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Report to the Chairman, Committee on Finance, U.S. Senate

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SOCIAL SECURITY DISABILITY

SSA Quality Assurance Improvements Can Produce More Accurate Payments

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Health, Education, and
Human Services Division

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June 3, 1994

The Honorable Daniel Patrick Moynihan
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

This report, prepared at your Committee's request, examines the effectiveness of quality assurance (QA) mechanisms used by the Social Security Administration (SSA) to promote the accuracy and consistency of disability determinations under the Disability Insurance (DI) and Supplemental Security Income (SSI) programs.[1] In 1993, the DI program provided about $34.6 billion to 5.3 million disabled workers and their dependents, and the SSI program provided about $24 billion to 6 million recipients. Although SSA administers these programs, state agencies called disability determination services (DDS) determine whether claimants are disabled according to program rules.[2]

In recent years, disability benefit claims have increased significantly and at an unprecedented rate. SSA and DDSs have been unable to keep up with the high rate of claims submitted for benefits. From fiscal years 1982 through 1989, the average number of claims received yearly was about 1.6 million and the number of claims pending averaged about 266,000. By contrast, in 1993, claims receipts numbered 2.6 million, and claims pending more than doubled to about 555,000.

Your Committee was concerned about the effect of increasing workload pressures on the quality of disability determinations. To address this concern, we evaluated (1) the reliability of SSA's reported accuracy rates and (2) the effectiveness of SSA's QA mechanisms to ensure the accuracy and consistency of DDS disability determinations and minimize erroneous payments. To perform our work, we reviewed SSA's QA policies and procedures and the results of QA reviews. We discussed QA issues with SSA officials at headquarters and at selected SSA regional offices and DDSs. (App. I completely describes our scope and methodology.)

[1]The former Chairman requested our review.

[2]DDSs number 54—1 in each state, the District of Columbia, Puerto Rico, and Guam. South Carolina also has a separate agency for the blind.

Results in Brief

Since 1980, SSA has reported national accuracy rates for DDS disability determinations of at least 94 percent. Some people have questioned the reliability of these reports. Current accuracy rates reflect SSA's decisions about how errors should be measured. By its nature, the disability determination process involves judgment about whether claimants' impairments are sufficiently disabling for them to qualify for benefits. Except when judgments are clearly wrong, SSA's review program is generally designed to not assess errors, even though the agency's QA reviewers may have a different opinion on the eligibility decisions reached.

Currently, SSA is undertaking a disability reengineering effort to fundamentally rethink and radically redesign the disability determination process. This effort offers a way to improve the quality of DDS disability determinations. SSA should, for example, ensure the effective use of performance accuracy standards. Since establishing accuracy standards in 1981, SSA has not reviewed their effectiveness. In our view, the effective use of accuracy standards can provide DDSs an incentive to seek continued quality improvement. In addition, to the extent that the judgments of QA reviewers are incorrect and cases are not returned to DDSs for correction, the reliability of the accuracy rates used to measure whether DDSs meet standards is questionable.

A redesigned QA process should enhance the ability of DDSs to ensure the quality of their determinations. As SSA pursues its reengineering project, it should address the issue of how DDSs can improve the quality of their determinations. DDS internal QA programs are critical to correcting the root causes of errors. SSA, however, has not ensured the effective design and operation of DDS internal QA programs.

Currently, SSA is required by law to perform a mass review of one-half of the DDSs' DI award determinations before they take effect. Ideally, such determinations should be corrected before they leave the DDSs. Until this has been accomplished, however, SSA's mass preeffectuation review is a cost-effective interim quality control mechanism. Since 1980, this review has helped increase the accuracy of DDSs' favorable DI determinations and saved more than $2 billion in unnecessary trust fund expenditures. Although SSA's reengineering effort may make the disability determination process less subject to error, it will take some time to realize the results. In the meantime, millions of dollars more could be saved. For example, if physician consultants had reviewed all the cases selected in 1992, an additional $84 million in estimated savings would have been realized. To

perform such an expanded physician review would have required an additional $10 million in administrative expenditures.

Background

DI is the nation's primary source of income replacement for disabled workers insured under Social Security. A parallel program, SSI, provides benefits for aged, blind, and disabled indigent persons. Some people, whose work histories are so limited that they quality for very low DI benefits, can receive DI and SSI benefits concurrently. DI recipients are also eligible for Medicare benefits, and SSI recipients are eligible for Medicaid benefits. DI funding is provided through a trust fund and SSI funding through general revenue appropriations. DDSs generally use the same standards and procedures for determining disability in both programs.

SSA administers the disability programs with the assistance of DDSs, which make the initial determinations on whether claimants' impairments are sufficiently disabling for them to qualify for benefits.[3] DDSs also reconsider unfavorable initial determinations when requested by claimants, and they periodically review the condition of those receiving benefits to determine their continued eligibility. SSA refers to the later review as a continuing disability review (CDR). SSA funds the DDSs and provides them with guidance for making disability determinations.

To measure DDS performance accuracy, SSA reviews random samples of each DDS's initial award and denial determinations and computes individual DDS accuracy rates, which it compares to accuracy standards. Also, to inform the Congress and others of how well claims are being adjudicated, SSA uses the results of its random sample review to compute a national accuracy rate (based on combined award and denial accuracy). In 1993, SSA's random samples constituted 1.4 percent of DDSs' initial disability determinations.

Legislative Requirements for QA

In 1980, the Congress enacted the Social Security Disability Amendments. These amendments were enacted to help promote accurate and consistent disability determinations as well as to strengthen SSA's oversight of DDSs. First, the amendments required that SSA establish performance standards for DDSs. In 1981, SSA established a performance accuracy standard of 90.6 percent. This standard, referred to as a threshold level, is the lowest standard of quality that SSA will accept from DDSs. If a DDS's accuracy rate does not fall below the threshold standard for two consecutive calendar

[3]Impairment refers to the medical problem(s) affecting someone's capacity to work.

quarters, SSA said that it would not interfere in that DDS's operations. In addition, SSA established an accuracy target standard of 97 percent for performance and service delivery, which DDSs should constantly strive to attain. SSA said it would negotiate intermediate goals with DDSs each year as stepping-stones to reach the target standard.

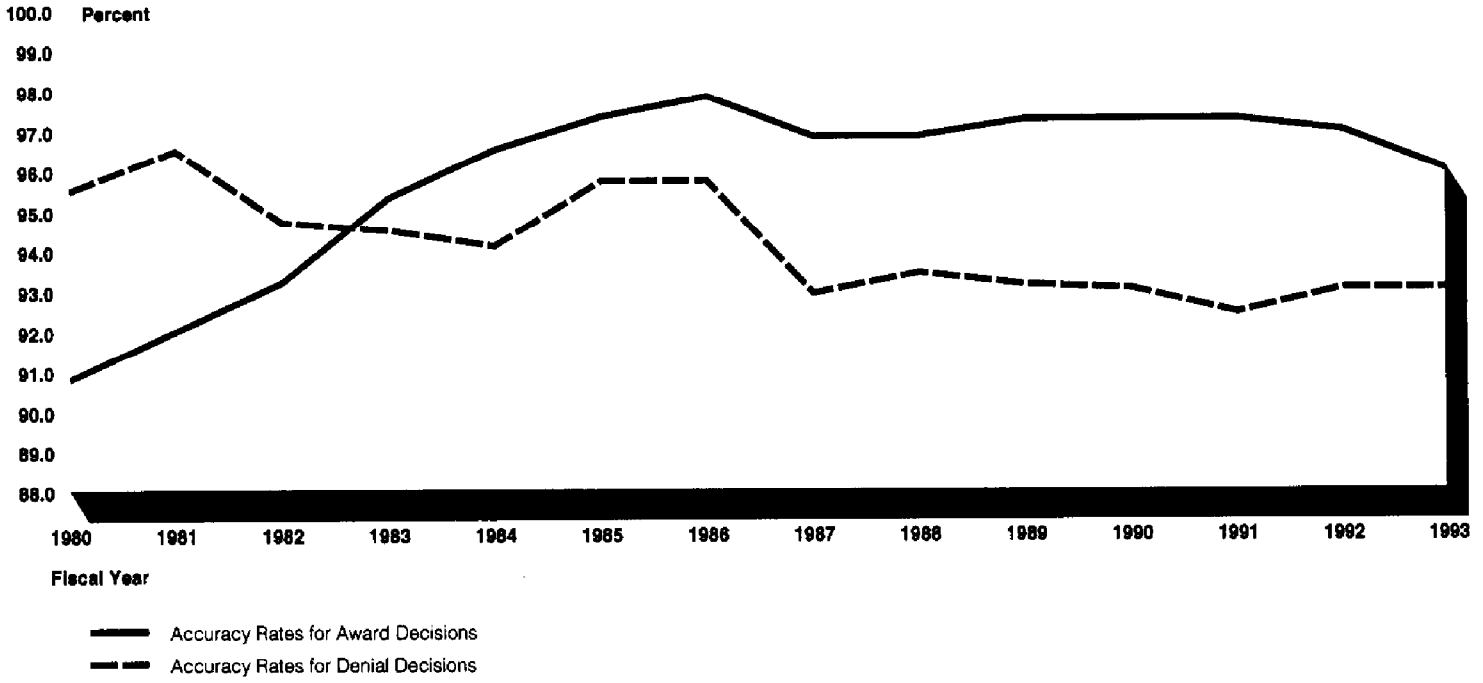
Second, the 1980 amendments required SSA to review 65 percent of all favorable DI initial and reconsideration awards and CDR continuances made by DDSs before they take effect—referred to as a preeffectuation review.[4] This review, by reducing the number of incorrect DI awards, helps to protect the solvency of the DI Trust Fund.[5] In 1990, the Omnibus Budget Reconciliation Act (OBRA) reduced this review to one-half of DI initial and reconsideration awards, plus a sufficient number of CDR continuances to ensure their accuracy. OBRA also required—to the extent feasible—that SSA target its reviews to awards most likely to be incorrect.

Since 1980, trends in the accuracy of initial DDS award and denial determinations show that award accuracy rates generally improved during 1980 through 1993, while denial accuracy rates generally declined. See figure 1.

[4]The law permitted this review to be implemented in phases: at least 15 percent in the first year, 35 percent in the second year, and 65 percent thereafter.

[5]SSA reviews awards for DI benefits and for concurrent DI and SSI benefits. By preventing incorrect concurrent DI and SSI awards from taking effect, SSA also reduces unnecessary SSI payments.

Figure 1: Trends in Accuracy Rates of Initial Awards and Denials



(Fiscal Years 1980-1993)

Source: SSA.

For fiscal year 1992, SSA estimated that about 7,100 DI[6] and 7,600 SSI claimants were incorrectly awarded benefits and that about 31,000 DI and 24,000 SSI claimants were incorrectly denied benefits. Incorrectly denied claimants may need to submit to several appeal levels before receiving their rightful benefits. (Additional information on QA for the disability programs appears in app. II.)

Subjectivity of the Disability Determination Process

The disability determination process frequently involves judgment to determine whether claimants' impairments are sufficiently disabling for them to qualify for benefits. In recent years, changes in adjudication policies (such as the need to give increased emphasis to pain and to

[6]After taking into account cases corrected before payment because of SSA's quality measurement and preeffectuation review, the number of incorrectly awarded DI claimants was reduced to 4,400.

treating physicians' opinions) have increased the amount of judgment involved in making disability determinations.

To determine whether a claimant qualifies for disability benefits, the application proceeds through a five-step sequential evaluation process developed by SSA (see app. III). As the application proceeds through each step of the process, the amount of judgment involved in making a disability determination generally increases. At step four in the process, for instance, DDS physicians are to perform a residual functional capacity (RFC) assessment to judge whether claimants can perform certain activities despite their limitations. These RFC assessments are viewed as highly judgmental. For physical impairments, an RFC assessment is used to generally categorize a claimant's ability to work by various levels of exertion (such as sedentary or light). A one-level difference in such categories can make the difference between award or denial of benefits. In fiscal year 1992, 34 percent of DDS awards were determined on the basis of RFC assessments.

SSA's Efforts to Reengineer the Disability Determination Process

In October 1993, SSA began a disability reengineering project to fundamentally rethink and radically redesign its disability determination process, from start to finish. SSA expects to change the process to make it easier for individuals to file for and, if eligible, receive disability benefits promptly and efficiently. A goal of these efforts is to increase the accuracy and consistency of disability determinations. As part of this effort, SSA also has a goal of improving the QA process.

SSA Has Never Reviewed the Effectiveness of Accuracy Standards

SSA has never reviewed the effectiveness of its performance accuracy standards in promoting continued quality improvement. For example, after setting a 90.6-percent threshold standard in 1981, SSA never raised the standard, even though DDSs had met or exceeded the standard since 1988. In addition, SSA has not evaluated whether its QA reviewers correctly apply rules that they are to follow in deciding if a DDS's determination is in error. To the extent that these rules are misapplied and cases are not returned to DDSs for correction, the reliability of the accuracy rates used by SSA to measure whether DDSs meet standards is questionable.

Accuracy Standards Unchanged Since 1981

SSA has not evaluated the effectiveness of its accuracy standards since establishing them in 1981. By 1993, however, four DDSs had accuracy rates that met or exceeded the 97-percent target level. In addition, 10 other DDSs

had accuracy rates of between 96.0 and 96.9 percent. (See app. IV for fiscal year 1993 DDS accuracy rates.) Furthermore, since 1988, no DDS has fallen below the 90.6-percent threshold standard for two consecutive calendar quarters.

To develop the 1981 threshold standard, SSA used 1979 national accuracy rates and set the level at one standard deviation below the national mean accuracy rate. In adopting this methodology, SSA took what it called a "middle-of-the-road" approach. SSA believed a higher threshold would have imposed an unrealistic demand on DDSs and a lower threshold would have done little more than reinforce the status quo. At that time, an estimated 13 DDSs would not meet the 90.6-percent threshold level. Using this same approach, the threshold level, if raised in 1993, would have been 93.5 percent. In 1993, 12 DDSs had performance accuracy rates that fell below 93.5 percent for two consecutive quarters. In regard to a threshold level of performance, SSA said that this level should be periodically raised to (1) ensure continued improvement in public service, (2) emphasize the importance of accurate and well-documented decisions, and (3) give DDSs an incentive to further improve performance.

In setting accuracy standards, SSA said it would periodically reevaluate whether they continued to be effective in promoting further quality improvement. According to SSA, however, no evaluation has been made. SSA officials suggested that such an evaluation not be limited to SSA's current approach to setting standards. The officials, for example, suggested that, because of the general decline in denial accuracy rates since 1980, SSA may need to establish separate standards for award and denial determinations. In addition, SSA may need to redefine the point at which it provides DDSs with management assistance because of poor performance.

Reliability of Reported Accuracy Rates Is Questionable

Because of the subjectivity of the disability determination process, SSA established, in the late 1970s, QA rules to reduce or prevent its QA reviewers from superimposing their judgments on DDS decisionmakers. Although these rules may be appropriate, SSA has not evaluated whether its QA reviewers are correctly applying them.

SSA instructs its QA reviewers to avoid substituting their judgment for that of the DDS when they believe that a DDS's determination to award or deny benefits can be equally supported by the evidence in the case file. In such situations, the QA reviewers do not record an error and the case is not

returned to the DDS for correction. SSA had no readily available information to determine the frequency with which this "substitution-of-judgment" rule is applied.

SSA has another rule that its QA reviewers must follow when they find that required documentation is missing from the case file. Before returning cases with missing documentation to a DDS for correction, SSA instructs its QA reviewers to judge whether the DDS should have obtained all required documentation to support its determination. If a QA reviewer believes that obtaining the missing documentation is unlikely to reverse a DDS's determination, the case is not returned for correction. Instead, the missing documentation is classified as a technical deficiency.[7] As a result of this "probability-of-reversal" rule, about 1,600 (4 percent) cases reviewed for quality measurement purposes in fiscal year 1992 had missing documentation errors that were not included in SSA's reported accuracy rates.

SSA has not determined whether its substitution-of-judgment and probability-of-reversal rules are being applied correctly. To the extent that QA reviewers misapply these rules by not returning cases with errors to DDSs, reported accuracy rates are overstated. For example, if a case with missing documentation had been returned for further development, the additional evidence obtained may have shown that a DDS's disability determination was incorrect.

SSA Has Not Ensured the Effective Design and Operation of DDS Internal QA Programs

To improve the accuracy of disability determinations, the root causes of errors need to be corrected. Effective QA reviews at the DDS level are critical to meeting this objective. Currently, however, DDSs have varied programs of internal QA, and many may not be staffed adequately. SSA does not prescribe DDS internal QA program design nor their staffing and funding. A 1989 SSA internal study recommended that SSA establish requirements to ensure that DDSs have effective internal QA programs, but SSA did not implement this recommendation.

As part of its QA structure, SSA requires that each DDS have an internal QA program to detect and correct the root causes of errors in all aspects of claims adjudication. However, SSA does not prescribe program design or staffing. Instead, SSA gives DDSs maximum management flexibility to design

[7]SSA classifies errors into one of three categories: performance accuracy, period of disability, and technical. Although errors from all three categories are used to monitor DDSs' performance, only performance accuracy errors are included in reported accuracy rates. See appendix II for additional information.

and operate QA programs that best suit their particular needs. Only if a DDS fails to meet the minimum level of acceptable quality will SSA impose specific QA requirements as part of its plan to improve performance.

Nevertheless, SSA provides DDSs with discretionary guidelines that describe a full range of QA activities recommended by SSA. For example, to be effective, SSA recommends that an internal QA program provide a systematic review of issues involved in all aspects of DDS claims processing to detect and correct deficiencies and problems. SSA also recommends that DDSs establish an independent QA unit to perform ongoing and systematic reviews of random samples of all types of disability determinations. Based on an analysis of findings from the sample case review and other sources of feedback, SSA also recommends that the QA unit separately target high-risk (deficiency-prone) cases for review. Based on a QA unit's analysis of findings, SSA further recommends that special studies be conducted to (1) identify the root causes of errors, (2) recommend corrective actions, (3) experiment with new methods for improving claims adjudication, and (4) determine training needs.

A DDS random sample and targeted review of error-prone cases is necessary because SSA's quality measurement sample is generally too small to reliably identify all error trends or root causes of errors that may occur in all aspects of claims processing. For example, SSA's quality measurement sample included only 0.6 percent of the initial decisions made by the California DDS during fiscal 1993. California QA officials said they needed to review a separate random sample of cases to supplement the limited information provided from SSA's sample.

In addition, SSA's quality measurement review is an end-of-line review focused on the outcome of the adjudicative process (decisional and documentational accuracy). SSA recommends that DDSs also focus on the process by which they develop and adjudicate claims to fully evaluate and maintain the quality of their final determinations. Recommended process issues that may affect outcomes include appropriateness of consultative medical examinations, contacts of all medical sources, and adequate explanations of the rationale for determinations made.

In 1989, an SSA internal work group studied the effectiveness of DDS internal QA programs. This study was initiated because various courts had criticized the ability of DDSs to apply disability determination criteria consistently and because a prior SSA study found that SSA's requirements were inadequate to ensure a minimum level of QA activity. Previously, due

to a lack of information on DDS QA programs, SSA asked DDSs to provide information on their QA programs. SSA found that the design of DDS internal QA programs varied considerably in the use of QA principles, such as random samples. We also found similar variation during our visits to six DDSs. For instance, three of the six DDSs reviewed all types of determinations, four DDSs selected cases randomly, and two DDSs performed only targeted reviews.

The work group recommended that SSA ensure that DDSs have effective internal QA programs. In 1989, SSA internally circulated the work group's recommendation for review. In 1990, SSA decided not to implement the recommendation. When we asked why this recommendation was not implemented, SSA stated that its decision at that time was based on its preference to continue allowing DDSs maximum flexibility in designing their QA programs.

DDSs have had problems devoting adequate staff to their QA programs. As we reported in 1993, we surveyed DDSs nationwide to determine the effects of heavy claim processing workloads on their operations as well as other matters.[8] Nineteen of the DDSs told us that, due to heavy claim processing workloads, QA staff were spending between 41 and 100 percent of their time processing claims. Another eight DDSs said that QA staff spend 21 to 40 percent of their time processing claims. In our view, heavy workload pressures require more—rather than less—QA activity. It is reasonable to assume that since SSA projects that DDSs will continue to experience heavy claim processing workloads in the future, DDS use of QA staff for other duties is likely to continue.

Preeffectuation Review as an Interim Quality Control Mechanism

Although SSA's reengineering effort may make the disability determination process less subject to error, it will take some time to realize the results. In the meantime, as an interim quality control mechanism, SSA's required mass preeffectuation review is currently cost effective. Since 1980, this review has saved more than $2 billion in unnecessary expenditures. Nevertheless, millions of dollars more could be saved from this review.

Benefits of Preeffectuation Review

For fiscal year 1992, SSA estimates that each person awarded DI benefits will receive, on average, DI and Medicare lifetime benefits of about $79,000. Thus, by preventing just one incorrect DI award determination from taking

[8]See Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).

effect, SSA's fiscal 1992 preeffectuation review saved the DI and Medicare trust funds about $79,000 in lifetime benefit payments.

As required by law, SSA's fiscal year 1992 preeffectuation review included one-half of DDSs' favorable DI and concurrent initial and reconsideration determinations. In total, this review changed about 3,700 favorable DI determinations (1.3 percent) to denials, saving the trust funds about $186 million or $9 for every $1 spent performing the review.[9]

Based on SSA data, we estimated that the remaining one-half of the fiscal year 1992 DI initial awards—which SSA is not required to review—contained about 1,700 incorrect awards. These incorrect awards are estimated to result in erroneous lifetime benefit payments of $137 million from the DI and Medicare trust funds.

Also, SSA is not required to and does not perform a preeffectuation review of favorable SSI-only determinations. However, of the 479,000 SSI disability awards made by DDSs in fiscal 1992,[10] SSA estimates that DDSs incorrectly awarded benefits to about 7,600 claimants. Based on SSA data, we estimated that these claimants would receive an estimated $303 million in erroneous lifetime SSI benefit payments, excluding any Medicaid benefits received.

Another benefit of a preeffectuation review is that once individuals are incorrectly awarded benefits, it is unlikely that their benefits will be discontinued. SSA is required by law to perform a CDR to ensure that people receiving DI benefits are still eligible for them.

However, we reported in 1993 that, since fiscal year 1987, SSA has conducted only about half of the more than 2 million required CDRs.[11] Furthermore, for people to be removed from the disability rolls, SSA generally must demonstrate that individuals have experienced medical improvement in their impairments and can return to work. SSA officials said that, generally, it is difficult to show medical improvement for people who were not medically disabled when awarded benefits. Because of this,

[9]Fiscal year 1992 was the most current year that such data were available. The $186 million reflects the fact that an estimated 38 percent of individuals whose awards are changed to denials will successfully appeal the denial. Administrative costs to SSA were $20.4 million, excluding any costs that DDSs may incur in handling returned cases.

[10]Represents recipients receiving only SSI disability benefits. Claimants for SSI disability may be awarded both DI and SSI benefits concurrently.

[11]See Social Security Disability: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993).

it is important to ensure that only those qualified for disability are awarded benefits. Preeffectuation reviews accomplish this by changing incorrect awards before they take effect.

Targeting reviews can also be beneficial. In 1990, we recommended to the Congress that section 221(c) of the Social Security Act be revised to permit SSA to conduct a more cost-effective targeted review of favorable DI determinations.[12] At that time, we found that SSA reviewed cases randomly, rather than target its review to the most error-prone cases. As a result, in OBRA of 1990, the Congress required that SSA—to the extent feasible—target its reviews to awards most likely to be incorrect.

During fiscal year 1992, SSA selected about 63 percent of the preeffectuation review cases from error-prone categories. By targeting, SSA saved a total of $186 million, including an estimated $30 million in lifetime benefits due solely to targeting. For fiscal year 1994, SSA expects about 75 percent of its preeffectuation review cases to be in error-prone categories.

Cost Effectiveness of Current Preeffectuation Review Effort Can Be Improved

SSA can further improve the savings from its current preeffectuation review effort by increasing the proportion of cases reviewed by physicians. As demonstrated by quality measurement review results, the preeffectuation review does not return as many deficient determinations to DDSs for correction as the quality measurement review does. For example, during fiscal year 1992, SSA returned 3.0 percent of DI initial determinations in the quality measurement sample, but only 2.2 percent in the preeffectuation sample. SSA officials said this difference resulted because physicians review nearly all cases in the quality measurement sample, but only about one-quarter of the cases under preeffectuation review.

Based on data provided by SSA, we estimate that, if physicians had reviewed all preeffectuation review cases in 1992, about 1,700 more incorrect awards would have been identified. Preventing these incorrect awards would have saved an additional $84 million in lifetime benefit savings for the DI and Medicare trust funds.[13] The estimated cost of this expanded physician review would have been about $10 million. SSA QA

[12]See Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

[13]Fiscal year 1992 was the most current year that data were available. The $84 million reflects the fact that an estimated 38 percent of individuals whose awards are changed to denials will successfully appeal the denial.

officials told us that, despite the cost effectiveness of physician review, competing internal priorities for administrative funds have limited the number of physician consultants to review cases.

Conclusions

SSA has not reviewed the effectiveness of its accuracy standards in promoting continued quality improvement. However, since 1988, no DDS has fallen below the 90.6 percent threshold standard for two consecutive quarters. Thus, to promote continued quality improvement, the threshold standard should be raised. In addition, as SSA pursues its reengineering effort, it may need to develop new approaches to establishing standards and ensuring their effective use.

SSA has not evaluated whether its QA reviewers are correctly applying the substitution-of-judgment and probability-of-reversal rules. To the extent that SSA's QA reviewers misapply these rules by not returning cases with errors for correction, reported accuracy rates for DDSs are overstated.

A reengineered QA structure should enhance the ability of DDSs to ensure the quality of their determinations. Significantly improving accuracy and consistency requires that the root causes of errors in the disability determination process be identified and corrected. Effective DDS internal QA programs are critical to correcting the root causes of errors. Currently, however, SSA does not prescribe DDS QA program design, staffing, or funding.

Agency officials should recognize that it will take some time to realize the results of the disability reengineering effort. In the meantime, millions of dollars more in erroneous benefit payments can be saved by improving the effectiveness of SSA's mass preeffectuation review.

Recommendations

We recommend that the Commissioner of Social Security do the following:

- Evaluate the effectiveness of performance accuracy standards in promoting continued quality improvement, including raising the current threshold standard and considering new approaches to setting and using accuracy standards.
- Determine whether QA reviewers are correctly applying the substitution-of-judgment and probability-of-reversal rules.
- Establish requirements to ensure that DDSs have internal QA programs that effectively identify and correct the root causes of errors, including the

extent to which any additional QA requirements would result in the need for increased QA staffing.

- Develop a plan to increase the savings gained through preeffectuation reviews by increasing the proportion of cases reviewed by physician consultants.

Agency Comments

We requested written comments on a draft of this report from SSA, but none was provided. However, SSA officials did provide us with written technical comments that we incorporated in the report, as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Commissioner of SSA, and other interested parties. If you have any questions regarding this report, please contact Barry D. Tice, Assistant Director, at (410) 965-8021 or William E. Hutchinson, Assignment Manager, at (410) 965-8928. Other major contributors to this report are Ira B. Spears, Evaluator-in-Charge, and Natalie H. Herzog, Site Senior.

Sincerely yours,

Jane L. Ross

Jane L. Ross
Associate Director
Income Security Issues

Contents

Abbreviations

CDR	continuing disability review
DDS	disability determination service
DI	Disability Insurance
DQB	disability quality branch
OBRA	Omnibus Budget Reconciliation Act
OPIR	Office of Program Integrity and Reviews
QA	quality assurance
RFC	residual functional capacity
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income

Scope and Methodology

We performed our audit work at Social Security Administration headquarters in Baltimore, Maryland. We discussed quality assurance issues with responsible officials in the Office of Program Integrity and Reviews (OPIR), the Office of Disability Program Quality, the Office of Disability, the Office of Operations Management and Program Integration, and the Office of the Actuary. We also reviewed legislation, regulations, operational instructions, and reports relative to our review.

We also performed work at SSA's Atlanta, Chicago, and Seattle regional offices. We discussed with responsible officials their quality assurance oversight responsibilities relative to the disability determination services. Also, to better understand SSA's quality measurement and preeffectuation reviews, we talked with QA officials as well as case examiners and physicians in the Atlanta, Chicago, and Seattle disability quality branches (DQB) of the OPIR.

To gather information on DDS internal QA programs and get a broader view of QA-related issues, we visited DDSs in Alabama, California, the District of Columbia, Georgia, Kentucky, and Washington. We also telephoned 15 other DDSs. We discussed QA-related issues with responsible officials and, at the DDSs visited, reviewed records related to internal DDS QA activities.

We conducted our review between October 1992 and November 1993 in accordance with generally accepted government auditing standards.

Quality Assurance in the Disability Programs

The Social Security Administration uses a three-tier quality assurance structure to promote accurate and consistent disability determinations: SSA requires state disability determination services to have internal QA programs (tier one); SSA's regionally based disability quality branches review samples of DDS determinations (tier two); and SSA headquarters staff review samples of cases previously examined by the DQBs (tier three).

At tier one, SSA requires DDSs to establish internal QA programs. However, SSA permits DDSs to vary the design and operation of their QA programs to suit their particular needs. Before the 1980 QA amendments, SSA not only required that DDSs have an internal QA program but also specified how such programs be designed. However, when SSA established performance accuracy standards in 1981, it initially decided to delete its requirement that DDSs have internal QA programs. Although the Congress had previously expressed its view that DDS internal QA programs are vital, SSA believed that the use of standards would be sufficient to advance the quality of disability determinations toward continued improvement. In its final regulations, however, SSA maintained the requirement for DDS internal QA programs, but did not prescribe such programs' internal design, staffing, or funding.

At tier two, SSA's QA staff located in regionally based DQBs review random samples of DDS disability determinations to measure accuracy and consistency.[1] These staff also perform the required preeffectuation review and report to the Office of Program Integrity and Reviews at SSA headquarters. Case examiners who are SSA employees and physician consultants perform the regionally based reviews. Before case examiners can return cases involving a medical issue to DDSs for correction, physicians must find or agree that the determinations are incorrect or are inadequately supported by the evidence in the case file.

At tier three, OPIR monitors consistency among its DQBs by reviewing a sample of cases previously reviewed by the staff. In 1992, this review found that the staff were 99.1 percent correct in deciding to return cases to DDSs and 98.5 percent correct in deciding not to return cases.

SSA classifies errors found from its quality measurement review into one of three categories:

[1]The samples are designed to have a 95-percent chance of reporting DDSs' accuracy rates within 5 percentage points of the true universe value.

- Performance Accuracy—decisional or documentational errors that have the potential to change a disability determination (for example, from a denial to an award).
- Period of Disability—errors that can affect the amount of benefits by changing the period of disability.
- Technical—errors caused by noncompliance with statutory, regulatory, and administrative requirements that do not have an evident potential for changing a disability determination or a period of disability.

Although SSA uses errors from all three categories to monitor DDSs' performance, only performance accuracy errors are counted in DDS performance accuracy rates.

SSA records a performance accuracy error when evidence in the case file shows that a DDS made an incorrect determination or when the case file does not contain sufficient documentation to support the determination and the missing evidence has some potential for changing the determination. Of the approximately 36,000 initial determinations reviewed in fiscal year 1993, about 1,800 had errors classified as performance accuracy errors that were returned to DDSs, resulting in a 94.2-percent performance accuracy rate.

When a DDS agrees that SSA's findings are correct, it changes its determination or obtains additional supporting documentation. If the DDS gets additional documentation, it may support changing the determination or it may better support the DDS's original determination.

In addition, SSA will rescind an error if a DDS can successfully rebut the error. For example, in fiscal year 1992, DDSs rebutted 208 (about 9 percent) of the 2,267 cases returned by SSA. In 82 of the rebutted cases (about 4 percent), the errors were rescinded. After accounting for reversals of original DDS determinations and rescinded errors, SSA calculated a fiscal year 1992 accuracy rate of 97 percent.[2]

Of the 3.3 million favorable and unfavorable disability determinations made by DDSs in fiscal year 1993, SSA reviewed about 55,000 (1.7 percent) for quality measurement purposes. See table II.1.

[2]This accuracy rate is generally referred to as the net accuracy rate. It represents how many original DDS determinations were found ultimately correct whether they were sufficiently documented or not.

Table II.1: Disability Determinations Included in SSA's Quality Measurement Review (fiscal year 1993)

Type of determination	Total	Number reviewed	Percent
Initial	2,514,010	35,941	1.4
Reconsideration	746,512	12,855	1.7
CDRs[a]	27,583	6,016	21.8
Totals	**3,288,105**	**54,812**	**1.7**

Note: Quality measurement samples include Disability Insurance, Supplemental Security Income, and concurrent DI/SSI favorable and unfavorable determinations.

[a]Continuing disability review.

Although, as shown in table II.1, the quality measurement sample constituted 1.4 percent of DDS initial determinations nationally, the proportion of initial determinations sampled for each DDS varies considerably. Such variation is due to SSA's design of the sample to produce quarterly, state-by-state, combined initial performance accuracy rates as required by its standards of performance regulations. Under this design, the same sample size is generally required for a small or large universe, resulting in a greater percentage of the universe being sampled for a small DDS than for a large DDS. For example, SSA drew a sample of about 30 percent of the Alaska DDS's 2,600 initial determinations, but less than 1 percent of the Texas DDS's 161,000 initial determinations.

To meet the legislative requirement for a preeffectuation review of one-half of DI initial and reconsideration award determinations made by DDSs, SSA reviewed about 278,000 of such determinations in fiscal year 1993. Beyond this requirement, SSA also reviewed about 3,000 CDR continuance determinations.[3] See table II.2.

[3]CDR continuances are not counted toward the 50-percent preeffectuation review requirement. However, SSA's review includes CDR continuances to meet a legislative requirement that a sufficient number be reviewed to ensure their accuracy.

Table II.2: Disability Determinations Included in SSA's Preeffectuation Review (fiscal year 1993)

Type of determination	Total	Number reviewed	Percent reviewed
Initial	475,279	224,952	47.3
Reconsideration	61,403	53,111	86.5
Total	**536,682**	**278,063**	**51.8**
CDRs	15,450	2,977	19.3

Note: Cases selected for preeffectuation review include DI and concurrent DI/SSI initial and reconsideration award determinations, but not SSI-only favorable determinations. Included in this review were about 10,800 initial and 2,800 reconsideration award determinations as well as about 3,000 CDR continuance determinations that had been reviewed previously for quality measurement purposes.

Five-Step Sequential Evaluation Process for Determining Disability

Applications for benefits under the Disability Insurance or Supplemental Security Income program are processed through a five-step evaluation, referred to as the sequential evaluation process. Applications continue through the five steps until a determination of disability or no disability is reached.

In the first step, SSA field office personnel determine if claimants are currently engaged in substantial gainful activity (SGA).[1] If claimants' work activity meets the definition of SGA, they are not considered disabled, regardless of medical condition, and are denied benefits.

If an applicant is found not to be engaged in SGA, the SSA field office forwards the application to a state disability determination service for processing through the remaining four steps of the sequential evaluation process. In step two, the DDS determines whether a claimant has an impairment or combination of impairments that is severe and could be expected to last at least 12 months, the duration requirement in the disability definition.

The DDS collects all necessary medical evidence, either from those who have treated the claimant or, if that information is insufficient, from an examination conducted by an independent source. Once all medical evidence has been obtained, if the record shows that a claimant's impairment does not meet the standard for a severe impairment, benefits are denied.

If the claimant is not denied at step two, the DDS proceeds to step three to determine if the claimant's impairment corresponds to a medical condition on SSA's Listing of Impairments.[2] At this step, benefits are allowed if an impairment meets all the requirements of a listing or if the severity of an impairment is medically equivalent to a listed impairment. If the claimant's condition does not meet or equal the requirements in the listing, the evaluation proceeds to step four.

Steps four and five—the final two steps of the sequential evaluation process—are designed to determine whether a claimant has vocational limitations that, when combined with the medical impairment(s), prevent the claimant from working. In step four, the DDS uses its physician's assessment of the claimant's residual functional capacity to determine

[1]Regulations currently define SGA as monthly earnings of more than $500.

[2]The listing contains strict medical criteria that identify impairments considered severe enough, in and of themselves, to prevent any gainful activity.

whether the claimant's former work could still be performed. For physical impairments, an RFC is expressed in certain demands of work activity (for example, ability to walk, lift, carry, push, pull, and so forth); for mental impairments, an RFC is expressed in psychological terms (for example, whether a person can follow instructions or handle stress). If the DDS finds that a claimant can perform work done in the past, benefits are denied.

In the fifth and last step, the DDS determines if a claimant who cannot perform work done in the past can do other work that exists in a significant amount in the national economy.[3] Using SSA guidelines, the claimant's age, education, vocational skills, and RFC are considered to determine what other work, if any, the claimant can perform. Unless the DDS concludes that the claimant can perform work that exists in the national economy, benefits are allowed.

During the disability determination process, benefits can be denied for reasons relating to insufficient documentation or to lack of cooperation by the claimant. These reasons include a claimant's failure to (1) provide medical or vocational evidence deemed necessary to determine disability, (2) submit to a consultative examination needed to provide evidence of disability, or (3) follow prescribed treatment for an impairment. Benefits will also be denied if the claimant asks the DDS to discontinue processing the case.

[3]By definition, work in the national economy must be available in a significant amount in the region where the applicant lives or in several regions of the country. It is inconsequential whether (1) such work exists in the applicant's immediate area, (2) job vacancies exist, or (3) the applicant would actually be hired.

Fiscal Year 1993 DDS Accuracy Rates Accuracy Rates (in percent)

DDS	Awards	Denials	Awards and denials combined
Vermont	99.4	97.4	98.4
Minnesota	99.4	96.4	97.8
South Carolina (blind)	97.5	97.0	97.2
District of Columbia	98.8	95.7	97.0
Maine	99.4	94.8	96.9
Nebraska	98.7	95.5	96.8
Wyoming	96.4	97.2	96.8
Indiana	98.4	95.8	96.7
Alaska	97.7	95.4	96.6
Tennessee	98.0	95.4	96.4
New Mexico	97.7	95.6	96.3
Wisconsin	99.7	93.9	96.1
Alabama	98.0	95.0	96.0
Massachusetts	98.0	94.2	96.0
Illinois	97.6	94.6	95.8
Puerto Rico	97.5	94.6	95.8
Michigan	98.4	93.7	95.7
New Hampshire	98.1	93.7	95.7
Oklahoma	97.8	94.5	95.6
Montana	97.6	94.6	95.6
Iowa	94.3	96.3	95.5
Delaware	97.0	93.9	95.4
West Virginia	96.2	95.0	95.4
Nevada	97.9	92.5	95.2
North Carolina	97.4	93.7	95.2
Arkansas	94.8	95.2	95.1
Kansas	93.8	96.2	95.1
Utah	96.9	92.9	95.0
Colorado	95.9	94.2	95.0
Hawaii	98.8	92.1	94.9
Oregon	98.8	91.9	94.9
Texas	96.0	93.9	94.6
Rhode Island	97.5	92.0	94.5
Ohio	96.4	93.0	94.5
South Dakota	95.7	93.6	94.5
Florida	95.7	93.7	94.4

(continued)

DDS	Awards	Denials	Awards and denials combined
Kentucky	94.7	94.0	94.3
North Dakota	97.7	91.6	94.1
Missouri	95.0	93.5	94.0
Idaho	96.7	91.9	93.9
Georgia	96.4	92.5	93.9
South Carolina	98.2	90.9	93.7
Connecticut	97.7	90.7	93.6
Virginia	95.1	92.5	93.5
Arizona	96.0	91.4	93.3
Maryland	96.9	91.1	93.1
New York	91.7	94.2	93.1
Mississippi	94.9	91.4	92.5
Washington	95.6	89.7	92.4
Pennsylvania	94.6	91.0	92.4
Louisiana	96.8	90.0	92.0
California	94.4	90.4	91.9
New Jersey	92.8	89.2	90.9

Note: Accuracy rates are ranked by awards and denials combined. Rates reflect only initial determinations.

Source: SSA quality assurance reports.

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