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The Medical Improvement Standard: An Ounce of Presumption Is Worth a Pound of Cure

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I. INTRODUCTION

Massive termination of Social Security disability benefits has stirred considerable controversy over the procedure employed to separate wrongfully-terminated, deserving recipients from malingers. After meeting the statutory definition of "disability," most recipients are not automatically granted continuous benefits. Rather, the Social Security Administration (SSA) undertakes periodic investigations to determine whether recipients continue to remain eligible for disability compensation.  

1 The statutory definition of "disability" for Social Security purposes is set forth as follows in 42 U.S.C. § 423(d)(1)(A)(1982): "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."

2 The Social Security Administration is an agency within the Department of Health and Human Services. The agency's regulations governing Federal Old Age, Survivors and Disability Insurance Benefits, and Supplemental Security Income for the Aged, Blind and Disabled are codified in 20 C.F.R. pts. 404 and 416 (1984). The sections that cover the decision whether to continue disability benefits are found in 20 C.F.R §§ 404.1588-.1598 (1984). Section 404.1589 specifically provides:

After we find that you are disabled, we must determine from time to time if you are still eligible for disability cash benefits. We may begin an investigation for this purpose for any number of reasons, including your failure to follow the provisions of the Social Security Act or these regulations. If our investigation shows that we should suspend payment of your benefits, we will notify you in writing and give you an opportunity to reply. In Section 404.1590 we describe those events that may prompt us to investigate whether you continue to be disabled.
If after review the recipient is deemed no longer disabled, this termination decision may be challenged. Disputes concerning appropriate procedures used in the appeals process led to the implementation of an evidentiary hearing at the reconsideration level. Should the unfavorable decision be upheld, the recipient may then request a formal hearing before an Administrative Law Judge (ALJ). If necessary, the final administrative remedy, a request for review by the Appeals Council, may be exercised. The SSA is an agency governed by the Department of Health and Human Services; consequently, a decree of the Appeals Council represents the final decision of the Secretary of Health and Human Services (Secretary) concerning a disability claim. If a claimant remains dissatisfied with that determination, judicial review of the Secretary's decision may be commenced in a United States District Court.

3 42 U.S.C. § 405(b)(2)(1982) provides:

(2) In any case where—
(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,
(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and
(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Secretary not to be entitled to such benefits, any reconsideration . . . shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individuals . . . the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B).

4 This expression refers to the termination decision which is, in effect, unfavorable to the claimant. A favorable decision is one granting or continuing an individual's benefits. The terms "termination," "cessation," and "unfavorable decision" will be used interchangeably throughout the text.

5 Hearings, 20 C.F.R. §§ 404.929-.965 (1984). The claimant is provided with an opportunity to appear in person, submit new evidence, examine the evidence used in the decision under review, and question and present witnesses. An ALJ will conduct such proceedings and issue a decision based on the record.

6 Appeals Council Reviews, 20 C.F.R. §§ 404.967-.981 (1984). The role of the Appeals Council is defined in these regulations. Specifically, § 404.979 permits the Appeals Council to affirm, modify or reverse the hearing decision made by the ALJ. The Council is also given authority to adopt, modify, or reject a recommended decision, as well as remand a case back to the ALJ.

7 42 U.S.C.A. § 405(g)(West 1983) provides the following:
Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.
Procedural questions concerning terminations were settled by a 1982 Amendment to the Social Security Act that mandated face-to-face reconsideration hearings. Problems remained, however, regarding which party bore the burden of proof in presenting evidence of continued disability. Initial disability determinations were generally based on a compilation of hospital records, physicians' reports, and testimony which indicated that the claimant was disabled. Conflicts centered on which party was responsible for furnishing similar evidence when continued disability was denied. An even greater dispute concerned the standard of review employed to terminate disability benefits. Since 1977, the Secretary had terminated benefits on the basis of whether new or current medical evidence obtained for review indicated disability. This was done without regard for the prior determination that the claimant was disabled. Benefit recipients and their counsel, however, advocated the adoption of a medical improvement standard in which disability benefits continued as long as the claimant's condition had not medically improved. The litigation prompted by this dispute resulted in rulings by a majority of the federal circuit courts that disability benefits cannot be terminated without a showing that a disabled person had medically improved. These decisions culminated in the inclusion of a medical improvement standard for review of possible termination cases in the Social Security Disability Benefits Reform Act of 1984 signed into law on October 9, 1984.

Although this Note will briefly outline the administrative process followed in evaluating continuing disability, its primary focus will be on the newly-enacted medical improvement standard. Specifically, decisions giving rise to the standard will be reviewed with an examination of the courts' rationales for adopting such a standard. The text of the 1984 Amendment will then be compared to case law to determine whether it reflects any of the courts' reasons for adoption. Possible interpretations and potential problems will be pointed out. Finally, the standard's future impact on disability recipients will be discussed.

Thus, as long as the action is timely commenced, the district court has jurisdiction to review the matter. This court cannot review the evidence de novo; rather, review is limited to determining whether the Secretary's final decision is supported by substantial evidence. Allen v. Califano, 613 F.2d 139 (6th Cir. 1980); Futernick v. Richardson, 485 F.2d 647 (6th Cir. 1973).

8 See supra note 3.


10 The Social Security Scandals, Newsweek, Sept. 24, 1984, at 32. The article focused on the plight of several individuals currently involved in disability appeals, emphasizing the delays in agency action and payment of benefits after entitlement was re-established.

11 See 42 U.S.C. § 1396(f)(1982) for the statutory standard of review for termination of disability benefits. See Part IV of this note for a summarized version of the medical improvement standard.
II. OVERVIEW OF THE DISABILITY TERMINATION PROCEDURE USED IN MONITORING CLAIMS OF CONTINUED DISABILITY

The Social Security disability program provides for joint administration between the states and the federal government, which acts through the Secretary and the SSA. Any state may enter into an agreement with the Secretary under which a state agency will make disability determinations with respect to individuals in that state with such determinations being treated as decisions of the Secretary. Should a state fail or be unwilling to make disability determinations, the Secretary will assume this function.

Disability claimants initially file their applications and any evidence supporting their position in a Social Security district or branch office; the file is then transferred to a state agency for further investigation and medical evaluation. Based on the agency's inquiry, a recommendation for allowance or disallowance of the claim will be made. If the claim is denied, the individual may request a reconsideration of the decision. Should the claim be denied again, the claimant may return to his or her local Social Security office and request a face-to-face hearing before an Administrative Law Judge. In most cases, this hearing is the first time that the applicant is actually seen by the party responsible for making

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12 42 U.S.C.S. § 421(a)(1)(Law. Co-op. 1973), which provides:
In the case of any individual, the determination of whether or not he is under a disability . . . shall be made by a State agency, notwithstanding any other provision of law, in any state that notifies the Secretary in writing that it wishes to make such disability determinations commencing with such month as the Secretary and the State agree upon, but only if (A) the Secretary has not found, under subsection (b)(1), that the State agency has substantially failed to make disability determinations in accordance with the applicable provisions of this section or rules issued thereunder, and (B) the State has not notified the Secretary, under subsection (b)(2), that it does not wish to make such determinations. If the Secretary once makes the finding described in clause (A) of the preceding sentence, or the State gives the notice referred to in clause (B) of such sentence, the Secretary may thereafter determine whether (and, if so, beginning in the month and under what conditions) the State may again make disability determinations under this paragraph.

13 The state agency acts for the local SSA office, which is governed by the Department of Health and Human Services. Thus, the state disability determinations are ultimately treated as those of the Secretary of Health and Human Services.


15 H. McCormick, SOCIAL SECURITY CLAIMS AND PROCEDURES, § 12, at 17 (3d ed. 1983) (hereinafter cited as H. McCormick). Disability determinations by the state agency are made by an evaluation team composed of a physician and a lay specialist.

16 Id. at 17-18. If the claim is allowed, benefits are certified for payment.

17 Id. at 18. The individual will file a formal request for reconsideration with the local Social Security office. New evidence concerning the claimant's condition may be filed at this time. The claim is then reviewed again.
the disability determination. Upon receiving an unfavorable decision from the ALJ, both the applicant and the SSA may request review by the Appeals Council; an appeal to a federal district court may be taken after administrative remedies have been exhausted.

After the Secretary has determined that an individual is disabled and benefits have been awarded, the agency regulations provide for periodic reviews to determine whether recipients continue to meet the statutory definition of disability. This provision for re-evaluation was prompted by a dramatic increase in the disability incidence rate between 1968 and 1975, with an accompanying decrease in disability termination rates during the same period. This increase in the number of disability benefit recipients was attributed to the following: a) healthy beneficiaries continuing to receive benefits, b) administrative changes in determination of a beneficiary's improved condition, and c) the belief that high benefits levels encouraged healthy individuals to remain on the rolls.

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18 Id. McCormick classifies the state agency as "perhaps one of the weakest links in the entire disability determination procedure" because personal examinations of the claimant are not undertaken in most cases.

19 20 C.F.R. §§ 404.967, 404.981 (1984). While the Appeals Council primarily reviews the hearing, it will consider new evidence which is material to a disputed issue. 20 C.F.R. § 404.976(b)(1984). See supra note 7 for a discussion of the scope of the federal court review.


21 SENATE REP. No. 408, 96th Cong., 2d Sess. 3, reprinted in 1980 U.S. CODE CONG. & AD. NEWS 1277, 1307. The conference report details reasons for both the incidence in benefit recipients and decline in termination decisions. Much of this information was drawn from Experience of Disabled Workers' Benefits Under OASDI, 1972-1976, ACTUARIAL STUDY NO. 95 (June 1978)(reported in SENATE REP. No. 408). An underlying problem of significant importance was the variance among different state agency determinations. The subjectivity of the state decisions was a factor warranting consideration. While the overall incidence of disability benefit awards may have increased markedly from 1968 to 1975, individual states' figures were inconsistent.

22 SSA actuaries believed that healthier individuals were afforded continued benefits although they were ineligible. A change in the definition of disability contributed to this problem. The definition of disability in the 1965 Amendment granted benefits if the disabling condition was expected to last at least 12 months; this change liberalized the past definition which required permanent disability. Actuaries indicated the current definition contributed to healthier individuals remaining on the disability rolls. SENATE REP. No. 408, 32, reprinted in 1980 U.S. CODE CONG. & AD. NEWS at 1310.

23 SENATE REP. No. 408, 32, reprinted in 1980 U.S. CODE CONG. & AD. NEWS at 1310. The increase in disability caseloads forced the SSA to curtail some of its policing activities. Prior to 1970, ten percent of the disability beneficiaries were subject to random investigations checking adherence to SSA guidelines. The magnitude of cases to be processed grew from 1971-1974 leaving time and manpower to investigate only four percent of benefit awards. Id.

24 SENATE REP. No. 408, 32, 36-37, reprinted in 1980 U.S. CODE CONG. & AD. NEWS at 1310, 1314-15. The SSA concluded that the high benefit payments were a "formidable incentive to maintain beneficiary status especially when the value of medicare and other benefits are considered." Loss of benefits was viewed as deterring beneficiaries from attempting to
Other factors also contributed to the increased number of disability beneficiaries. Prior to 1972, the SSA reviewed a majority of the allowances made by state agencies before such benefits were granted. However, a growing caseload coupled with cost and staff reductions prompted the SSA to conduct random sample reviews involving only five percent of all allowances. In contrast to the pre-1972 method, the state decisions were examined only after benefits were awarded. Finally, the SSA credited increased workloads, plus emphasis on expeditious processing of claims with lowering the quality of decisions rendered. This use of the phrase “decline in quality” is ambiguous. On the one hand, it could refer to actual carelessness by claims examiners because expeditious processing was stressed. Alternatively, it could voice a general feeling by the SSA that standards were too lax, thus accounting for the rise in benefit recipients.

The concern over lack of uniform standards heightened, thus prompting congressional action. The SSA was given authority to formulate guidelines for use by the states in making disability determinations. State agencies were given the option of complying with the federal regulations or turning over administration of their disability program to the SSA.

Early SSA practices permitted termination of benefits without affording recipients prior notice or hearing. Such procedures were deemed by one federal district court to violate due process; however, hearing by the

engage in trial work periods. The increase in benefit levels was attributed to wage growth in the economy, since wages were a factor in formulas. However, when benefit levels were very low a disabled person might continue working even if his impairment limited him to low earnings, because such earning were still higher than benefit payments.

This review of state determinations provided some nationwide uniformity in benefit decisions. The SSA was able to monitor the type of impairments deemed disabling as well as the number of allowances granted by a particular state. If one state appeared to award a disproportionate amount of benefits, the SSA could step in and review the procedures employed by the state in question.

A random selection of five percent of all awards made at each level of the administrative process, i.e., reconsideration, hearing, etc., are reviewed. These decisions may not adequately reflect the criteria used by the states; in addition, they may not truly represent the actual type and number of awards made by each state.

The questionable quality of decisions was also attributed to a lack of uniform criteria among the various state agencies. Depending on one's state of residence, and even the particular AJJ assigned, similarly disabled persons could receive different decisions. The report lists New Jersey as the leader in granting benefits on initial applications (53.1 percent) and Alabama as the least sympathetic to claimants (22.2 percent). Id. at 1331.

42 U.S.C.S. § 421(b)(1984). This provision outlines the procedure used by the SSA both in reviewing and assuming the state agency functions.

Wright v. Finch, 321 F. Supp. 383, 386 (D.D.C. 1971). The court specifically held that "[a] beneficiary must be given adequate notice and opportunity to participate in the deter-
Supreme Court was avoided when the Secretary issued new regulations providing that reviews could be conducted before cessation of benefits. The uniform procedures (also called “paper hearings”) outlined in those regulations are currently followed. They provide for advance notification to a beneficiary advising him or her that a review of the file indicates disability has ceased and benefits will be terminated. The recipient then has the opportunity to rebut such a finding by supplying additional medical evidence leading to a contrary conclusion. This evidence will be considered and a final determination made; if the state agency determines that the recipient is no longer disabled, benefits will stop.

While the court determined that formal hearings were not required prior to termination, it recommended that beneficiaries be given time to supply evidence supporting their position. Furthermore, the court stated that an impartial decision maker should resolve conflicting evidence rather than the investigator who compiled the record. Since the regulations abolished the summary adjudication and instituted procedures to be followed, the Supreme Court withheld “judicial action pending reprocessing under the new regulations.”

We will give you a summary of the information we have. We will also tell you why we have determined that you are not now disabled, and will give you a chance to reply. If it is because of—(1) Medical reasons. The advance notice will tell you what the medical information in your file shows; (2) Your work activity. The advance notice will tell you what information we have about the work you are doing or have done, and why this work shows that you are not disabled; or (3) Your failure to give us information we need or do what we ask. The advance notice will tell you what information we need and why we need it or what you have to do and why.

If you agree with the advance notice, you do not need to take any action. If you desire further information or disagree with what we have told you, you should immediately write or telephone the State agency or the social security office that gave you the advance notice or you may visit any social security office. If you believe you are now disabled, you should tell us why. You may give us any additional or new information, including reports from your doctors, hospitals, employers or others, that you believe we should have. You should send these as soon as possible to the local social security office that gave you the advance notice. We consider 10 days to be enough time for you to tell us, although we will allow you more time if you need it. You will have to ask for additional time beyond 10 days if you need it.

If we make a determination that you are not now disabled, your benefits will stop. You will receive a formal written notice telling you why you are not disabled and the month your benefits should stop. If your spouse and children are receiving benefits on your Social Security number, we will also stop their benefits and tell them why. The notices will also explain your right to reconsideration if you disagree with our determination.

After a cessation decision is rendered, the usual administrative remedies, i.e., reconsideration, hearing before an ALJ, etc., are available.
The constitutionality of these so-called "paper hearings" was subsequently challenged in *Mathews v. Eldridge.* The *Eldridge* Court concluded that the paper hearings comply with due process requirements, thus rendering evidentiary hearings prior to termination of benefits unnecessary. Three factors were considered by the court in examining the due process challenge: 1) private interest affected; 2) erroneous deprivation of interest through the procedures used; and 3) the government's interest, especially the burden created by a change in procedure. The Court found that applicants were afforded an effective process for asserting their claims prior to administrative action through the SSA's notification of its tentative assessment on periodic review. In addition, the SSA provided a summary of the relevant evidence that the claimant could challenge. The Court apparently believed this notice gave a claimant an opportunity to tailor his or her rebuttal to the evidence the agency deemed crucial for determination. However, the Court ignored the fact that a claimant may not know the contents of such evidence, thus making it nearly impossible for him or her to counter effectively the agency's decision. The Court further held that a disability beneficiary's due process rights were protected since administrative procedures provided for a right to an evidentiary hearing after the termination of benefits, as well as judicial review of the termination decision.

Despite the Supreme Court's holding in *Eldridge,* subsequent amendments to the Social Security Act created a pretermination hearing process for cessation cases. The Virgin Island Source Income-Social Security Disability Benefit Appeal Act of 1982 provides for periodic review of cases at

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34 424 U.S. 319 (1976). The *Eldridge* case raised considerations similar to those discussed in *Goldberg v. Kelly,* 397 U.S. 254 (1970). In *Goldberg,* the Supreme Court held that the Due Process Clause of the fourteenth amendment entitled welfare recipients to oral evidentiary hearings prior to termination of benefits. *Goldberg* invalidated the prior procedure which permitted termination of benefits without prior notification or hearing. A similar procedure continued in terminating Social Security disability benefits and was upheld in *Eldridge.*

35 424 U.S. at 349. The Court gave substantial deference to "the good-faith judgments of the individuals charged by Congress with the administration of social welfare programs" in formulating agency procedures. *Id.*

36 *Id.* at 335. The Court ultimately found private interests were significantly affected, although to a lesser degree than the welfare recipients in *Goldberg.* The Court concluded that adequate procedural safeguards existed because much of the decision rested on medical reports, supported by x-rays, and other objective evidence. *Id.* at 345. Finally, the court held that the government's interest in conserving fiscal and administrative resources substantially outweighed individual rights. *Id.* at 347-49.

37 *Id.* at 346. The recipient's notification listed information, generally medical reports, which was employed by the agency in its decision making process. However, such letters usually list the name of the physician and date of the report considered rather than specific findings or diagnoses by the doctors.

38 *Id.* at 340.

39 See *supra* note 3 for the full text of the provision outlining the procedures to be followed by state agencies.
least once every three years. Should such review yield a finding of non-disability, "any reconsideration . . . shall be made only after opportunity for an evidentiary hearing . . . which is reasonably accessible to such individual." The "hearings," in actuality, are conducted more as an interview, although the disability claimant may have counsel in attendance and present new evidence or witnesses. Such reviews are conducted by the state agency after an individual files for reconsideration of a termination decision. The reconsideration requests are filed with the claimant's local Social Security office which then forwards the file to the disability determination agency. In addition, the claimant retains the option to continue receiving benefits through the time of his or her hearing before an ALJ. This review procedure, however, is limited to medical disability cessation claims.

On its face, the reconsideration hearing process affords claimants better opportunity to prove that they remain disabled; however, the benefits may be illusory. Individuals now receiving disability undergo closer examination before their benefits are continued. This is true because their disability status is checked more frequently (every three years) than the past sporadic reviews. Furthermore, the SSA has tightened its disability standards.

In contrast, the reconsideration process gives claimants the option to continue receiving benefits during a portion of the appeals process. On the surface, this appears to be a claimant-oriented provision; however, it must be remembered that recovery of any overpaid benefits may be undertaken in the event that a finding of "not disabled" becomes the final decision of the Secretary. Thus, the policing of disability recipients previously alluded to in the legislative history to the 1980 Amendment was put into practice.

III. EVOLUTION OF THE MEDICAL IMPROVEMENT STANDARD IN THE COURTS

The Social Security Administration's accelerated review of disability cases, coupled with its new policy of using current medical evidence as basis for benefit terminations, accounted for the "Great Disability Disas-
ter of 1981-1984." Of the 1.2 million cases reviewed during that time, 491,000 recipients were cut from the rolls, although 215,000 have since been reinstated and many remain at various stages in the appeals process. As a result, judicial intervention became the norm as disability appeals flooded the courts.

Early opinions focused discussion on the issue of which party should bear the burden of proving continuing disability. Several courts presumed that a claimant remained disabled, absent a showing of countervailing evidence; similarly, other courts articulated specific standards requiring medical improvement before benefits could be terminated.

A. Allocation of the Burden of Proof

In one of the first cases deciding the issue of which party must show continuing disability, Marker v. Finch, the court held "the standards to be applied by the court in reviewing a termination of benefits do not differ materially from those applied in reviewing a denial of benefits." Similar standards are used in evaluating both initial application and termination cases; consequently, the court concluded that claimants have the burden of proving disability in termination cases. When their cases are reviewed, beneficiaries must meet the same disability standards that were in effect when their initial applications were filed. Since claimants had the burden of proving disability in an initial entitlement case, the court's logic dictated that they retain this burden on review.

In Miranda v. Secretary of Health, Education and Welfare, the First Circuit Court of Appeals explained the difficulties associated with a strict allocation of the burden of proof to one party:

It is true that one claiming benefits is sometimes described as having the "burden of proof", meaning that he must furnish requisite medical and other evidence within his grasp, . . . and show reasonable diligence in maintaining his claim . . . . For his part, however, the Secretary must make an investigation that is not

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44 Senate Rep. No. 48, see supra note 21, discussed in notes 24-26.
45 See supra note 10.
46 Pursuant to 42 U.S.C. § 405(g), judicial review of a decision made by the Secretary is appropriate when the issue is to determine whether the Secretary's decision is supported by substantial evidence. These actions are filed in a federal district court.
48 Id. at 909. The court's justification rested on the fact that disability benefits are not paid continuously after the initial award to a claimant. A claimant would be subject to ongoing review of his case. At the review, the case would be handled in the same manner as an initial application.
49 Id. at 909-10. In termination and initial entitlement cases, the burden of proof is allocated in the same manner.
50 514 F.2d 996 (1st Cir. 1975).
wholly inadequate under the circumstances . . . . These responsibilities resist translation into absolutes, especially because social security proceedings are not strictly adversarial. For this reason we see no point in deciding abstractly whether the "burden of proof" at a termination proceeding is on the claimant or the Secretary. Both have responsibilities. 51

The sound reasoning of this analysis cannot be overstated. The court intuitively recognized that both parties involved have an obligation to insure a fair review of the benefit recipient's file. Since the ultimate issue in cessation cases is whether the termination decision is supported by substantial evidence, the parties' responsibilities for creating a complete record on which to base the review becomes important. Both the claimant and the Secretary should submit evidence bearing on the claimant's disabled condition or lack thereof. The trier of fact may then render a decision based on a complete record.

Subsequently, the Third Circuit Court of Appeals, in Torres v. Schweiker, 52 provided a persuasive rationale for "believ[ing] the view that the burden of proof remains with the claimant in a termination case . . . ." 53 In support of its position the court first relied on Mathews v. Eldridge: 54 "In order to establish initial and continued entitlement to disability benefits a worker must demonstrate that he is [disabled]," and that, "[t]o satisfy this test the worker bears a continuing burden of showing, by [appropriate medical means], that he is disabled." 55 From this statement, the Torres court concluded that the description of the termination procedures mandated allocation of the burden of proof to the claimant. Secondly, the court sought guidance from the statutory definition of disability which prohibited a finding of disability unless the claimant "furnish[ed] such medical and other evidence . . . as the Secretary may require." 56 The court reasoned that such language placed the burden of proving medical disability squarely on the claimant.

51 Id. at 998 (citations omitted). Finding that both parties had the duty to submit evidence supporting their respective positions, the Miranda court believed a fair adjudication was possible by determining whether the termination decision was supported by substantial evidence. In the context of a disability case, substantial evidence is defined as evidence that "a reasonable mind might accept as adequate to support a conclusion." Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938).
52 682 F.2d 109 (3d Cir. 1982).
53 Id. at 111. The court recognized that the ALJ, not the reviewing court, generally determined which party has the burden of proof. In this case, however, the ALJ did not explicitly address that issue. Since the question of disability "might have turned on who had the burden of proof" the court determined this issue was appropriate for their consideration.
54 424 U.S. 319 (1976); see supra notes 34-36.
55 424 U.S. at 336.
56 42 U.S.C. § 423(d)(5)(1982). In its entirety, this section provides that "[a]n individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require."
Finally, the court employed its earlier decision in *Rossi v. Califano* as a framework for allocating the burden of proof in termination cases. *Rossi* held that a claimant established his *prima facie* case of disability by showing that he cannot return to his former work; the court, in *Torres*, extended this standard to cessation cases. Proving inability to return to one's past work, however, does not guarantee an award of disability benefits; rather the claimant's age, education and work experience must be considered in determining whether he can perform another type of job; only if he is unable to perform another type of job is the claimant found to be disabled. The question of which party had the burden of introducing evidence on this issue was not answered in *Rossi*. In *Torres*, however, the court reasoned that "considerations of fairness and policy required that the Secretary bear the risk of non-persuasion on the element of disability on which the Secretary is in a better position than the claimant to introduce evidence." The court recognized that the Secretary, in comparison to claimants, has both a greater financial base and more convenient access to job availability information; this places the Secretary in a better position to introduce such evidence. While the claimant continues to bear the ultimate responsibility for proving disability, the burden of proof shifts to the Secretary on the final issue of alternate jobs. The analysis of the *Torres* court echoes the *Miranda* decision by recognizing that both parties have obligations in disability proceedings.

**B. Presumption of Continued Disability**

The *Miranda* opinion noted that after the initial disability determination is made, there is a presumption of continued disability. The court held that termination of benefits could be based either on current evidence showing a claimant's improved condition, or on evidence that a claimant's condition was not as severe as initially believed. However, in a

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57 602 F.2d 55 (3d Cir. 1979).
58 20 C.F.R. § 404.1521(f)(1)(1984). This section states:
If you cannot do any work you have done in the past because you have a severe impairment, we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled.

*Id.*
60 514 F.2d 996 (1st Cir. 1975).
footnote, the court rejected a past ruling that discouraged consideration of evidence from a prior determination. Instead, the court stated that "it would be wrong for the Secretary to terminate an earlier finding of disability on no basis other than his appraisal of the earlier evidence." This statement gave presumptive effect to the earlier determination of disability. Following this rationale, a comparison of the current medical evidence with that supporting the prior finding of disability is required when a beneficiary’s case is re-evaluated. The court’s decision protects claimants in two ways: first, a finding of disability could not be overturned simply because the state agency concluded that the prior grant of benefits was erroneous; second, the court hinted that benefits must continue if medical improvement in the recipient’s condition could not be established. The court thus articulated a reasonable method for conducting continuing disability reviews.

Once certain evidence establishes the existence of a disability, logic dictates that the same evidence cannot also indicate nondisability. Courts continued to rely on the *Miranda* analysis and once again the use of prior evidence as the sole basis for overruling the previous determination was struck down. In *Simpson v. Schweiker*, the Eleventh Circuit Court of Appeals held:

If, however, the evidence in a continuation case is substantially the same as the evidence had been in the initial disability benefits request case, benefits must be continued. Otherwise, termination of benefits will often depend not on a finding of changed condition, but simply on the whim of a changed ALJ.

The *Simpson* decision addressed valid concerns. The court recognized that problems existed due to the lack of uniform standards for review and noted that in all likelihood the party evaluating the case on review would

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61 *Id.* at 998 n. *.* The *Miranda* court refused to uphold the proposition that the Secretary cannot take into account medical evidence considered earlier when the disability was first established. See Pedroza v. Secretary, 382 F. Supp. 916 (D.P.R. 1974). Rather, the court opined that the ALJ should "appropriately contrast the relative strength or weakness of earlier medical evidence and relevant earlier events with claimant's current condition." 514 F.2d at 998 n. *.* Accordingly, an individual could not be stricken from the disability rolls unless evidence showing nondisability was submitted. Proof that the original impairment was not as severe as initially believed was also sufficient to justify termination of benefits.

62 691 F.2d 966 (11th Cir. 1982).

63 *Id.* at 969. Such concerns were addressed by Congress in *SENATE REP. NO. 408, 96th Cong., 2d Sess. 53, reprinted in 1980 U.S. CODE CONG. & AD. NEWS 1277, 1331.* The committee report noted that reversals of state agency determinations varied among ALJs. From January to March, 1979, 33 percent of the ALJs awarded claims to zero to 46 percent of the cases they decided; 46 percent granted benefits to 46-65 percent of cases heard; and 21 percent awarded claims to 65 to 100 percent of the claimants who appeared before them.
differ from the one who initially granted disability benefits. Additionally, absent guidelines, ALJs were free to devise their own evaluation methods, and the prior disability determinations might not be considered. Inequitable decisions clearly abound under such a system, especially where existing disability definitions differ from those initially developed. Improved claimants whose cases were reviewed by sympathetic ALJs may remain on the rolls; in contrast, truly disabled individuals may lose benefits should their cases be reviewed by ALJs who refused to consider previous evidence. The likelihood of this situation prompted the Simpson court's second suggestion—that some effect be given to prior disability determinations.

The trend toward giving presumptive effect to prior determinations was followed in Patti v. Schweiker. In the opinion of the Ninth Circuit Court of Appeals, "all the presumption does is impose on the Secretary a burden to come forward with evidence that the claimant's condition has changed." The court justified its position in this way: "A presumption, of course, does not affect the ultimate burden of proof. It does, however, impose 'on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption.'" Under such reasoning, a claimant is still required to prove his case. Once disability has been presumed, the claimant retains the burden of showing that his condition remains disabling. Thus, evidence supporting continued disability must be supplied by the claimant, much like the procedure outlined in Torres. The Secretary then has the opportunity to rebut the claimant's position.

In a subsequent decision, Kuzmin v. Schweiker, the Third Circuit made an important distinction when discussing the presumptive effect given a prior disability determination:

We make a distinction between the issue of the existence of a medical condition and the issue of the existence of statutory disability. There is no policy reason to presume the continuation of a medical condition. Since such conditions may and do change, no consideration of administrative consistency is implicated. On the other hand, the Secretary's prior determination that a particular

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64 45 Fed. Reg. 55,566 (1980). This publication details updated regulations. Also contained are policies followed by the SSA which were never codified as specific regulations. Included were "other policies we [the SSA] have adopted based on our experiences in evaluating disability claims over many years." Id.
65 669 F.2d 582 (9th Cir. 1982).
66 Id. at 587.
67 Id. (quoting FED. R. EVID. 301). The court was "unable to discern any reason" why this principle could not be applied in disability benefit cases. Id.
68 714 F.2d 1233 (3d Cir. 1983).
medical condition has resulted in a statutory disability does implicate administrative consistency.\textsuperscript{69}

Under this rationale, little effect is given to the fact that a claimant continues to suffer from an impairment experienced at the time initial benefits were first granted. If this condition originally met the statutory definition of disability, however, presumptive effect is given and the claimant is deemed to remain disabled. By recognizing the need for consistent determinations, the \textit{Kuzmin} court reinforced the call for uniform standards made by other courts. At the same time, the court assured that some uniformity would prevail by its standard, at least until specific regulations were promulgated by the Secretary.

Thus, the presumption of continued disability assured some degree of uniformity in disability decisions. Specifying which party bore the burden of proving continued disability eliminated confusion in the re-evaluation process. The particular evidence needed to prove continued disability was further demonstrated by the courts' development of medical improvement standards.

\textbf{C. The Medical Improvement Standard}

The dispute over the medical improvement standard was prompted by a change in the regulations issued by the Secretary of Health and Human Services:

\textit{We explain a new policy on when disability is considered to stop. At one time, we would not find that disability or blindness had stopped unless the medical evidence showed that the person's condition had improved since we last determined that he or she was disabled. About three years ago, we changed this policy and began to find that disability or blindness had stopped if we found, on the basis of new evidence, that the person was not disabled or blind as defined by law.}\textsuperscript{70}

This announcement indicated that the Secretary had previously relied on an improvement standard, but such a policy had been abolished in favor of basing the re-evaluation solely on evidence obtained at the time of the periodic review. The new regulations made it clear that "disability ends

\textsuperscript{69} \textit{Id.} at 1237. The court believed that a claimant would not be unduly burdened by producing evidence that his condition remains unchanged; one claiming disability would undoubtedly remain under some treatment or medical supervision. However, this rationale ignores the plight of low-income beneficiaries who may not have regular physicians and may receive treatment only infrequently. While many of these persons remain statutorily disabled, they lack the requisite proof because their finances do not provide much leeway for treatment.

when current evidence shows that the individual is able to engage in substantial gainful activity regardless of whether actual improvement can be demonstrated.\textsuperscript{71} The SSA's apparent disregard for its prior determinations met with disfavor in the courts, especially in those courts which had adopted the presumption of continuing disability rationale.

In \textit{Rush v. Secretary of Health Services},\textsuperscript{72} the Eighth Circuit refused to endorse the Secretary's new regulation; rather, it stated "'an agency's interpretation of its own regulation is entitled to deference by the courts . . . [however], an agency's interpretations are not conclusive and courts are not bound by them.'\textsuperscript{73} The court concluded that the new regulations "do not say what the Secretary says they mean. They do not even come close to saying that a prior determination of disability may be disregarded without any new evidence.'\textsuperscript{74}

The \textit{Rush} court further stressed that SSA policies were inconsistent as a result of the new regulations:

\begin{quote}
We also note that the Secretary is entitled to rely on a prior determination that a claimant is not disabled and, without holding a hearing, dismiss a second claim on the ground that it is barred by the doctrine of res judicata . . . . We believe that a prior determination that a claimant's condition is disabling should be given similar preclusive effect to prevent the termination of benefits solely on a reappraisal of the prior evidence.\textsuperscript{75}
\end{quote}

The court's analysis clearly demonstrates that the SSA's refusal to give its prior determinations presumptive effect was arbitrary. The new regulation illustrated yet another problem created by a lack of uniform standards to determine disability. After a termination of benefits based on current evidence, a claimant's only apparent safeguard was an appeal to a

\begin{footnotes}
\textsuperscript{71} \textit{Id.} at 55,583. The Secretary stated that requiring a clear showing of improvement "can result in the payment of benefits to persons who can engage in substantial gainful activity and who are no longer disabled or blind within the meaning of the law." \textit{Id.} The Secretary continued:

The decision that a person's disability or blindness has ended will not be based on a reexamination of old evidence but will be based on new evidence which will have to reasonably show that the person is able to perform substantial gainful activity. We do not agree that a finding that a person is disabled or blind should be allowed to stand in the face of evidence to the contrary simply because of the lack of evidence clearly showing medical improvement. We do not feel these regulations are unfair and we believe that the requirements of these new regulations provide adequate safeguards for persons who are still disabled or blind.

\textit{Id.}

\textsuperscript{72} 738 F.2d 909 (8th Cir. 1984).
\textsuperscript{73} \textit{Id.} at 914 (citing \textit{Cunningham v. Tuau}, 728 F.2d 1101, 1105 (8th Cir. 1984)).
\textsuperscript{74} 738 F.2d at 914.
\textsuperscript{75} \textit{Id.} The court continued, however, that it would enforce administrative \textit{res judicata} when a properly adjudicated dispute was involved.
\end{footnotes}
court with the hope that a sympathetic judge would give presumptive effect to the prior disability determination.

Most courts recognized that the "medical improvement" and "presumption of continued disability" standards are essentially identical. In fact, "[t]he presumption of disability approach . . . accomplishes the same thing as an improvement standard . . . [and] typically incorporates an improvement standard . . . . Under either standard benefits may not be terminated without showing that the recipient's medical condition has improved." Despite the similarities between the two standards, the circuit courts were divided over which one of these standards was controlling.

Circuits adopting the medical improvement standard concentrated attention on the findings revealed by comparing prior and current medical evidence. The significance of this comparison was first illustrated in Cassiday v. Schweiker:

Given that the evidence continued to show the existence of the same condition, and given that there was no question of improvement, . . . we think Mrs. Cassiday made out a prima facie case and the burden had shifted to the Secretary to justify the termination of benefits.

The court thus articulated a two-part standard requiring that the claimant continue to suffer from the same condition as when he was first declared disabled and that the evidence reveal improvement in this condition. This test was to be applied when comparing evidence from the prior disability evaluation with that obtained at the time of the periodic review.

Rather than enunciate specific standards, several courts spoke of medical improvement in general terms. For example, in Hayes v. Secretary of Health, Education and Welfare, the Sixth Circuit determined that the evidence did not "support the conclusion that termination of Hayes' benefits..."

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78 Id. at 634-35. The opinion noted that the Third, Sixth, Eighth, Ninth, and Tenth Circuits adopted the medical improvement standard while the Fifth Circuit followed the presumption of disability approach. The Holden decision stated that the Ninth and Fourth Circuits adopted the presumption of continuing disability; it mentioned that the Eleventh Circuit followed an improvement standard. 584 F. Supp. at 473. In a footnote, the Holden court found that the Second Circuit "has neither rejected nor adopted the medical improvement standard" while "no available opinion sets forth the views of the District of Columbia Circuit on this question." Id. at 474 n. 8.
79 663 F.2d 745 (7th Cir. 1981).
80 Id. at 749. The court's reference to the claimant's lack of improvement became a widely discussed factor in preventing termination of benefits; however, when read in the context of the opinion it appears to be merely a passing reference.
81 656 F.2d 204 (6th Cir. 1981).
fits was proper because her condition had improved. The Fifth Circuit required evidence "suggest[ing] that the condition has improved or that it was not as serious as once thought." Such decisions failed to define the level of improvement necessary to support a termination decision.

Other courts, however, explained the concept of improvement. The Second Circuit's decision in DeLeon v. Secretary of Health and Human Services stated that a "comparative standard should be employed in deciding whether to terminate an individual's benefits. If the claimant's condition improves to the point where he or she is able to engage in substantial gainful activity, benefits are no longer justified, and may be terminated by the Secretary." In contrast to other circuits, the DeLeon court required substantial evidence of improvement before benefits could be terminated. A slight improvement in the recipient's condition would not warrant cessation of benefits. According to this court's test, the Secretary had to show sufficient recovery to the point that the claimant could return to substantial gainful activity before he was deemed "improved."

The Eighth Circuit held that termination of benefits would be affirmed "by showing that there was clear and specific error in the prior determination or by producing new evidence that the claimant's medical condition has improved, that the claimant has benefitted from medical or vocational therapy or technology, or that the claimant's condition is not so disabling as originally supposed." Under this standard, new evidence showing improvement was required for cessation of benefits. Improvement could be demonstrated specifically by participation in therapy or training or by a conclusion that the prior finding was erroneous based on current medical knowledge. Thus, the court provided some guidance as to the type of evidence needed to show improvement.

Holden v. Heckler, a class action challenging the Secretary's standard for terminating benefits, contained perhaps the most comprehensive definition of medical improvement. The Holden opinion required material.

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82 Id. at 206. The court did not elaborate on specific findings of improvement necessary to prove the claimant's case.
83 Buckley v. Heckler, 739 F.2d 1047, 1049 (5th Cir. 1984). The Buckley court held that evidence of improvement was needed to rebut the presumption of continuing disability; however, substantial evidence was not required to prove the claimant's disability had ceased. Id. Presumably, any evidence was sufficient to disprove the claimant's disabled state.
84 734 F.2d 930 (2d Cir. 1984).
85 Id. at 937. The court also noted some ramifications associated with abolishing the presumption of continued disability. Id. The court recognized that arbitrary decisions would occur without some uniform standard; thus, it mandated application of the improvement standard in cases where an individual was previously found disabled.
86 Id. at 936. See supra note 83 for the Fifth Circuit's view concerning evidence necessary to rebut a prior determination.
87 Rush, 738 F.2d at 916.
medical improvement in a recipient's condition before benefits could be terminated.

Material improvement means that in comparison to the last most recent decision, the medically determinable physical or mental impairment(s) which prevented the person from doing substantial gainful activity and entitled the individual to disability benefits has decreased to the point that the person can now perform substantial gainful activity. This improvement must be demonstrated by medical evidence consisting of signs, symptoms, and laboratory findings and must show positive changes in functional abilities, symptoms or laboratory findings or that the effect of the impairment(s) on the person has decreased.\(^\text{89}\)

Additional methods of demonstrating improvement were also outlined.\(^\text{90}\) From the Holden court's explicit definitions, both benefit recipients and the Secretary were advised of the type of evidence necessary to support a termination decision. Benefits could not be arbitrarily terminated based on a conclusory statement that the claimant had improved; rather, objective medical evidence including laboratory findings and symptoms was required to show improvement. The court also expanded the avenues available for terminating benefits by including advancements in therapy, improved diagnostic techniques, and vocational rehabilitation as acceptable reasons. This decision clearly eliminated any ambiguities plaguing the demonstration of improvement in a benefit recipient's condition.

Various medical improvement standards, both general and specific, were adopted by the circuit courts for application in Social Security disability appeals. Such action, however, remained the claimant's sole remedy. The SSA ignored the court decisions and continued to terminate

\(^{89}\) Id. at 494-95.

\(^{90}\) Id. at 495. Specifically, improvement may also be found when:

(a) New medical evidence shows that while an individual's underlying condition may not have changed, advances in medical therapy or technology have reduced or eliminated the effect the condition had on the individual; or

(b) New or improved diagnostic techniques or other medical evaluations show that an individual's previously determined medical condition is not as serious as it was supposed to be at the time of the most recent prior determination; or

(c) New evidence shows that while an individual's underlying condition may not have changed, the individual's vocational abilities have so improved through education or training acquired up to the time of the most recent determination of disability that he or she is able to engage in substantial gainful activity; or

(d) The individual has compensated or adjusted to the effects of his medical condition, resulting in the ability to engage in substantial gainful activity, or there has been a change in prognosis.

Id.
benefits based on current medical evidence alone. Congress finally took action and included a medical improvement standard in the 1984 Amendment to the Social Security Act.

IV. THE STATUTORY MEDICAL IMPROVEMENT STANDARD

The Social Security Disability Benefits Reform Act of 1984 was signed into law on October 9, 1984. The initial purposes of the Act were three-fold: 1) to clarify statutory guidelines for determination processes to ensure that no beneficiary loses benefits as a result of a careless or arbitrary decision; 2) to provide more humane and understandable application and appeal processes for disability applicants and those appealing terminations; and 3) to standardize the policy making procedures and to conform with standard practice of federal law, by requiring the Secretary to adhere to Federal Circuit Court of Appeal rulings. While it is questionable whether these goals can be achieved, the amendment in its final form does include a standard for reviewing the termination of disability benefits.

The new medical improvement standard outlines seven situations in which termination of disability benefits is justified:

1. substantial evidence demonstrates that
   a. there has been any medical improvement in the individual's impairment or combination of impairments [other than improvement not related to his or her ability to work] and
   b. the individual is now able to engage in substantial gainful activity (SGA); or
2. substantial evidence, consisting of new medical evidence, and a new assessment of RFC, demonstrates that although there is no medical improvement

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91 The SSA adopted a practice of "non-acquiescence" and continued to follow its own policy regulations rather than circuit court decisions. In Hillhouse v. Harris, 547 F. Supp. 82, 92 (W.D. Ark. 1982), the court noted that the SSA was bound to follow the decisions of the court of appeals unless or until they were reversed by the Supreme Court. While both the House and Senate proposed amendments addressed non-acquiescence, no statutory provision was included in the 1984 Amendment. The joint committee urged the Secretary to seek resolution of this issue in the Supreme Court. H.R. Rep. No. 618, 98th Cong., 2d Sess. 22-27, reprinted in 1984 U.S. Code Cong. & Ad. News 3039, 3059-63.


(a) a person has benefitted from advances in medical or vocational therapy or technology relating to ability to work, and
(b) the individual is now able to perform SGA; or

(3) substantial evidence demonstrates that although there is no medical improvement
(a) the person has benefitted from vocational therapy, and
(b) the individual can now perform SGA; or

(4) substantial evidence, based on new or improved diagnostic techniques or evaluations indicates that the person's impairment or combination of impairments is not as disabling as it was originally believed to be at the time of the prior determination and that therefore the individual is able to perform SGA; or

(5) substantial evidence contained in the file at the original determination or new evidence shows that the prior determination was in error; or

(6) there is substantial evidence that the original decision was fraudulently obtained; or

(7) the individual is currently engaged in SGA (except where he or she is eligible under Section 1619), or fails without good cause to cooperate in the review or follow prescribed treatment or cannot be located.95

The first test permits termination of benefits if there is substantial evidence demonstrating any medical improvement in the individual's impairment and the person is now able to engage in substantial gainful activity (SGA). This provision, however, poses several problems. Most significantly, evidence showing any medical improvement appears to be acceptable to meet the first part of the test. Such language appears to indicate that even a slight change in one's condition would sufficiently signify improvement.

While providing that improvement must be shown by "substantial evidence,"96 the amendment contains a loophole that is potentially harmful to low-income beneficiaries. As noted, evidence from the prior determination must be compared to evidence currently obtained in order to demonstrate improvement. Evidence supporting an initial determination

95 42 U.S.C.A. § 423(f)(West Supp. 1985) sets forth the exact statutory language of the medical improvement standard. This Note paraphrases the statute and will refer to the amendment's text in summarized form.

Final rules governing SSA's interpretation of the medical improvement standard have been published at 50 Fed. Reg. 50,118 (1985) and codified at 20 C.F.R. §§ 404.1579, 404.1586, 404.1594, and 416.994 (December 6, 1985).

96 See supra note 51 for the definition of substantial evidence.
consists of any available hospital records, attending physician reports, statements of the claimant, and consultative examination reports requested by the SSA. If sufficient objective findings establish disability, benefits are awarded. Many low-income beneficiaries, however, do not have regular physicians and receive infrequent treatment; thus, they have little evidence substantiating their claim to present to SSA. In such cases, claimants are referred to a physician employed by the agency for a one-time consultative examination (CE) to assess disability. "CEs, however, frequently work to the detriment of a claimant and in no way are an effective substitute for the testimony of a claimant's treating physician."

The use of so-called "volume providers" (medical sources that perform a large number of CEs) to conduct CEs has drawn criticism concerning the quality of examinations conducted. Problems presented are the consulting physician's inability to obtain an adequate medical history or his concentration on one aspect of a claimant's condition. Yet, these examinations may provide an indigent claimant's only proof of whether his condition has or has not improved.

Upon periodic review, if the beneficiary failed to provide evidence from his own medical sources, he would be sent to a SSA physician for a consultative examination. Despite the fact that the exam will include objective measurements of the claimant's condition, a certain amount of

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90 20 C.F.R. §§ 404.1512 (1984) (detailing the claimant's responsibility to submit evidence); § 404.1513 (listing acceptable sources of evidence); and § 404.1517 (explaining the procedure and reasons for scheduling a consultative examination).
98 20 C.F.R. § 404.1513(b) (1984). Objective findings include signs which can be observed and laboratory findings such as clinical tests and x-rays. See 20 C.F.R. § 404.1528(b), (c) (1984).
99 20 C.F.R. § 404.1517 (1984). This section provides:
If your medical sources cannot give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person who will do it. We will also give the examiner any necessary background information about your condition when your own physician will not be doing the examination or test.

Id.
100 Barber, Social Security Disability Hearings: Securing Additional Medical Evidence for the Indigent Claimant, 37 Ad. L. Rev. 479, 485 (1985). This article details some of the problems presented by employing consulting physicians to evaluate disability claimants.
101 UNITED STATES GOVERNMENT ACCOUNTING OFFICE HRD-86-23, SSA CONSULTATIVE MEDICAL EXAMINATION PROCESS IMPROVED; SOME PROBLEMS REMAIN (1985) [hereinafter cited as GAO/HRD-86-23].
102 Id. at 16.
103 Barber, supra note 100, at 486.
104 Id.
subjectivity may enter into the doctor's conclusion.\textsuperscript{105} Thus, this doctor's findings may indicate that the claimant's condition has improved from the time of his last evaluation. According to the amendment, substantial evidence of "any medical improvement" justifies termination of benefits.

Secondly, benefits can be terminated absent medical improvement if new evidence demonstrates that the claimant "benefitted" from medical or vocational therapy related to work ability. In addition, a present ability to engage in SGA must be shown. This new evidence must include a reassessment of the individual's residual functional capacity (RFC)\textsuperscript{106} to engage in work activities. The third section provides for termination of benefits absent medical improvement if benefit from vocational therapy and ability to perform SGA can be demonstrated.\textsuperscript{107} The "benefit" derived from successful completion of therapy is a greater work capacity by the individual. Both sections disregard a claimant's lack of improved physical condition, apparently assuming that the individual's participation in some kind of therapy renders him fit to return to work. Neither provision requires a showing of medical improvement in order for benefits to stop. This provision actually discourages beneficiaries from seeking therapy because the term "benefitted" is left open to interpretation—does it mean mere participation in therapy? Or, will demonstration of a certain level of

\textsuperscript{105} A consultative examiner who derives a substantial annual income from SSA may be more apt to want to please his employer. The Government Accounting Office study indicates that volume providers' average gross income from CEs in the 1983 fiscal year was \$348,672. While 61 percent of the physicians received an annual income ranging from \$100,000 to \$250,000 as a result of CEs, six volume providers earned over \$1 million. GAO/HRD-86-23, supra note 101, at 47.

\textsuperscript{106} 20 C.F.R. § 404.1545 (1984). The term residual functional capacity is generally defined as:

Your impairments may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is what you can still do despite your limitations. If you have more than one impairment, we will consider all of your impairments of which we are aware. We consider your capacity for various functions as described in the following paragraphs; (b) physical abilities; (c) mental impairments, and (d) other impairments. Residual functional capacity is a medical assessment. However, it may include descriptions (even your own) of limitations that go beyond the symptoms that are important in the diagnosis and treatment of your medical condition. Observations of your work limitations in addition to those usually made during formal medical examinations may also be used. These descriptions and observations, when used, must be considered along with the rest of your medical record to enable us to decide to what extent your impairment keeps you from performing particular work activities. This assessment of your remaining capacity for work is not a decision on whether you are disabled, but is used as the basis for determining the particular types of work you may be able to do despite your impairment. Then, using the guidelines in §§ 404.1560 through 404.1569, your vocational background is considered along with your residual functional capacity in arriving at a disability decision. Id.

\textsuperscript{107} This section is not specifically included in either group of exceptions to medical improvement as contained in the regulations. See 20 C.F.R. § 404.1594(d)(1985).
skill be required? If the former, then any claimant who has participated in some type of therapy may be stricken from the disability rolls since his participation in a rehabilitation program could be deemed a "benefit of advances in therapy."

The second test is particularly troublesome in that it permits a reassessment of residual functional capacity (RFC) without a showing of change in the beneficiary's condition. If the claimant's condition has not improved, it is reasonable to conclude that RFC remains equally unchanged. Furthermore, the provision fails to state what type of "new evidence" is required. Would a report discussing a continued impairment, having findings as detailed as the prior evidence, and showing no improvement be considered "new evidence" simply because it is by a different doctor (one unconnected with the prior determination)? Permitting such a substitution of judgment would have a prejudicial impact on beneficiaries' entitlement to continued benefits. In its present form, this ambiguous provision supplies the basis for potentially unfounded and arbitrary termination decisions.

The fourth situation allows termination of benefits where new or improved diagnostic techniques indicate that the impairment is not as disabling as believed at the time of the prior determination and that, therefore, the claimant can perform SGA. The first three situations contained in the standard are essentially two-part tests, requiring a showing of either improvement or therapy and the present ability to engage in SGA. However, the ambiguous phrasing of the fourth section "and that therefore the individual is able to perform SGA" leads to a different conclusion. This section can be interpreted as meaning that, because heightened medical awareness or knowledge discounts the prior finding, the individual is deemed able to perform SGA.

However, the use of "new or improved techniques" may place claimants at a disadvantage in meeting their burden of proving continuing disability. For instance, in determining the severity of a back impairment, SSA medical advisors place greater weight on the results of a myelogram than on x-ray findings. Such internal policies are not published; conse-

108 The regulations specify that RFC is a medical assessment; consequently, a new RFC seems unnecessary if the individual's medical condition has not improved.

109 The agency regulations require that even if the exception for new and improved diagnostic techniques applies, a present ability to engage in SGA is also required. 50 Fed. Reg. 50,118, 50,120 (December 6, 1985). The regulations, therefore, bring this test of medical improvement in conformity with the others.

110 See 1 M. HOUTS, LAWYERS' GUIDE TO MEDICAL PROOF §§ 501.02, 502.01 (1984). In discussing the diagnosis of conditions causing lumbar spine pain, this text states that "[n]o x-ray diagnosis is possible unless [the] fundamental difference in density of soft tissue in the spinal cord can be demonstrated on the x-ray film." Id. at § 502.01. Use of a myelogram permits the soft tissue to be seen on the x-ray which in some cases may furnish the only proof of a disabling back condition. Id. at § 502.12(10). Claimants are generally unaware of this "evidence hierarchy," thus making their burden of proof almost impossible to meet.
quently, claimants do not know what the SSA considers to be "better evidence." This hinders the ability of claimants to meet their burden of proof. Claimants may not supply results from a myelogram merely because they believe x-rays are sufficient objective findings to document their impairment. SSA's internal policies generally are exempt from the Administrative Procedure Act's rule-making procedures, which require publication of proposed rules; however, there is value in requiring the publication of rules affecting substantial rights of claimants. A claimant's ability to establish his prima facie case is hampered by the government physicians' use of the unpublished "evidence hierarchy;" publication of these policies would lessen their prejudicial impact on claimants.

SSA final rules address this problem with respect to the agency's use of new and improved diagnostic techniques to evaluate medical improvements. The regulations provide that a cumulative listing of changed evaluative techniques since 1970 will be published in the Federal Register and updated periodically. This practice will allow claimants to present evidence of their disability by objective test results which SSA has specified as acceptable. While this listing may not curb SSA's tendency to dismiss certain evidence favorable to claimants as unsatisfactory in view of other evaluative methods which are available, claimants will be put on notice as to SSA's expected course of action.

In order to stop benefits, the fifth provision requires a showing by prior evidence or by new evidence that the prior award of benefits was erroneous. Using prior evidence contravenes the principle of res judicata, which holds that a final decision on the merits of a case is conclusive as to

111 Administrative Procedure Act, 5 U.S.C.S. § 553(a)(2)(Law. Co-op. 1980). This section exempts matters relating to agency management or personnel, or to public property, loans, grants, benefits or contracts from rule-making procedures. Since it is considered a benefit program, SSA procedures would be exempt.

112 Rivera v. Patino, 524 F. Supp. 136, 148 (N.D. Cal. 1981). The court specifically held that "[a]dministrative rules,... having a substantial impact upon private rights may not be made without notice and comment procedures, even if the rule is exempt from Section 553."

113 20 C.F.R. § 404.1594(d)(2)(ii)(1985). This section states that information about new or improved techniques will be provided in two ways: through changes in the techniques required in the medical criteria listed in Appendix 1 of Subpart F of Pt. 404 or by publication in the Federal Register.

114 An example of SSA's evidence hierarchy is demonstrated in Sec. 4.00G.4. Cardiovascular System, 20 C.F.R. Pt. 404, Subpart P, Appendix 1 (1985). The medical criteria requires that treadmill exercise tests control over other evidence. Only if such tests are unacceptable can other diagnostic tests be used to prove disability. Claimants having coronary artery obstruction generally present cardiac catheterization reports as evidence of their condition. If the catheterization report details findings equal to those listed in the medical criteria of Appendix 1, the claimant should be found "disabled." However, in these cases, SSA may order a treadmill exercise test and compare it to other medical criteria. Regardless of the catheterization results, the claimant may be found "not disabled" based on the exercise test. This practice is prejudicial to certain claimants who meet the medical requirements for disability based on the catheterization, yet are denied benefits by virtue of the controlling treadmill tests.
the rights of the parties and constitutes an absolute bar to a subsequent action involving the same claim. The Secretary applies *res judicata* to its prior denials of benefits and dismisses new applications alleging the same disabilities that were previously denied. In the interest of consistency, this principle should be equally applied to prior grants of benefits. Keeping the original determination intact would not preclude termination of benefits; rather, the Secretary would be free to apply one of the other tests contained in the new Act to prove the disability has ended.

The sixth test permits termination of benefits when substantial evidence shows that the original decision was fraudulently obtained. The final situation requires benefits to stop if the recipient is currently engaging in SGA. These two provisions are justified; by scrutinizing cases on review with these two factors in mind, SSA could eliminate abuses which may plague the system.

In comparison to the medical improvement standards derived from case law, this amendment most closely resembles the *Holden* standard. The legislative standard, however, contains one glaring omission. Despite extensive discussion by the courts, the amendment does not provide for a presumption of continuing disability. Rather, the legislative standard of proof provides that "any determination . . . shall be made on the basis of the weight of the evidence and on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled." The legislature intended for decisions to be made "on a basis which is as nearly neutral as possible."

Congress "eliminate[d] any confusion that might result from shifting burdens of proof" and concluded that "the claimant's obligations to establish the existence of his disability with regard to the CDI [continuing disability investigation] proceeding are the same as his obligations with regard to an initial determination." Congress placed the burden of proof squarely on the claimant; however, the legislators ignored the fact that the presumption of continued disability has the same effect. As noted, the ultimate burden of proof is not affected by a presumption. Once disability is presumed, the claimant continues to have the burden of showing that he remains disabled. The only burden the Secretary must meet is to rebut

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115 BLACK'S LAW DICTIONARY 1174 (5th ed. 1979).
116 20 C.F.R. § 404.957(c)(1)(1984). The SSA's arbitrary application of *res judicata* was discussed in *Rush*, 738 F.2d at 914.
117 See supra notes 89-90.
118 42 U.S.C. § 423(f)(1984)(emphasis added). This provision was phrased "to avoid any misinterpretation with respect to the role of the claimant and the Secretary in pursuing evidence or with respect to the non-adversarial nature of the proceeding." H. CONF. REP. NO. 1039, 98th Cong., 2d Sess. 26, reprinted in 1984 U.S. CODE CONG. & AD. NEWS 3080, 3084.
120 Id.
the claimant's allegation of disability by showing that the claimant can perform other jobs. Before the Secretary is required to show such evidence, however, the claimant must have already met his burden of proof.\textsuperscript{121}

The enactment of a medical improvement standard is almost meaningless in view of the loopholes created. Consider the following example: A claimant's file comes up for a periodic review and he furnishes evidence demonstrating that his condition remains unchanged since the time benefits were initially awarded. Presumptive effect is not given to this prior determination and despite the claimant's unchanged condition, a new reviewer may conclude that the condition was never disabling; therefore, the initial determination was erroneous and termination of benefits is warranted. Conceivably, the claimant would be liable for repayment of those benefits which were "erroneously" awarded. SSA could then begin proceedings for recovery of the overpaid benefits.\textsuperscript{122} This scenario is entirely possible, especially in view of the medical improvement standard provision that allows benefits to be terminated after a finding that the original award was erroneously granted.

Congress's desire to abolish the presumption of continued disability conflicts with basic principles of evidence. Presumptions are often used to "tilt" the case in order to achieve certain social objectives.\textsuperscript{123} This aim certainly fails in the case of the medical improvement standard. Congress failed to include a presumption of disability in the interest of "neutrality." This omission appears to allow a balanced review of the claimant's file; in actuality, the case tilts in the SSA's favor. A presumption does not relieve the party asserting it from the burden of proving his case; rather, it "imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption."\textsuperscript{124}

As applied to the medical improvement standard, a presumption that the claimant remains disabled would not change the analysis. Upon review, the claimant would be presumed disabled based on the decision from his last review. He would be required to present evidence substantiating the fact that his condition remains unchanged from that date. The burden of proof would then shift to the SSA to rebut this conclusion. The Secretary could apply the exceptions which it has codified from the statutory standard at this stage.

In its present form, the entire continuing disability review procedure creates a presumption of medical improvement which the claimant must rebut. If SSA did not presume medical improvement over a period of time,

\textsuperscript{121} 20 C.F.R. §§ 404.1521(e),(f)(1984). These sections contain the final steps of the Secretary's sequential analysis employed in evaluating a disability case.

\textsuperscript{122} SSA procedures covering overpayment of benefits are found at 20 C.F.R. §§ 404.501-404.515 (1985).

\textsuperscript{123} C. McCormick, Evidence § 343 (2d ed. 1972).

\textsuperscript{124} Fed. R. Evid. 301.
there would be no need for periodic reviews of claimants' disabilities and benefits would be paid continuously. From its inception, therefore, the medical improvement evaluation is not a neutral process. Claimants are now subject to having the error exception applied to the previous disability determination which apparently is not conclusive. Presuming continued disability would balance the review rather than sway it in the claimant's favor; this is desirable because the Social Security Act is remedial in nature and is to be liberally construed in favor of disability.\textsuperscript{125}

Some of the regulations governing implementation of the improvement standard illustrate this presumption of improvement. One exception deals with new or improved diagnostic techniques to show the individual's impairment is not as disabling as previously believed. The provision states that "improved methods for measuring and documenting the effect of various impairments on the ability to do work" may serve as a basis for finding that a claimant is no longer disabled.\textsuperscript{126} The following example is listed in the regulations:

The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.\textsuperscript{127}

To accurately measure whether improvement has occurred, another Master's 2-step test should be administered at the time of the periodic review. By introducing "new and improved" techniques such as the EKG into the analysis, the issue of improvement becomes clouded. The EKG may indicate that the claimant has the RFC to perform a certain level of work; under this exception, therefore, SSA would terminate the claimant's benefits. Using two different measurement tools may not accurately indicate improvement since it is akin to comparing apples and oranges. Under the new regulation, SSA will view the EKG as controlling simply because it is a "new or improved" evaluative technique. Acceptance of the EKG because of its nature as an advanced diagnostic tool presumes a claimant's condition is not as disabling as was previously believed. This may not be true in all cases.

This flaw in the improvement standard will undoubtedly lead to extensive litigation that could have been prevented by retaining the presump-

\textsuperscript{125} Williams v. Califano, 590 F.2d 1332 (5th Cir. 1979); Miles v. Celebrezze, 233 F. Supp. 767 (W.D.S.C. 1964).

\textsuperscript{126} 20 C.F.R. § 404.1594(d)(2)(1985).

\textsuperscript{127} Id.
tion of disability. In so doing, the claimant would need to prove his condition persists to the point that he continues to be incapable of doing his former job. The Secretary could then rebut the presumption by applying the medical improvement exceptions. Since these exceptions require improvement or therapy and the ability to engage in SGA, the Secretary's burden would remain essentially unchanged.\footnote{See supra notes 57-59 and accompanying text. The Secretary's burden of proof is to demonstrate that the claimant can engage in some type of work existing in substantial numbers in the national economy, 20 C.F.R. § 404.1520(f)(1985).}

V. CONCLUSION

Including a medical improvement standard in the 1984 amendment to the Social Security Act was viewed by Congress as a panacea to the confusion created by massive termination of disability benefits upon periodic reviews. The threat of arbitrary termination decisions had long plagued the Social Security disability system due to the lack of uniform guidelines for reviewing continuing disability cases. The medical improvement standard outlines much-needed criteria for use in conducting periodic re-evaluations of disability recipients; yet, the newly-enacted standard has the potential for creating additional problems.

The improvement standards developed in the courts specifically allocated the burden of proof between the parties. Despite the fact that claimants retained the ultimate burden of proving their continued disability, beneficiaries were presumed to remain disabled unless the Secretary introduced evidence to the contrary. Citing neutrality in decision-making as a goal, Congress eliminated the presumption of continued disability from the amendment. Absent this presumption, problems with the burden of proof remain.

As a result, a claimant's \textit{prima facie} case is more difficult to establish, especially in view of certain phrasing used in portions of the standard. Substantial evidence demonstrating any improvement may disprove the claimant's position. On the surface, this level of evidence appears adequate to contradict a claim of continued disability; however, it must be remembered that substantial evidence requires only "more than a mere scintilla."\footnote{Consolidated Edison v. NLRB, 305 U.S. 197, 229 (1938).} Thus, substantial evidence does not even approach the weight of evidence which the claimant is required to present.\footnote{See supra note 51. Substantial evidence is "more than a mere scintilla" but less than a preponderance of evidence. However, a claimant must continue to prove his case by a preponderance, which makes his burden greater than that of the Secretary.} The amendment apparently requires very little evidence to demonstrate improvement and justify the termination of benefits.

In addition to problems with the burden of proof, eliminating the presumption of continued disability apparently permits the Secretary to ter-
minate benefits by deeming the prior conclusion erroneous. As a result, the Secretary's inconsistent policy of applying the doctrine of *res judicata* only to his own prior benefit denials is impliedly endorsed.

In its present form, the medical improvement standard is a mixed blessing. It provides a much-needed definition of the term "medical improvement" that can be employed by the Secretary when conducting periodic reviews. The standard clearly provides the guidance that the prior system lacked. On the other hand, problems still abound. The elimination of the presumption of disability forces claimants to prove their case far beyond a preponderance of the evidence while the Secretary's rebuttal may be structured in terms of substantial evidence. While claimants may have initially believed that the enactment of a medical improvement standard was a victory, they must become aware of the pitfalls it contains.

The medical improvement standard ensures beneficiaries that there is some measure of consistency in the periodic review process. Until newly-enacted regulations are actually applied to termination cases, the courts can enjoy a somewhat lightened docket; at least until the next onslaught of cases challenging the Secretary's interpretation of the medical improvement standard.

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