%
Denver Region	**11,109**	**7,564**	**68%**
Salt Lake City, UT	2,329	1,768	76%
Fargo, ND	1,779	1,279	72%
Denver, CO	3,312	2,194	66%
Billings, MT	1,979	1,274	64%
Colorado Springs, CO	1,710	1,049	61%
San Francisco Region	**33,507**	**22,032**	**66%**
Santa Barbara, CA	1,003	822	82%
San Rafael, CA	1,305	1,034	79%
Sacramento, CA	3,750	2,855	76%
San Francisco, CA	1,481	1,123	76%
Las Vegas, NV	785	589	75%
San Jose, CA	1,555	1,162	75%
Oakland, CA	1,326	963	73%
Honolulu, HI	418	298	71%
Phoenix, AZ	2,381	1,664	70%
Tucson, AZ	2,168	1,488	69%
Orange, CA	1,479	985	67%
San Diego, CA	2,528	1,587	63%
Stockton, CA	1,900	1,151	61%
Los Angeles-W, CA	2,343	1,384	59%
Downey, CA	852	499	59%
Los Angeles-DT, CA	1,157	645	56%
Long Beach, CA	1,561	868	56%
Fresno, CA	2,017	1,106	55%
San Bernardino, CA	2,220	1,188	54%
Pasadena, CA	1,278	621	49%
Seattle Region	**10,257**	**7,430**	**72%**
Spokane, WA	2,442	2,046	84%
Seattle, WA	3,453	2,479	72%
Eugene, OR	2,133	1,435	67%
Portland, OR	2,229	1,470	66%

Table D-2 Osteoarthrosis and Allied Disorders National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Boston Region	**2,547**	**1,883**	**74%**
Regional Office Staff	11	11	100%
Portland, ME	295	244	83%
Manchester, NH	347	279	80%
Boston, MA	668	516	77%
Hartford, CT	319	240	75%
Springfield, MA	360	262	73%
New Haven, CT	289	190	66%
Providence, RI	258	141	55%
New York Region	**7,904,**	**5,325**	**67%**
Mayaguez, PR	81	65	80%
Brooklyn, NY	924	734	79%
Voorhees, NJ	489	384	79%
Jericho, NY	887	684	77%
Ponce, PR	104	79	76%
San Juan, PR	444	335	75%
Albany, NY	560	395	71%
Bronx, NY	443	298	67%
New York, NY	834	549	66%
Newark, NJ	688	441	64%
White Plains, NY	470	282	60%
Syracuse, NY	616	348	56%
Buffalo, NY	1,036	563	54%
Queens, NY	328	168	51%
Philadelphia Region	**10,614**	**7,167**	**68%**
Charleston, WV	690	597	87%
Huntington, WV	555	424	76%
Harrisburg, PA	631	480	76%
Baltimore, MD	1,228	916	75%
Wilkes-Barre, PA	529	381	72%
Roanoke, VA	658	458	70%
Washington, D.C.	603	415	69%
Richmond, VA	502	334	67%
Pittsburgh, PA	758	498	66%
Morgantown, WV	510	333	65%
Elkins Park, PA	679	427	63%
Philadelphia, PA	521	323	62%
Johnstown, PA	443	272	61%
Cranberry, PA	78	46	59%
Charlottesville, VA	747	436	58%
Norfolk, VA	610	345	57%
Dover, DE	300	168	56%
Philadelphia-E, PA	572	314	55%

Table D-2 Osteoarthrosis and Allied Disorders National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Atlanta Region	**21,887**	**16,321**	**75%**
Greenville, SC	1,475	1,256	85%
Birmingham, AL	987	839	85%
Kingsport, TN	771	652	85%
Chattanooga, TN	796	662	83%
Montgomery, AL	478	394	82%
Nashville, TN	544	443	81%
Macon, GA	694	560	81%
Florence, AL	493	387	78%
Knoxville, TN	580	449	77%
Atlanta-N, GA	726	562	77%
Memphis, TN	616	461	75%
Orlando, FL	708	528	75%
Mobile, AL	763	567	74%
Greensboro, NC	1,290	954	74%
Paducah, KY	416	305	73%
Louisville, KY	723	529	73%
Raleigh, NC	1,366	991	73%
Tampa, FL	724	520	72%
Charlotte, NC	1,196	858	72%
Tupelo, MS	327	234	72%
Middlesboro, KY	297	210	71%
Jackson, MS	293	204	70%
Savannah, GA	624	433	69%
Columbia, SC	1,151	798	69%
Charleston, SC	983	678	69%
Atlanta, GA	607	410	68%
Fort Lauderdale, FL	420	274	65%
Jacksonville, FL	631	410	65%
Lexington, KY	658	423	64%
Hattiesburg, MS	353	213	60%
Miami, FL	197	117	59%
Chicago Region	**14,886**	**10,744**	**72%**
Regional Office Staff	16	16	100%
Evanston, IL	824	689	84%
Chicago, IL	887	727	82%
Orland Park, IL	951	762	80%
Detroit, MI	678	520	77%
Flint, MI	631	466	74%
Cincinnati, OH	923	677	73%
Milwaukee, WI	834	606	73%
Oak Brook, IL	750	544	73%
Fort Wayne, IN	754	543	72%
Cleveland, OH	1,002	713	71%
Indianapolis, IN	1,203	855	71%

Table D-2 Osteoarthrosis and Allied Disorders National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Minneapolis, MN	804	570	71%
Evansville, IN	483	336	70%
Grand Rapids, MI	726	504	69%
Columbus, OH	793	540	68%
Lansing, MI	556	378	68%
Oak Park, MI	798	542	68%
Peoria, IL	570	370	65%
Madison, WI (Satellite)	155	97	63%
Dayton, OH	548	289	53%
Dallas Region	**11,417**	**7,704**	**67%**
Regional Office Staff	2	2	100%
Albuquerque, NM	1,061	847	80%
Tulsa, OK	922	706	77%
Fort Smith, AR	652	494	76%
Little Rock, AR	1,393	1,050	75%
Oklahoma City, OK	796	581	73%
Dallas-DT, TX	1,099	781	71%
Alexandria, LA	462	307	66%
Houston-DT, TX	557	349	63%
New Orleans, LA	241	149	62%
Dallas-N, TX	862	528	61%
McAlester, OK	277	169	61%
San Antonio, TX	1,055	642	61%
Houston, TX	739	443	60%
Metairie, LA	191	110	58%
Fort Worth, TX	692	367	53%
Shreveport, LA	416	179	43%
Kansas City Region	**4,237**	**2,765**	**65%**
St. Louis, MO	798	657	82%
Omaha, NE	358	249	70%
West Des Moines, IA	349	219	63%
Springfield, MO	409	256	63%
Creve Coeur, MO	1,031	635	62%
Wichita, KS	616	376	61%
Kansas City, MO	676	373	55%
Denver Region	**2,187**	**1,511**	**69%**
Salt Lake City, UT	479	383	80%
Fargo, ND	410	298	73%
Billings, MT	326	216	66%
Denver, CO	658	427	65%
Colorado Springs, CO	314	187	60%
San Francisco Region	**8,882**	**5,684**	**64%**
Santa Barbara, CA	174	141	81%
San Rafael, CA	332	248	75%
San Francisco, CA	343	253	74%

Table D-2 Osteoarthrosis and Allied Disorders National Average Allowance Rate – 70%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Las Vegas, NV	190	138	73%
Honolulu, HI	80	58	73%
San Jose, CA	317	229	72%
Oakland, CA	449	322	72%
Sacramento, CA	962	687	71%
Tucson, AZ	459	315	69%
Orange, CA	389	266	68%
Phoenix, AZ	559	382	68%
San Diego, CA	612	383	63%
Stockton, CA	503	303	60%
Fresno, CA	421	249	59%
Downey, CA	367	217	59%
San Bernardino, CA	512	288	56%
Long Beach, CA	524	292	56%
Pasadena, CA	423	234	55%
Los Angeles-DT, CA	597	321	54%
Los Angeles-W, CA	669	358	54%
Seattle Region	**2,080**	**1,531**	**74%**
Spokane, WA	528	435	82%
Portland, OR	457	333	73%
Seattle, WA	690	495	72%
Eugene, OR	405	268	66%

Table D-3 Diabetes Mellitus National Average Allowance Rate – 67%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Boston Region	**1,394**	**1,003**	**72%**
Regional Office Staff	3	3	100%
Manchester, NH	182	152	84%
Portland, ME	134	105	78%
Boston, MA	325	238	73%
New Haven, CT	207	146	71%
Hartford, CT	207	141	68%
Springfield, MA	207	140	68%
Providence, RI	129	78	60%
New York Region	**3,424**	**2,124**	**62%**
Ponce, PR	21	16	76%
Voorhees, NJ	287	214	75%
Albany, NY	143	104	73%
San Juan, PR	96	67	70%
Jericho, NY	207	142	69%
Brooklyn, NY	477	322	68%
Mayaguez, PR	19	12	63%
Bronx, NY	338	203	60%
Newark, NJ	478	284	59%
Syracuse, NY	254	148	58%
New York, NY	475	275	58%
Buffalo, NY	351	195	56%
White Plains, NY	143	77	54%
Queens, NY	135	65	48%
Philadelphia Region	**7,763**	**5,075**	**66%**
Charleston, WV	531	468	88%
Harrisburg, PA	530	415	78%
Baltimore, MD	716	527	74%
Huntington, WV	320	234	73%
Washington, D.C.	301	216	72%
Richmond, VA	236	164	69%
Roanoke, VA	371	250	67%
Wilkes-Barre, PA	487	328	67%
Elkins Park, PA	575	375	65%
Pittsburgh, PA	647	403	62%
Morgantown, WV	459	274	60%
Johnstown, PA	347	205	59%
Charlottesville, VA	435	253	58%
Philadelphia, PA	502	284	57%
Cranberry, PA	46	25	54%
Dover, DE	230	124	54%
Norfolk, VA	394	209	53%
Philadelphia-E, PA	636	321	50%

Table D-3 Diabetes Mellitus National Average Allowance Rate – 67%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Atlanta Region	**14,621**	**10,367**	**71%**
Kingsport, TN	426	360	85%
Macon, GA	546	448	82%
Greenville, SC	356	292	82%
Birmingham, AL	674	537	80%
Chattanooga, TN	472	362	77%
Nashville, TN	299	229	77%
Tampa, FL	891	679	76%
Knoxville, TN	328	249	76%
Paducah, KY	294	223	76%
Atlanta-N, GA	459	344	75%
Greensboro, NC	688	512	74%
Florence, AL	336	250	74%
Montgomery, AL	440	316	72%
Mobile, AL	598	428	72%
Charlotte, NC	640	456	71%
Columbia, SC	263	186	71%
Raleigh, NC	707	497	70%
Memphis, TN	460	320	70%
Atlanta, GA	524	364	69%
Savannah, GA	595	410	69%
Orlando, FL	769	518	67%
Louisville, KY	365	243	67%
Charleston, SC	399	264	66%
Jackson, MS	335	219	65%
Jacksonville, FL	676	434	64%
Tupelo, MS	324	208	64%
Fort Lauderdale, FL	581	364	63%
Lexington, KY	359	206	57%
Middlesboro, KY	177	99	56%
Miami, FL	298	163	55%
Hattiesburg, MS	342	187	55%
Chicago Region	**7,947**	**5,727**	**72%**
Chicago, IL	752	612	81%
Evanston, IL	500	397	79%
Regional Office Staff	9	7	78%
Orland Park, IL	566	434	77%
Flint, MI	233	173	74%
Fort Wayne, IN	383	284	74%
Cincinnati, OH	461	339	74%
Oak Park, MI	415	301	73%
Grand Rapids, MI	406	293	72%
Detroit, MI	399	286	72%
Columbus, OH	381	272	71%
Lansing, MI	265	189	71%

Table D-3 Diabetes Mellitus National Average Allowance Rate – 67%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Minneapolis, MN	445	317	71%
Cleveland, OH	547	387	71%
Evansville, IN	304	212	70%
Milwaukee, WI	307	209	68%
Oak Brook, IL	453	308	68%
Indianapolis, IN	444	289	65%
Peoria, IL	341	219	64%
Madison, WI (Satellite)	58	37	64%
Dayton, OH	278	162	58%
Dallas Region	**10,745**	**6,853**	**64%**
Tulsa, OK	503	397	79%
Albuquerque, NM	1,017	774	76%
Fort Smith, AR	242	183	76%
Oklahoma City, OK	569	422	74%
Little Rock, AR	681	492	72%
Dallas-DT, TX	1,153	827	72%
Houston-DT, TX	642	405	63%
Alexandria, LA	468	291	62%
Regional Office Staff	5	3	60%
Houston, TX	822	488	59%
New Orleans, LA	322	191	59%
San Antonio, TX	1,608	943	59%
Fort Worth, TX	788	439	56%
Metairie, LA	219	120	55%
Dallas-N, TX	1,131	618	55%
McAlester, OK	149	78	52%
Shreveport, LA	426	182	43%
Kansas City Region	**2,298**	**1,509**	**66%**
St. Louis, MO	506	386	76%
Springfield, MO	186	132	71%
Omaha, NE	230	154	67%
Wichita, KS	225	148	66%
West Des Moines, IA	217	141	65%
Creve Coeur, MO	612	369	60%
Kansas City, MO	322	179	56%
Denver Region	**1,451**	**1,004**	**69%**
Salt Lake City, UT	296	241	81%
Colorado Springs, CO	222	158	71%
Fargo, ND	200	136	68%
Denver, CO	503	326	65%
Billings, MT	230	143	62%
San Francisco Region	**5,643**	**3,448**	**61%**
Santa Barbara, CA	115	97	84%
San Rafael, CA	131	107	82%
Las Vegas, NV	171	127	74%

Table D-3 Diabetes Mellitus National Average Allowance Rate – 67%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
San Jose, CA	279	207	74%
Tucson, AZ	312	217	70%
Sacramento, CA	399	272	68%
Oakland, CA	201	136	68%
San Francisco, CA	229	154	67%
Orange, CA	265	177	67%
Phoenix, AZ	372	241	65%
San Diego, CA	419	253	60%
Downey, CA	250	145	58%
Honolulu, HI	73	42	58%
Fresno, CA	333	182	55%
Los Angeles-DT, CA	396	215	54%
San Bernardino, CA	366	197	54%
Pasadena, CA	309	164	53%
Los Angeles-W, CA	433	229	53%
Stockton, CA	257	129	50%
Long Beach, CA	333	157	47%
Seattle Region	**1,119**	**829**	**74%**
Spokane, WA	269	215	80%
Eugene, OR	171	131	77%
Seattle, WA	422	313	74%
Portland, OR	257	170	66%

Table D-4 Disorders of Muscle, Ligament, and Fascia National Average Allowance Rate – 65%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Boston Region	**2,807**	**2,047**	**73%**
Regional Office Staff	2	2	100%
Portland, ME	617	496	80%
Manchester, NH	594	476	80%
Boston, MA	466	351	75%
Hartford, CT	278	208	75%
New Haven, CT	195	128	66%
Springfield, MA	408	245	60%
Providence, RI	247	141	57%
New York Region	**3,149**	**2,025**	**64%**
Jericho, NY	197	165	84%
Mayaguez, PR	42	34	81%
Voorhees, NJ	152	118	78%
Ponce, PR	57	43	75%
Brooklyn, NY	213	159	75%
San Juan, PR	245	182	74%
Bronx, NY	174	124	71%
Albany, NY	324	206	64%
Syracuse, NY	345	219	63%
Newark, NJ	252	148	59%
New York, NY	314	184	59%
Queens, NY	90	49	54%
Buffalo, NY	547	294	54%
White Plains, NY	197	100	51%
Philadelphia Region	**5,747**	**3,520**	**61%**
Charleston, WV	407	336	83%
Huntington, WV	350	255	73%
Washington, D.C.	208	144	69%
Harrisburg, PA	425	294	69%
Roanoke, VA	413	276	67%
Wilkes-Barre, PA	396	261	66%
Baltimore, MD	289	190	66%
Richmond, VA	292	177	61%
Pittsburgh, PA	360	206	57%
Cranberry, PA	14	8	57%
Philadelphia, PA	273	156	57%
Elkins Park, PA	450	253	56%
Johnstown, PA	258	144	56%
Charlottesville, VA	418	231	55%
Norfolk, VA	373	189	51%
Morgantown, WV	311	155	50%
Philadelphia-E, PA	308	148	48%
Dover, DE	202	97	48%

Table D-4 Disorders of Muscle, Ligament, and Fascia National Average Allowance Rate – 65%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Atlanta Region	**12,446**	**8,689**	**70%**
Greenville, SC	693	575	83%
Birmingham, AL	445	368	83%
Nashville, TN	361	297	82%
Kingsport, TN	460	368	80%
Chattanooga, TN	441	346	78%
Montgomery, AL	227	169	74%
Macon, GA	298	221	74%
Tampa, FL	842	617	73%
Knoxville, TN	393	282	72%
Memphis, TN	424	301	71%
Atlanta-N, GA	297	210	71%
Greensboro, NC	807	570	71%
Raleigh, NC	726	505	70%
Orlando, FL	557	385	69%
Mobile, AL	406	276	68%
Charlotte, NC	648	436	67%
Louisville, KY	342	227	66%
Florence, AL	200	132	66%
Tupelo, MS	225	148	66%
Columbia, SC	371	243	65%
Paducah, KY	237	154	65%
Middlesboro, KY	188	122	65%
Atlanta, GA	259	168	65%
Miami, FL	59	38	64%
Hattiesburg, MS	204	131	64%
Charleston, SC	585	359	61%
Fort Lauderdale, FL	225	138	61%
Jackson, MS	190	116	61%
Savannah, GA	427	259	61%
Lexington, KY	476	277	58%
Jacksonville, FL	433	251	58%
Chicago Region	**6,341**	**4,091**	**65%**
Columbus, OH	5	4	80%
Evanston, IL	429	342	80%
Chicago, IL	266	207	78%
Regional Office Staff	9	7	78%
Orland Park, IL	325	246	76%
Cincinnati, OH	108	78	72%
Oak Brook, IL	346	234	68%
Milwaukee, WI	762	507	67%
Detroit, MI	376	243	65%
Fort Wayne, IN	172	108	63%
Minneapolis, MN	780	479	61%
Indianapolis, IN	316	192	61%

Table D-4 Disorders of Muscle, Ligament, and Fascia National Average Allowance Rate – 65%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
Flint, MI	454	275	61%
Grand Rapids, MI	404	244	60%
Oak Park, MI	524	315	60%
Dayton, OH	5	3	60%
Evansville, IN	195	115	59%
Peoria, IL	327	187	57%
Madison, WI (Satellite)	205	117	57%
Lansing, MI	326	186	57%
Cleveland, OH	7	2	29%
Dallas Region	**5,577**	**3,591**	**64%**
Regional Office Staff	1	1	100%
Albuquerque, NM	844	637	75%
Fort Smith, AR	393	290	74%
Little Rock, AR	932	672	72%
Tulsa, OK	360	258	72%
Dallas-DT, TX	417	270	65%
Alexandria, LA	225	138	61%
Houston, TX	337	205	61%
Oklahoma City, OK	278	164	59%
Houston-DT, TX	252	147	58%
Dallas-N, TX	335	191	57%
Metairie, LA	65	37	57%
San Antonio, TX	468	264	56%
McAlester, OK	78	42	54%
New Orleans, LA	113	55	49%
Shreveport, LA	157	73	46%
Fort Worth, TX	322	147	46%
Kansas City Region	**2,972**	**1,788**	**60%**
St. Louis, MO	489	361	74%
Omaha, NE	360	252	70%
Springfield, MO	358	216	60%
Wichita, KS	341	205	60%
Creve Coeur, MO	638	374	59%
West Des Moines, IA	360	178	49%
Kansas City, MO	426	202	47%
Denver Region	**2,017**	**1,242**	**62%**
Fargo, ND	508	331	65%
Billings, MT	334	212	63%
Salt Lake City, UT	163	102	63%
Denver, CO	691	423	61%
Colorado Springs, CO	321	174	54%
San Francisco Region	**9,956**	**6,083**	**61%**
Santa Barbara, CA	282	221	78%
Las Vegas, NV	158	117	74%
San Rafael, CA	384	282	73%

Table D-4 Disorders of Muscle, Ligament, and Fascia National Average Allowance Rate – 65%			
Location	**Number of Dispositions**	**Number of Allowances**	**Allowance Rate**
San Francisco, CA	524	370	71%
Sacramento, CA	841	589	70%
San Jose, CA	566	395	70%
Honolulu, HI	120	83	69%
Oakland, CA	844	566	67%
Tucson, AZ	459	302	66%
Phoenix, AZ	588	364	62%
Stockton, CA	507	307	61%
Orange, CA	561	332	59%
San Diego, CA	771	444	58%
Fresno, CA	595	336	56%
Los Angeles-W, CA	610	322	53%
Downey, CA	257	133	52%
Los Angeles-DT, CA	348	179	51%
San Bernardino, CA	667	342	51%
Long Beach, CA	475	231	49%
Pasadena, CA	399	168	42%
Seattle Region	**2,113**	**1,411**	**67%**
Spokane, WA	486	391	80%
Seattle, WA	697	452	65%
Eugene, OR	420	258	61%
Portland, OR	510	310	61%

Agency Comments

SOCIAL SECURITY

MEMORANDUM

Date: July 30, 2010 Refer To: S1J-3

To: Patrick P. O'Carroll, Jr.
Inspector General

From: James A. Winn /s/
Executive Counselor
to the Commissioner

Subject: Office of the Inspector General Draft Report, "Disability Impairments on Cases Most Frequently Denied by Disability Determination Services and Subsequently Allowed by Administrative Law Judges" (A-07-09-19083)--INFORMATION

Thank you for the opportunity to review and comment on the draft report. Please see the attached response to your findings and recommendations.

Please let me know if we can be of further assistance. Please direct staff inquiries to Rebecca Tothero, Acting Director, Audit Management and Liaison Staff, at (410) 966-6975.

Attachment

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL DRAFT REPORT, "DISABILITY IMPAIRMENTS ON CASES MOST FREQUENTLY DENIED BY DISABIITY DETERMINATION SERVICES AND SUBSEQUENTLY ALLOWED BY ADMINISTRATIVE LAW JUDGES" (A-07-09-19083)

We offer the following comments:

General Comments

At the beginning of the report you state, "The objective of our review was to identify the impairments of initial disability cases most frequently allowed at the Office of Disability Adjudication and Review's (ODAR) hearing level and evaluate the characteristics of these cases." Throughout the report, you then present a large amount of information and in several places say there are wide variations in the statistical data you compiled. You do not say explicitly that one may draw any conclusions from the numbers, but the overwhelming amount of data you present may lead the average reader to erroneously conclude otherwise.

Much of the data you present in the report is very familiar to us. For example, we are well aware that administrative law judges (ALJ) allow a high percentage of disability determination services' (DDS) denials. On page 3, you acknowledge that we explained some of the factors that influence those ALJ decisions. We can also explain the reasons for some of the other variances, but not for each one you cite. In any statistical study, there will likely be some degree of variability in the results, but variability does not necessarily pinpoint problems. Our Office of Quality Performance (OQP) analyzes raw data in a manner similar to the approach used. However, OQP refines its analyses, assesses whether there may be problems, and then targets studies to areas that deserve the most attention. OQP routinely uses these methods to assess program integrity.

You state several times that you will be doing additional audit work based on your findings. For example on page 4 you say, "We plan to initiate an audit that will further evaluate the impact claimant age has on disability determinations at the DDS and hearing levels. At that time, we will make recommendations, as appropriate." The term "further evaluate" is a common theme throughout, and we believe it supports our opinion that the audit report itself does little more than lay the groundwork for more substantive audits you may conduct in the future. Again, we recognize that you do not necessarily draw conclusions from the data. You even make the point on page 13, "We are not suggesting that the variances in allowance rates among hearing offices and ALJs resulted in inaccurate hearing level decisions." But you make this important point only once about a single situation, and it is at the very end of the report. We believe you should explain on page 1 under "Objective" that your audit represents preliminary work, forms a basis for future reviews, and the reader should not infer any conclusions from the data.

Page and Paragraph/Sentence Specific Comments

Page 6, 3rd paragraph, first sentence reads:

"If claimants with the four impairments we analyzed had representatives earlier in the disability process, some of them may have received an allowance decision at the DDS level, saving them time and SSA money."

Comment

You do not substantiate that increased claimant representation at the DDS level would result in more allowances. Adding representation to the DDS level does not remove the differences that exist at the hearing level. Given the time between the initial application and the hearing, it is common for an applicant's impairment to become more severe thereby further limiting residual functional capacity (RFC). Representation is effective at the ALJ level because of the *de novo* hearing processes in play. In such an environment, the representative can serve as a facilitator in obtaining additional evidence and eliciting appropriate testimony at the hearing to ensure that the ALJ addresses the claimant's due process, allegations of disability, and other interests. On page 5, you state that ALJs use vocational experts to assess RFC. That statement is inaccurate. ALJs determine RFC and present that information to a vocational expert to determine whether jobs exist in the national economy that the claimant could perform given that RFC and other factors.

In reviewing the factors such as claimant representation that you used to conduct your assessment (as well as those listed in Appendix C, which you did not use), we are surprised that you did not thoroughly address RFC. Under the *de novo* concept, ALJs can reassess the evidence that was before the DDS. Nowhere is this impact greater than with RFC assessment. About 80 percent of ALJ allowances are medical-vocational in nature, thereby requiring an RFC assessment (including many musculoskeletal impairments -- three of the four impairments in your report are musculoskeletal impairments). With most cases in this category, ALJs will often find that a claimant has an RFC that is more limited than the one found by the DDS. This is one factor that contributes to allowances at the hearing level.

Page 10, Table 5

Comment

You identify Alabama as one of the six States with denial rates and hearing level allowances greater than the national averages. You should include a footnote that the Alabama DDS is a "prototype State," as such, claimants can appeal directly to the hearing level and bypass the DDS reconsideration step. This affects allowance rates.

We conducted a "prototype data analysis" and examined the effect that prototype implementation has had on overall allowance rates and ODAR appeals. The report compares DDS allowance rates to the national average; however, there are a number of economic and demographic factors that may invalidate comparison across States and regions. As noted above, we are familiar with

much of the data you present in your report. In fact, we have studied this issue in particular. In 2002, our Office of Research, Evaluation, and Statistics conducted a study on consistency among disability allowance rates. In the study, we concluded that the variations in allowance rates were related to certain demographic and economic differences among States. You may access the study at: http://ssa.gov/policy/docs/workingpapers/wp98.pdf)

In addition, our Office of Disability Programs conducted a study of allowance rates for fiscal years (FY) 2001 through FY 2009 and determined it is misleading to make overall State comparisons. Reasons for that determination include:

- Allowance rates vary across Title types.
    - Title II initial claims have an allowance rate that is about 10 percentage points above the overall average, while concurrent Title II/XVI initial claims have an allowance rate that is about 10 percentage points below the overall average.
    - Title XVI initial adult claims have allowance rates several points below the overall average, while Title XVI children allowances are above the overall average.
- Initial disability claims workloads vary significantly by Title type (II, XVI adult or child, and concurrent II/XVI) from State to State.
- The rate of filing per age-eligible population for Title II, Title XVI adult or child, and concurrent Title II/XVI initial claims varies widely from State to State.

Because so many factors can affect decisions, we do not expect States to conform to any specified allowance rates. Claims accuracy and timely decisions are key components of good public service, and the DDSs work hard to issue sound decisions.

Note: Net accuracy in the Atlanta region, where five of six States you identify are located, is higher than the national average. This underscores the fact these States are making proper decisions.

Comments on Recommendations

Recommendation 1

Collect information related to claimant representation at the DDS level to determine whether representation results in more allowances at the DDS level. Based on the results of that assessment, determine whether additional efforts are needed to ensure claimants are made aware of the availability of claimant representation at the DDS level.

Comment

We agree. We may not produce reports that provide this information; however, we collect data regarding the claimant's representation via the Electronic Disability Collect System and store it in a database. We will review this information to assess if our field offices need to make additional efforts to ensure claimants are made aware of the availability of claimant representation at the DDS level. In the meantime, our offices are required under the Social Security Act and regulations to inform the claimant of his or her right to representation and to process the representative's fee arrangements. Field Offices routinely inform claimants of the right to representation through various communication methods, including interviews and notices. State DDSs, however, are under no legal requirement to do so. We suggest that you acknowledge this fact in the final report**.**

Finally, it has been our experience that claimants do not appoint a representative until we issue an initial denial letter. As we discussed above, one of the DDSs included in the review, Alabama, is a prototype State. The prototype process includes making initial determinations but not reconsideration determinations. Therefore, claimant representation in prototype DDSs, such as Alabama, would be unlikely.

Recommendation 2

Consider conducting a targeted review of disability determinations made in the six States we identified as having higher than average DDS denial rates and hearing level allowance rates for the four impairments we analyzed**.**

Comment

We agree. However, we will perform a quality review to determine the accuracy rates for the four specific impairment codes that you used in the six specific States identified in your draft report.

Recommendation 3

Consider analyzing variances between the hearing offices and ALJs with high and low allowance rates for the four impairments we analyzed to determine whether factors are present that support the variances.

Comment

We agree. The Appeals Council plans to begin quality review of unappealed, favorable ALJ decisions later in FY 2010. For purposes of the quality review, the Appeals Council plans to capture structured data that may lay the foundation for such an analysis. Based on the anticipated sample size, data sufficient for a reliable analysis will be limited to regional study and will likely not be available for over a year.

OIG Contacts and Staff Acknowledgments

OIG Contacts

Mark Bailey, Director, Kansas City Audit Division

Tonya Eickman, Audit Manager

Acknowledgments

In addition to those named above:

Shannon Agee

For additional copies of this report, please visit our web site at www.ssa.gov/oig or contact the Office of the Inspector General's Public Affairs Specialist at (410) 965-3218. Refer to Common Identification Number A-07-09-19083.

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Chairman and Ranking Member, Committee on Ways and Means

Chief of Staff, Committee on Ways and Means

Chairman and Ranking Minority Member, Subcommittee on Social Security

Majority and Minority Staff Director, Subcommittee on Social Security

Chairman and Ranking Minority Member, Committee on the Budget, House of Representatives

Chairman and Ranking Minority Member, Committee on Oversight and Government Reform

Chairman and Ranking Minority Member, Committee on Appropriations, House of Representatives

Chairman and Ranking Minority, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, House of Representatives

Chairman and Ranking Minority Member, Committee on Appropriations, U.S. Senate

Chairman and Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate

Chairman and Ranking Minority Member, Committee on Finance

Chairman and Ranking Minority Member, Subcommittee on Social Security Pensions and Family Policy

Chairman and Ranking Minority Member, Senate Special Committee on Aging

Social Security Advisory Board

Overview of the Office of the Inspector General

The Office of the Inspector General (OIG) is comprised of an Office of Audit (OA), Office of Investigations (OI), Office of the Counsel to the Inspector General (OCIG), Office of External Relations (OER), and Office of Technology and Resource Management (OTRM). To ensure compliance with policies and procedures, internal controls, and professional standards, the OIG also has a comprehensive Professional Responsibility and Quality Assurance program.

Office of Audit

OA conducts financial and performance audits of the Social Security Administration's (SSA) programs and operations and makes recommendations to ensure program objectives are achieved effectively and efficiently. Financial audits assess whether SSA's financial statements fairly present SSA's financial position, results of operations, and cash flow. Performance audits review the economy, efficiency, and effectiveness of SSA's programs and operations. OA also conducts short-term management reviews and program evaluations on issues of concern to SSA, Congress, and the general public.

Office of Investigations

OI conducts investigations related to fraud, waste, abuse, and mismanagement in SSA programs and operations. This includes wrongdoing by applicants, beneficiaries, contractors, third parties, or SSA employees performing their official duties. This office serves as liaison to the Department of Justice on all matters relating to the investigation of SSA programs and personnel. OI also conducts joint investigations with other Federal, State, and local law enforcement agencies.

Office of the Counsel to the Inspector General

OCIG provides independent legal advice and counsel to the IG on various matters, including statutes, regulations, legislation, and policy directives. OCIG also advises the IG on investigative procedures and techniques, as well as on legal implications and conclusions to be drawn from audit and investigative material. Also, OCIG administers the Civil Monetary Penalty program.

Office of External Relations

OER manages OIG's external and public affairs programs, and serves as the principal advisor on news releases and in providing information to the various news reporting services. OER develops OIG's media and public information policies, directs OIG's external and public affairs programs, and serves as the primary contact for those seeking information about OIG. OER prepares OIG publications, speeches, and presentations to internal and external organizations, and responds to Congressional correspondence.

Office of Technology and Resource Management

OTRM supports OIG by providing information management and systems security. OTRM also coordinates OIG's budget, procurement, telecommunications, facilities, and human resources. In addition, OTRM is the focal point for OIG's strategic planning function, and the development and monitoring of performance measures. In addition, OTRM receives and assigns for action allegations of criminal and administrative violations of Social Security laws, identifies fugitives receiving benefit payments from SSA, and provides technological assistance to investigations.