

GAO

Report to the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives

SOCIAL SECURITY DISABILITY

Collection of Medical Evidence Could Be Improved with Evaluations to Identify Promising Collection Practices





Highlights of [GAO-09-149](#), a report to the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

The timely collection of relevant medical evidence from providers, such as physicians and psychologists, is key to the Social Security Administration (SSA) process for deciding whether an estimated 2.5 million new claimants each year have impairments that qualify them to receive disability benefits. The initial determinations are generally made by state agencies called Disability Determination Services (DDSs). We evaluated: (1) the challenges, if any, in collecting medical records from the claimants' own providers and ways SSA and the DDSs are responding to these challenges; (2) the challenges, if any, in obtaining high-quality consultative exams and ways SSA and the DDSs are responding to these challenges; and (3) the progress SSA has made in moving from paper to electronic collection of medical evidence. We surveyed 51 DDS directors, visited 5 state DDSs, reviewed sample case files, and interviewed officials with SSA, DDSs, and associations for claimants and providers.

What GAO Recommends

GAO recommends SSA identify DDS evidence collection practices that may be promising, evaluate their effectiveness, and encourage implementation of successful practices in other states, as applicable. To do so, SSA should cost-effectively compile and assess additional data on the collection process. SSA should also work to identify and address barriers to expanded use of its online medical evidence submission options.

To view the full product, including the scope and methodology, click on [GAO-09-149](#). For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov.

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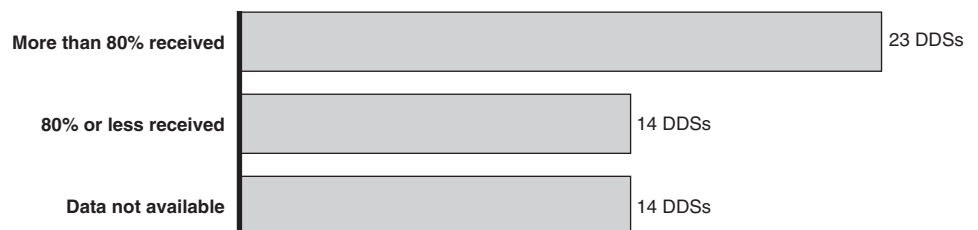
What GAO Found

Obtaining timely and complete medical records is a challenge to DDSs in promptly deciding disability claims, and DDSs have responded with additional provider contacts and adjustments to their payment procedures. Although DDSs pay most medical providers for medical records and SSA pays the DDSs to cover these expenses, 14 of 51 DDSs reported the percentage of requests for which they did not receive records was 20 percent or more in fiscal year 2007. In response to this challenge, all DDSs conduct follow-up with providers and claimants to urge them to provide records. Over half of the DDSs (34 of 51) have also implemented more timely payments for records and six increased the amount they pay. Although SSA evaluates DDS collection of medical records, it does not compile key data necessary to identify and share promising collection practices.

Recruiting and retaining qualified providers is a challenge to obtaining consultative exams needed to supplement insufficient medical records. For example, 41 of 51 DDSs reported routinely asking claimants' own providers to perform these exams; yet 34 reported providers never or almost never agree to do so. DDSs directors in our survey believe that current payment rates account for some of the difficulty recruiting and retaining consultative exam providers. In response to these challenges, 32 DDSs rely on medical providers who specialize in performing disability evaluations, and 20 pay providers for time spent preparing for appointments claimants fail to attend. SSA evaluates evidence from consultative exams, but these evaluations and the data they yield are too limited to identify and share promising DDS practices.

SSA has made progress moving to electronic collection of medical records, but faces challenges in fully implementing electronic retrieval and analysis of medical evidence. SSA now uses electronic images instead of paper copies of new claimants' records. Though SSA seeks to obtain all records electronically and provides options for online submission of records, only one large provider accounts for most of the records submitted online, and about half of all records received are on paper. To date, SSA has taken only limited action to identify and analyze the barriers providers face in using current electronic record submission options, and has not developed a strategy to address them. In the long run, SSA is participating in an advanced prototype to collect medical records in formats that can be searched and analyzed by electronically querying a hospital's records database and directly retrieving the claimants' records.

Some DDSs Face Challenges Receiving Requested Medical Records, Fiscal Year 2007



Source: GAO survey of DDS directors.

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Abbreviations

ALJ	administrative law judge
DDS	Disability Determination Services
DI	Disability Insurance
HIPAA	Health Insurance Portability and Accountability Act of 1996
SSA	Social Security Administration
SSI	Supplemental Security Income
VA	Department of Veterans Affairs

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United States Government Accountability Office
Washington, DC 20548

December 17, 2008

The Honorable Michael R. McNulty
Chairman
The Honorable Sam Johnson
Ranking Member
Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

The Social Security Administration (SSA) has faced challenges for decades in making accurate and timely decisions on whether claimants have impairments that qualify them to receive disability benefits. Some disability applicants whose claims are denied and appeal wait years for their claims to be decided at the final administrative appeals level, which can be a hardship. In fiscal year 2006, 30 percent of claims processed at the hearings stage alone took 600 days or more.¹ To help avoid such hardships and improve its process, SSA Commissioners have emphasized the need to make the right decision at the beginning of the process. The prompt collection of relevant medical evidence is key to SSA's process for deciding each year whether about 2.5 million new claimants have impairments that qualify them to receive disability benefits. SSA estimates that in fiscal year 2007, disability cases prompted an estimated 15 million to 20 million medical records requests sent to providers including hospitals, physicians, psychologists, and community health centers.² The number of new claimants is expected to increase as the baby boom generation ages. To promptly make consistent and accurate decisions on a high volume of claims, SSA needs efficient and effective methods to collect medical evidence, including records from claimants' own medical providers as well as consultative examinations and tests performed by other medical providers.

¹For a discussion of SSA's disability case backlog, see GAO, *Social Security Disability: Better Planning, Management, and Evaluation Could Help Address Backlogs*, [GAO-08-40](#) (Washington, D.C.: Dec. 7, 2007).

²For convenience, we use the term "medical record" to refer to medical evidence of record, which state agencies collect from claimants' medical providers in order to make disability determinations for SSA benefits. We use the term "electronic medical record" to refer to providers' computerized records.

To be eligible for disability benefits under SSA law, individuals must have a medically determinable impairment that prevents them from engaging in substantial gainful activity, and is expected to last at least a year, or result in death. The initial determination of disability is generally made by federally funded, SSA-authorized state agencies called Disability Determination Services (DDS). DDSs help claimants collect medical and other evidence of their impairments. When medical records obtained from claimants' own providers are inconclusive, DDSs obtain additional evidence through consultative examinations. In most cases, DDSs pay medical providers for the medical records and consultative exams at rates set by the states within limits set by SSA, and SSA pays DDSs to cover these expenses. SSA reported that in fiscal year 2007, it paid DDSs about \$1.7 billion dollars for their services, including \$123 million for medical records and \$311 million for consultative examinations. SSA and DDSs are working to transform what is largely a paper process into a computerized one, as the medical community moves to electronic medical records.

To respond to your concern about the adequacy of medical evidence collection in the disability determination process, we evaluated: (1) the challenges, if any, in collecting medical records from the claimants' own providers and ways SSA and DDSs are responding to these challenges; (2) the challenges, if any, in obtaining high-quality consultative exams and ways SSA and DDSs are responding to these challenges; and (3) the progress SSA has made in moving from paper to electronic collection of medical evidence.

To address these topics, we conducted background research and interviews with SSA, SSA Office of the Inspector General, and DDS officials. We also spoke with representatives of professional associations, including those representing people with disabilities; disability examiners; physicians; representatives of claimants; and medical providers. We conducted a Web-based survey of DDSs in all 50 states and the District of Columbia concerning medical evidence collection for initial disability decisions, including DDS practices for collection of medical records and medical opinions from claimants' own providers and from consultative exam providers.³ To learn more about how DDSs collect medical evidence, we reviewed a random, but nonprojectable, sample of 100 claim folders for initial DDS disability determinations during fiscal year 2007; to document the differences in medical evidence collection between the initial and

³For convenience, we refer to the 50 states and the District of Columbia as "states."

appeals levels, we reviewed a random sample of 50 administrative law judges' decisions and their associated claim folders. We conducted site visits to DDSs in large and small states in various geographic regions that purchased medical records for a relatively high or low percentage of claimants, and that requested consultative examinations for a relatively high or low percentage of claimants. Based on these criteria, we visited California, Mississippi, New York, Vermont, and Wyoming. We also analyzed SSA data concerning the disability determination process, including SSA data on DDS cases, and quality assurance reviews of DDS cases by SSA regional Disability Quality Branches. To assess progress in moving from paper to electronic collection of medical evidence, we reviewed SSA documents concerning SSA and the health industry's efforts and analyzed data compiled by SSA's computer system regarding receipts of evidence and discussed efforts to encourage electronic submission with SSA and DDS officials, as well as medical providers. We conducted our review between September 2007 and December 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. For details concerning our scope and methodology, see appendix I. For a summary of our review of randomly selected claim folders from the initial claim and the administrative appeal levels, see appendixes II and III, respectively.

Results in Brief

Obtaining timely and complete medical records is a challenge to promptly deciding disability claims, and DDSs have responded to this challenge with additional provider contacts and adjustments to their payment methods. SSA regulations generally require DDSs to make every reasonable effort to help claimants obtain records from the claimants' medical providers, and to place particular emphasis on opinions from the claimants' treating sources—providers who have an established treatment relationship with the claimants. However, some providers are slow or fail to submit requested medical records. In our survey of DDS directors, 14 of the 51 directors reported that they did not receive responses to 20 percent or more of their requests for medical records during fiscal year 2007. In response, almost all DDSs in our survey reported that they place additional follow-up calls to providers (45) or ask claimants to encourage their providers to submit records (50). Some have gone even further with more than half encouraging providers to respond by improving the timeliness or increasing the amount of their payments for medical records.

Specifically, 34 DDSs reported recently improving the timeliness of their payments for records, 6 DDSs reported increasing the amount they pay, and 2 reported providing incentive payments to providers who submit medical records promptly. SSA routinely conducts quality assurance reviews of DDS compliance with requirements for medical records collection and gathers data from DDSs on budget and program operations, but SSA does not identify and review the effectiveness of promising DDS medical evidence collection practices or compile consistent data necessary for such an evaluation, such as timeliness of medical records receipts.

Recruiting and retaining qualified providers is a challenge to obtaining consultative exams needed to supplement insufficient medical records and, in response, some DDSs have turned to providers who specialize in consultative exams or adopted flexible payment rates. DDS officials report difficulty finding enough medical providers willing to perform consultative exams, even among claimants' own providers—the preferred source for consultative exams under SSA regulations due to their familiarity with the claimant's condition. For example, 41 DDSs in our survey reported routinely asking claimants' own providers if they are willing to perform a consultative exam, but 34 of these DDSs said those providers never or almost never agree to do so. DDS directors we surveyed believe that current payment rates and provider concerns that disability claimants often fail to show up for scheduled exams account for some of the difficulty DDSs face recruiting and retaining willing providers. Most DDSs (32 of 51) reported that they often make consultative exam appointments with specialized medical providers whose practices focus primarily on disability evaluations, and 29 DDSs said using such providers has a moderately positive or very positive effect on the quality of the consultative exam reports they receive. In addition, some DDSs have modified their payments for consultative exams, paying providers for time spent preparing for a missed appointment, for example. While SSA routinely conducts quality assurance reviews of evidence obtained through consultative exams and gathers extensive data from the DDSs on spending for consultative exams, it has not evaluated the effectiveness of different DDS approaches to recruiting and paying consultative exam providers. For example, DDS officials cite provider frustration with missed appointments as a contributor to recruitment and retention challenges, yet SSA and the DDSs currently do not track the number of missed consultative exam appointments. Such data could be key for SSA to evaluate various DDS approaches to managing consultative exams and determining which approaches are sufficiently cost-effective at reducing “no-shows” and could be adopted in other DDSs.

SSA has made progress moving to electronic collection of medical records, but faces challenges in implementing electronic retrieval and analysis of medical records. As a beginning step in developing a more advanced process for electronic collection of medical records, SSA now uses electronic images instead of paper copies of new claimants' medical records. If a physician or hospital submits paper copies of a claimant's medical records, SSA scans them into its computer database. Electronic access to the records enables authorized SSA staff in other regions and policy staff in headquarters to review cases remotely. This provides opportunities for collaboration, which may contribute to more nationally consistent interpretations of SSA policy. SSA's goal is to receive all medical records electronically, but SSA faces challenges encouraging medical providers to use electronic submission options, given their varied ability to use such options. According to a study published in 2008, less than one-fifth of U.S. physicians surveyed have moved from paper to electronic records, and only 4 percent had fully functional electronic medical records systems. Despite maintaining several avenues for online submission, SSA still receives about half of all records on paper via the mail. Although SSA received 21 percent of records for disability claims through its online submission methods in September 2008, up from 12 percent about 2 years earlier, a single provider accounts for most of the records SSA receives online. Although SSA held a conference to give providers opportunities to air concerns about the difficulties they faced using SSA's Web site for submitting evidence online, SSA has conducted only limited study of the problems related to electronic submission of medical records. Although SSA's current process for collecting electronic images of medical records has brought significant advantages, the images are not well suited for electronic searches and analyses. For example, DDS examiners cannot use computers to electronically search a claimant's record for particular diagnoses and test results. SSA is taking steps to develop a more advanced method of online exchange of medical records in formats that are searchable. For example, SSA and a Boston hospital are developing a prototype to allow SSA to electronically query and retrieve the hospital's records for specific claimants—an innovation SSA hopes to expand to additional providers in the future.

We are recommending that SSA evaluate DDS medical evidence collection practices that may hold promise, compile key additional data to facilitate such an evaluation, and step up its efforts to identify and address barriers to online submission of medical evidence. SSA agreed with our findings and recommendations and noted both ongoing and planned actions to address our recommendations.

Background

SSA administers two programs under the Social Security Act that provide benefits to people with disabilities who are unable to work: Disability Insurance (DI) and Supplemental Security Income (SSI). According to SSA policy, to be eligible for either DI or SSI, an adult must be unable to engage in “substantial gainful activity”—typically work that results in earnings above a monthly threshold established each year by SSA—because of a medically determinable physical or mental impairment that is expected to last at least 12 months or result in death.⁴ Established in 1954, the DI program provides monthly benefits to workers (and their spouses and dependents) whose work history qualifies them for disability benefits and whose impairment is disabling. In 2007, SSA paid about \$99 billion in DI benefits to about 8.1 million workers, spouses, and dependents. The average monthly benefit was \$1,004 for disabled workers.⁵ SSI is a means-tested income assistance program created in 1972 that provides a financial safety net for people who are aged, blind, or disabled, and have low incomes and limited assets. Unlike the DI program, SSI has no prior work requirements. In 2007, SSA paid about \$37 billion in SSI benefits. As of December 2007 about 7.4 million recipients received an average monthly benefit of \$468. Some individuals with disabilities receive both DI and SSI benefits if they meet both DI’s work history requirements and SSI’s income and asset limits.

Disability Determination Process

The process to determine a claimant’s eligibility for SSA disability benefits is complex, involving several state and federal offices. The disability determination process, which is the same for DI and SSI claimants, involves an initial determination of disability and provides up to two levels of administrative review within SSA. A claimant first completes an application, or claim, for DI or SSI benefits, which includes information regarding illnesses, injuries, or conditions and a signature giving SSA permission to request medical records from medical care providers. Once the SSA field office staff verify that nonmedical eligibility requirements are met, the claim is sent to the state’s DDS office for determination of

⁴Monthly earnings thresholds for 2008 were \$1,570 for individuals whose eligibility is statutory blindness and \$940 for other individuals. Individuals under the age of 18 are considered disabled for the purposes of SSI if they have a medically determinable physical or mental impairment that results in “marked and severe functional limitations” expected to last at least 12 months or result in death.

⁵Average DI benefits amounts vary by recipient type. On average, disabled widow(er)s and disabled children receive lower monthly benefits than disabled workers.

medical disability.⁶ If the claim is approved, a claimant will be notified and will receive benefits, including limited retroactive benefits for some DI claimants.⁷ Additionally, if the claim is approved, a claimant may become eligible for Medicaid or Medicare health coverage.⁸ If the claim is rejected, a claimant has 60 days to request that the DDS reconsider its decision.⁹ If the DDS reconsideration determination concurs with the initial denial of benefits, the claimant has 60 days to appeal and request a hearing before an SSA administrative law judge (ALJ). A claimant may appeal an unfavorable administrative law judge decision to SSA's appeals council, which includes administrative appeals judges and appeals officers and, finally, to federal court. SSA and DDS officials (examiners and ALJs) determine disability using a five-step sequential process based on evidence such as medical findings and statements of functional capacity obtained during the initial determination process and updated as necessary at each appeal level. (See fig. 1.)

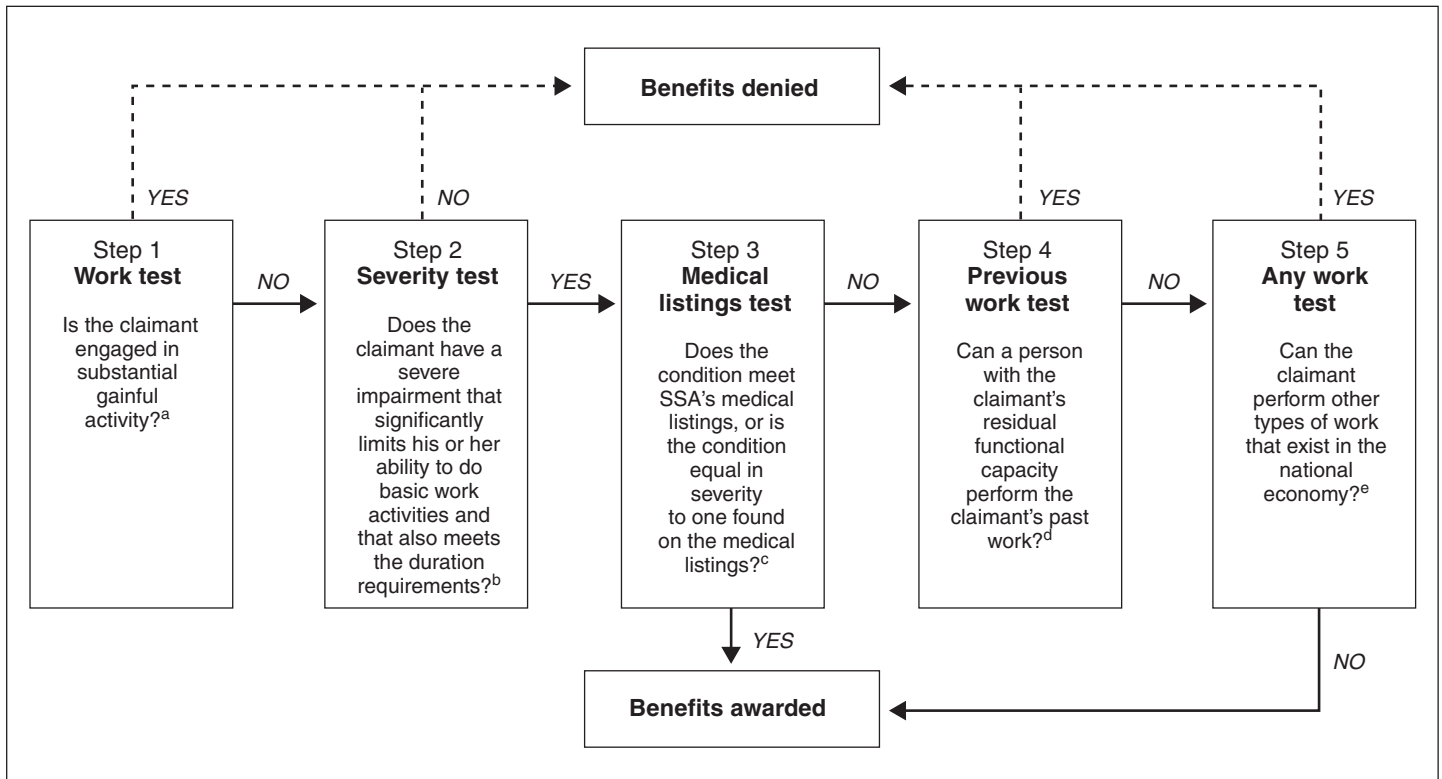
⁶SSA verifies different nonmedical requirements for the DI and SSI programs; for example SSA field offices verify, among other things, age, work credits, and current earnings for DI claimants and income and assets for SSI claimants. DDSs are separate state agencies with guidance and oversight provided by SSA.

⁷DI claimants may be eligible for retroactive benefits up to maximum of 12 months.

⁸In 32 states and the District of Columbia, claimants approved for SSI benefits become eligible for Medicaid. In several other states a separate application is required, and other states have their own eligibility requirements for Medicaid subject to certain limits. If approved for DI benefits, claimants will be eligible for Medicare benefits beginning 2 years after they were entitled to disability benefits. Some DI beneficiaries become eligible for Medicare benefits without a 2-year waiting period, for example, claimants who are kidney transplant or kidney dialysis patients.

⁹DDS officials not involved in the initial determination reconsider original and any new evidence. In some states, however, the decision is appealed directly to the SSA ALJ hearings office.

Figure 1: SSA's Five-Step Process for Determining Disability



Source: GAO analysis of SSA data.

^aIn 2008, the substantial gainful activity threshold was \$1,570 per month for blind recipients and \$940 per month for individuals with other disabilities.

^bEvidence considered at Step 2 must be primarily medical.

^cEvidence considered at Step 3 must be primarily medical. Medical listings are federal regulations detailing diagnoses and measures of severity that qualify a claimant as disabled under SSA law. See 20 C.F.R. Part 404, Subpart P, Appendix 1.

^dEvidence considered at Step 4 may include consideration of nonmedical evidence such as vocational information and work experience.

^eEvidence considered at Step 5 may include consideration of nonmedical evidence such as vocational information, age, education, and work experience.

Development of Medical Evidence for Initial Determinations

Generally, SSA requires DDSs to develop a complete medical history for each claimant for at least a 12-month period prior to the application. SSA guidance directs DDSs to request records from all providers who have treated or evaluated the claimant during this time period, except those

who treated only ailments clearly unrelated to the claimed impairment.¹⁰ DDSs generally pay providers for records and SSA pays the DDSs to cover these expenses.¹¹ Each DDS determines its payment rates for medical and other services necessary to make determinations, subject to certain limits.¹² DDSs request laboratory reports, X-rays, doctors' notes, and other information used in assessing the claimant's health and functional capability from many types of providers including: physicians or psychologists; hospitals; community health centers; schools (for child claimants); and Department of Veterans Affairs (VA), military, or prison health care facilities. In addition to medical evidence, DDSs review statements from the claimant or others about the claimant's impairment and ability to perform daily activities. SSA directs DDSs to make "every reasonable effort" to help the claimant obtain medical reports, which SSA defines as one initial medical records request and, if needed, one follow-up request within 10 to 20 days, when providers have not responded, unless experience with a particular provider warrants more time. DDSs allow a minimum of 10 days after the follow-up request for the provider to reply. When records indicate the claimant has been to other medical providers, DDSs also contact those providers for records. Generally records are placed in the claimant's case record.¹³

SSA regulations require that disability determinations place more, and in some cases controlling, weight on the opinions of a claimant's treating

¹⁰Medical records covering the full year prior to the application generally are not required when claimants reports they became disabled more recently. Certain situations may require medical records from earlier time periods.

¹¹According to SSA, federal providers, such as the VA, are not eligible for payments for medical records. Congress authorized SSA to pay for medical records for SSI claims from the program's inception because it was considered unreasonable to expect a claimant to pay for medical evidence for a need-based federal program. In 1980, Congress amended the Social Security Act to also allow payment for medical records under the DI program with the intent to obtain timely medical records and thereby reduce the need to order more expensive consultative exams.

¹²DDS payments for individual medical services are subject to federal or state limits. The DDSs have discretion within the available funding SSA provides them to purchase medical records and consultative exams as is necessary to process their workload target.

¹³As of January 2007, all DDSs were certified for processing initial claims electronically. A key feature is the use of claimant electronic folders. Electronic folders are electronic data repositories that replaced SSA's paper folder system, allowing information to be viewed and shared electronically by all disability processing components regardless of location.

providers.¹⁴ For example, a treating provider's opinion about the nature and severity of the claimant's impairment should generally be given controlling weight where their opinion is well supported by other substantial evidence in a claimant's case record.¹⁵

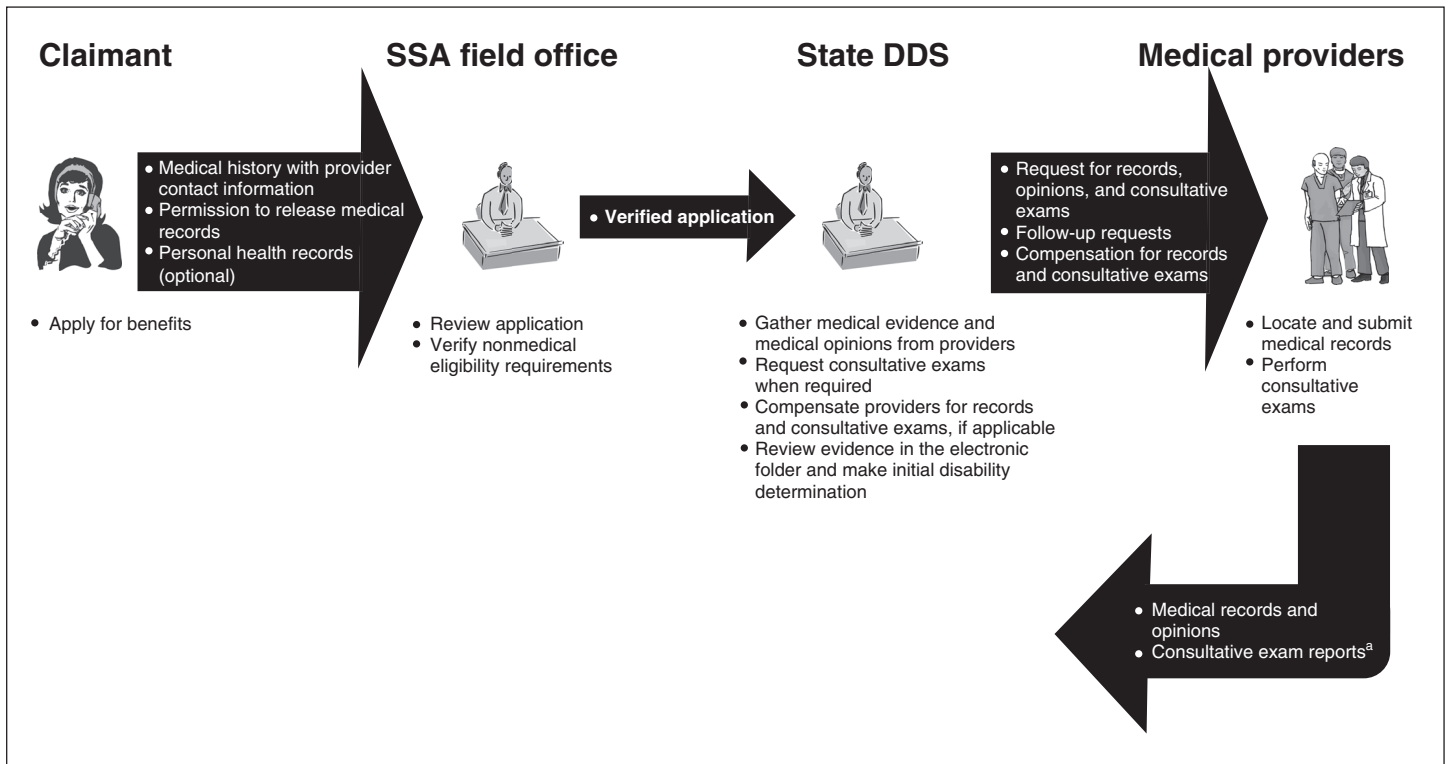
In claims where the gathered medical and nonmedical evidence is insufficient to support a disability determination, DDSs may order consultative exams or tests.¹⁶ DDSs pay providers to perform these examinations and SSA pays them to cover these costs. SSA regulations require that payments to providers for consultative exams not exceed the highest rate paid by federal or other state agencies for the same or similar services. The regulation allows states to determine the rates of payment and, as a result, DDS rates of payment for consultative exams vary nationwide. SSA regulations specify the types of providers who may perform these exams or tests, and require DDSs to recruit, train, and oversee them. SSA regulations also state that the claimant's own provider is generally the preferred source for consultative exams if qualified, equipped, and willing to perform the exams. (See fig. 2.)

¹⁴In order to establish whether claimants have a medically determinable impairment, SSA and DDSs must have evidence from medical providers who meet the definition of "acceptable medical sources," which generally include physicians, psychologists and, for the limited purpose of documenting a diagnosis within their fields of practice, podiatrists, optometrists, and speech-language pathologists. In this report, use of the term "medical provider" is intended to refer to an acceptable medical source as defined by SSA, and "treating provider" as a claimant's own medical provider as defined by SSA.

¹⁵The effect of controlling weight is that the DDS may not substitute its judgment for that of the treating provider. According to SSA's regulations, treating providers' opinions are entitled to more weight because those providers are most likely to have long-standing, detailed knowledge of claimants' medical impairments and "may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative exams or brief hospitalizations." 20 C.F.R. §404.1527(d)(2), §416.927(d)(2).

¹⁶DDSs will not order diagnostic tests that involve significant risk to the claimant.

Figure 2: Medical Evidence Collection for Initial Disability Determinations



Source: GAO analysis of SSA data; images (Art Explosion).

^aMedical records, opinions, and consultative exams from medical providers are stored in claimants' electronic folder by SSA or a scanning contractor.

To support DDSs' efforts to process claims quickly, SSA has established an expedited process for claims in which a determination of disability is likely. In September 2007, SSA implemented its Quick Disability Determination process nationwide after testing it in the Boston region. This process uses a computer model using certain key terms in the claim file to identify claims for which a decision of disability is likely and medical evidence establishing disability can be easily obtained. DDSs can use expedited processes for these claims; for example, DDS staff in a couple of states we visited explained how they request and receive

medical records for Quick Disability Determination cases by fax.¹⁷ SSA reported, for fiscal year 2007, that the national average processing time for all initial claims was 83 days. By comparison, during the pilot, the Boston region decided Quick Disability Determination claims in an average of 11 days.¹⁸ SSA also has policies to expedite claims involving diseases such as certain types of cancer that are terminal or otherwise so severe that they clearly meet SSA's definition of disability.

SSA performs a quality assurance review of a sample of more than 30,000 DDS decisions each year. SSA assesses the accuracy of the DDSs' determination and the sufficiency of the documentation for the DDSs' compliance with requirements for medical records collection and consultative exams process. Decisional deficiencies occur when a different determination should have been made, and documentation deficiencies occur when additional documentation is necessary in order to make the correct determination. SSA also collects extensive data on spending for consultative exams and requires DDSs to routinely report substantial budget, program operations, and management data to SSA.

Electronic Medical Record Collection

In 2004, President Bush called for widespread adoption of interoperable electronic health records within 10 years and issued an executive order assigning the coordination of the effort to the Department of Health and Human Services.¹⁹ Under the department's leadership, volunteer organizations designated to develop standards for the health care industry have prepared initial certification criteria for health information technology such as electronic patient records and records management systems. As businesses, providers decide when and whether to invest in these certified systems. Another executive order in 2006 directs certain

¹⁷According to SSA, though DDSs are required to perform expedited development for Quick Disability Determination claims, DDSs may fax requests for medical records for any claim regardless of the priority status of the claim. In addition to manually faxing, the DDSs may use SSA's Electronic Outbound Request (EOR) system to automatically fax the medical evidence request directly from the case processing system instead of printing.

¹⁸This was the Quick Disability Determination average from the start of the pilot until the preparation of SSA's 2007 Performance and Accountability Report, which was issued Nov. 7, 2007.

¹⁹Executive Order 13335, *Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* (Washington, D.C., Apr. 27, 2004).

federal agencies to “utilize, where available, health information technology systems and products that meet recognized interoperability standards.”²⁰ HHS also has awarded several contracts related to health information technology to address issues such as standardization, networking, and privacy and security. SSA collection of medical evidence is affected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which defines the circumstances in which an individual’s health information may be used or disclosed.²¹ In addition, HIPAA’s security provisions require entities that hold or transmit health information to maintain reasonable safeguards to protect the information against unauthorized use or disclosure and ensure its integrity and confidentiality.

DDSs Face Challenges Obtaining Medical Records from Claimants’ Providers

Determining eligibility for disability benefits is a complex, challenging task. DDS officials identified obtaining records from claimants’ medical providers as a major challenge to DDS examiners’ ability to quickly compile the necessary evidence for disability determinations. DDSs cited problems with the consistency of provider response to record requests, both in timeliness and completeness of records submitted. DDSs have responded to these challenges by conducting additional follow-up contacts with medical providers and claimants, and more than half of the 51 DDSs we surveyed reported adjusting their payment methods. Although SSA routinely reviews DDSs’ compliance with medical records collection requirements, SSA does not systematically identify and review the effectiveness of promising DDS medical evidence collection practices.

Medical Providers Do Not Respond Consistently to DDS Requests for Records

DDS officials identified provider response to medical records requests as a challenge in our survey of 51 DDSs. One DDS director reported in our survey that more than 300 providers in the state were considered “nonproductive” so that the DDS must send claimants who are patients of those providers to consultative exams when evidence from other sources is insufficient. One DDS director noted that public health clinics and

²⁰Executive Order 13410, *Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs* (Washington, D.C., Aug. 22, 2006). Since SSA does not administer or sponsor a health care program, it does not fall within the executive order’s directives. Programs subject to these directives include the Federal Employees Health Benefit Program, the Medicare program, programs operated directly by the Indian Health Service, the TRICARE program for the Department of Defense and other uniformed services, and the health care program operated by VA.

²¹Pub. L. No. 104-191 (1996).

hospitals are overburdened providing patient care and that medical records programs get short shrift. According to both DDS officials and providers we interviewed, generating records for disability claims takes lower priority than patient care and costs money for medical records staff time and contracted copy services, for example. One DDS official told us that some providers do not bill the DDS for records because the state's centralized payment system is slow and generates payments that are hard to reconcile with invoices. Examiners in another state told us that some providers refuse to submit requested records for claimants with unpaid bills, or charge the claimants instead of the DDS. DDSs also can have difficulty obtaining medical records when medical records are purged or moved to another location, or when facilities close or are destroyed.

DDSs request records from all providers who have treated the claimant for at least the 12 months preceding the application for benefits, except those who treated only minor ailments clearly unrelated to the claimed impairment or when the claimed disability began more recently. As a result, the volume of records requested is high: 13 DDSs reported sending over 200,000 requests in fiscal year 2007. Provider response to these requests for medical records is inconsistent; some submit records to the DDSs within 10 days, others never respond at all. Timeliness of medical record receipt is a central concern because SSA tracks how long it takes to process initial claims, and measures DDSs against regulatory performance standards. SSA reported that the national average processing time for initial claims was 83 days in fiscal year 2007.²² Although not all DDSs were able to complete our survey question on the volume of medical record requests and timeliness of provider responses, 32 of the 37 DDSs who did provide numbers reported receiving responses for up to 40 percent of their

²²SSA, *Social Security Administration: Fiscal Year 2007 Performance and Accountability Report*, at 49. This particular measure includes all calendar days from the date of application through either the date of the denial notice or the date the system completes processing an award of benefits for DI and SSI initial claims. In contrast, the regulatory performance standards for DDSs measure processing from the date the DDS receives the claim, and distinguish between DI and SSI claims. See 20 C.F.R. §404.1642.

requests for medical records within 10 days.²³ However, a substantial number of requests for medical records go unfulfilled. As shown in figure 3, 14 DDSs received less than 80 percent of requested records. Another 14 DDSs did not provide sufficient data in response to our survey to calculate the percentage of requests for which they received medical records.

Figure 3: Some DDSs Face Challenges Receiving Requested Medical Records, Fiscal Year 2007



Source: GAO survey of DDS directors.

Note: This figure indicates the estimated or computed percentage of requests for which DDSs received medical records. It presents information provided by 37 of the 51 DDS directors we surveyed about medical records they requested and received from providers for initial decisions during fiscal year 2007. Responses include both numbers calculated from DDS internal records (25) and estimated by the directors (9); the remaining 2 DDSs did not specify. Because of the way many DDS computer systems classify provider responses to requests for records, the counts of fulfilled requests could include responses from providers stating that records were not available for that claimant or for the dates requested by the DDS. See app. I for details about our analysis of survey responses.

DDS examiners request records from various types of providers including physicians or psychologists in individual or group practices; hospitals; community health centers; schools (for child claimants); and VA, military, or prison health care facilities. As shown in table 1, DDS directors we surveyed reported that some types of providers are more responsive to medical records requests than others.

²³Only 37 of the 51 DDSs surveyed provided complete information to our question on the number of medical records sent and responses received within different time frames. The 37 DDSs provided either data calculated by DDS internal records or estimates from the directors. The counts of fulfilled requests could include responses from providers stating that the requested records were not available. In addition to the records received within the defined time frames, 27 of the 37 responding DDSs also reported the percentage of requested records they received after the DDS had made its determination, which ranged from less than 1 percent to 47 percent of requested records. See app. I for details about our analysis of survey responses.

Table 1: DDS Directors' Opinions Regarding Providers' Responses to Requests for Medical Records, Fiscal Year 2007

Provider type	Providers submit medical records within 2 weeks					
	Always or almost always	Very often	Often	Sometimes	Never or almost never	No answer
Individual physician or psychologist	3	10	22	12	0	4
Group practice or multispecialty clinic	3	13	20	12	0	3
Hospital	5	11	18	12	2	3
VA health care facility	9	15	14	7	3	3
Public or community health clinic	2	8	12	23	2	4
Mental health clinic	1	7	15	23	2	3
School ^a	0	7	10	22	9	3
Prison health care facility	2	5	7	16	16	5

Source: GAO survey of DDS directors.

^aSchools may maintain records of evaluations performed by individuals who meet SSA's definition of medical providers. In addition, DDSs may request information from teachers and other school personnel about how a child claimant is functioning on a day-to-day basis when compared with other children who do not have impairments.

The task of obtaining a complete medical history²⁴ is further complicated when claimants do not identify all their medical providers when applying for benefits. Almost all of the 51 DDS directors (48) we surveyed reported that examiners at least sometimes identify providers who had not been listed on the claimant's application. Examiners may find out about additional medical providers as they review the records in the file, for example, and must generally request records from those providers. In our review of 100 initial claim files, we identified 19 in which DDS examiners requested records from providers who had treated the claimant but had not been identified on the application.

In addition to contacting multiple providers, DDS examiners must develop evidence for all of the claimed impairments, which can be numerous and include both mental and physical conditions. During our site visits, DDS

²⁴SSA regulations require the DDSs to develop a complete medical history, defined as records of the claimants' medical sources covering at least the 12 months preceding the application for benefits unless there is reason to believe additional time is needed or the claimant's application stated he or she became disabled less than 12 months before. 20 C.F.R. §§404.1512(d), 416.912.

claims examiners told us that claims involving mental impairments posed particular documentation challenges, noting that some claimants with mental impairments may have difficulty obtaining treatment or accurately describing their medical histories. Furthermore, SSA regulations include some specific requirements for collecting evidence of mental impairments. For example, generally where there is indication of a possible mental impairment, SSA regulations establish a special technique to be used when evaluating the severity of mental impairments, which includes rating the claimant's degree of functional limitation in four broad functional areas and recording the results of this evaluation on a standard document.

The opinions of providers with an ongoing treatment relationship with the claimant are a particularly important source of evidence for disability determinations. Treating providers' opinions about the nature and severity of the claimant's impairment often are given great deference in SSA regulations. Examiners must give controlling weight to treating providers' opinions if they are not inconsistent with the other substantial evidence in the case record and are well supported by medically acceptable clinical and laboratory diagnostic techniques.²⁵ Yet, of the 51 DDSs we surveyed, none reported that half or more were willing to provide such opinion statements, and 15 indicated that none or almost none were willing to provide the statements. Almost all DDSs (48 of 51) reported asking for treating sources' opinion statements in their initial medical records requests, but as table 2 shows, DDSs are not always successful at obtaining those statements, even after multiple requests, and the statements they receive are not always helpful in making their determinations.

²⁵As discussed above, the effect of controlling weight is that the DDS may not substitute its judgment for the opinion of the treating provider.

Table 2: DDS Receipt and Characterization of Medical Source Statements from Claimants' Treating Providers, Fiscal Year 2007

	Always or almost always	Very often	Often	Sometimes	Never or almost never	No answer
DDSs' receipt of medical source statements from treating providers						
Received after the DDS's initial request	0	2	4	24	19	2
Received after the DDSs' first follow-up request	0	0	1	27	17	6
Received after two or more follow-up requests	0	0	3	20	20	8
DDSs' characterization of medical source statements from treating providers						
Consistent with the other medical records in the claimant's file	0	2	10	34	2	3
Supported by medically accepted clinical and laboratory diagnostic techniques	0	1	7	35	5	3
Helpful in making the determination	2	8	13	22	3	3

Source: GAO survey of DDS directors.

In addition, as summarized in table 2, when DDSs receive medical source statements from treating providers, more than half of the DDSs find that those statements are only sometimes consistent with the other medical evidence in the file or well supported by medically acceptable clinical and laboratory diagnostic techniques.²⁶ One DDS director summarized the

²⁶Even if medical opinion statements from treating providers do not meet the conditions required to be given controlling weight, they are still important evidence that the DDS must consider. Opinions from providers who have treated or examined the claimant generally are given more weight than those from providers who have not. In our review of 100 fiscal year 2007 claimant files, DDS medical consultants' review forms indicated that a medical source statement from a treating or examining provider was present in 25 claims where the form was completed; in 10 of these cases, the medical consultants indicated that the statements were inconsistent with other evidence in the file.

difficulty in obtaining medical source statements as follows, in response to our survey:

A good and useful MSS [medical source statement] both states a quantification of the effects of the condition on the claimant's ability to function and an explanation as to how the assessment is supported by the evidence. These are rare. More often we receive "less useful" MSS's that only do the first part. Treating sources are generally OK with just sending records or including a statement such as "the patient has severe rheumatoid arthritis, remains under my care, and can't return to work for the foreseeable future." When we get such an MSS, we either are left to refute it or return it to the TS [treating source] for a better underlying analysis. This annoys them and usually does not come to a beneficial or happy result.

DDS officials and providers described various reasons why treating providers may be reluctant to submit medical source statements. Treating providers may be concerned that submitting their medical opinion to the DDS might interfere with the doctor-patient relationship, and they also typically focus on diagnosis and treatment rather than evaluation of functional ability. Providers also may have limited knowledge of SSA standards or the physical or mental requirements for different types of work.

Almost All DDSs Engage in Additional Follow-up Contacts to Encourage Provider Response; about Half Have Modified Their Payments

SSA regulations and guidance specify the timing of DDS requests for medical records but leave the methods of contact up to each DDS. If it does not receive records after one request, the DDS must make one follow-up request within 10 to 20 days unless the provider is known to take longer to respond.²⁷ After that, the DDS must generally give the provider an additional 10 days and then may send the claimant for a consultative exam if needed. Requests by mail remain the most prevalent method for requesting medical records, used at least very often by 42 of the 51 DDSs surveyed. All use fax to some extent, with slightly more (27) reporting they use fax at least often and 24 reporting using fax sometimes.

During our site visits, 6 of the 28 DDS examiners we interviewed told us that some providers raise concerns about privacy or compliance with HIPAA, for example, by insisting on a hard copy of the claimant's signed

²⁷All but four of the DDS directors reported that their DDS systems automatically generate a follow-up request for records that are not received after a certain time; the most frequently reported times are 12 and 21 days after the initial request.

authorization to release medical records. According to SSA, hard-copy, fax, or electronically transmitted versions of its official authorization form, signed and dated by the claimant, all comply with relevant state and federal laws and regulations, including HIPAA.

Once records are received, the DDS may need further contact with providers to clarify ambiguities or request additional information. SSA guidance require examiners to recontact a provider whose medical report contains ambiguities, conflicts either internally or with other evidence, is incomplete, or is not based on medically acceptable clinical and laboratory diagnostic techniques. In addition, SSA guidance directs the DDS's examiners to recontact a treating provider if the report contains an opinion on an issue reserved for SSA, such as whether the claimant is disabled or has a condition that meets one of the medical listings, without identifying the basis for that opinion.²⁸

If the initial recontact SSA requires is not successful, DDSs report pursuing additional approaches to encourage providers to submit or clarify records. These include making additional follow-up calls to providers, their assistants, or medical records staff and asking claimants to get in touch with their providers about sending in the records. In addition, DDSs conduct outreach to emphasize the importance of submitting medical records and contact providers to resolve questions about privacy. Privacy of medical records came up frequently in our discussions of the medical evidence collection process: DDS officials in each of the five states we visited indicated that some providers relay concerns about patient privacy and compliance with applicable protections.

DDS professional relations officers also supplement the examiners' contacts via provider education and outreach to medical societies. If information in the medical records requires clarification, DDS medical consultants, such as physicians or psychologists, also may contact providers directly.²⁹ SSA guidance permits DDSs to obtain verbal

²⁸These are administrative findings made on the basis of the medical and other evidence that must be made by SSA, or DDSs on its behalf. Issues reserved for SSA include a determination that the claimant is disabled according to the statutory requirements or a finding that the claimant's impairment meets or is equivalent to one of the listed impairments. SSA guidance does not require DDSs to recontact providers whom they know from experience are unable or unwilling to provide the requested information.

²⁹Other professionals, such as speech and language specialists, may also serve as DDS medical consultants.

statements from treating providers, then send summaries of those statements to the providers for their signatures to expedite the DDS determination process.

In addition to following up with providers and claimants, more than half of the 51 DDSs we surveyed reported modifying their payment methods for medical records.³⁰ To encourage provider response, 34 of the 51 DDS directors surveyed reported taking steps to improve the timeliness of their payments and 6 reported increasing their payment amounts. While only 30 DDS directors reported in our survey that their payment rates were high enough to ensure adequate medical records collection, some DDS directors commented that they had heard from some types of providers that their rates were not adequate; psychologists or other specialty providers, for example, reported that payments were adequate for some types of providers but not others. Asked in the survey how their payment rates compare with prevailing rates for medical records in their states, 3 of the 51 DDSs reported that their payment rates were above prevailing rates in their states, 19 reported that the rates were about the same, and 20 reported that their payment rates were below prevailing rates.³¹ Vermont's DDS instituted an incentive payment for prompt response because that state prohibits providers from charging for providing copies of health care records requested to support a claim or appeal under any provision of the Social Security Act or any other federal or state needs-based program.

³⁰By regulation, DDS payments for purchasing medical or other services necessary to make disability determinations may not exceed the highest rate paid by federal or other agencies in that state for the same or similar services. Within these parameters, DDSs medical records payments vary widely by method and amount, according to data they reported to SSA for fiscal year 2007. Methods include flat fees, per-page fees, and a combination of the two (a handling fee or standard payment for the first 10 pages, for example, and a per-page fee for additional pages). Regarding amounts, 36 DDSs have a maximum flat fee from a low of \$10 to a high of \$40, and per-page fees range from \$0.10 to \$1.00. One DDS (Alaska) pays providers for medical records on the basis of usual and customary charges rather than a fee schedule.

³¹The remaining nine directors either responded that they did not know how their payment rates compared with the prevailing rates in their states.

SSA Conducts Quality Assurance Reviews, but Does Not Gather Some Key Data on Varied DDS Approaches to Collecting Medical Records

While SSA conducts quality assurance reviews and collects data on program operations from DDSs, it has not systematically evaluated the effectiveness of the DDSs' varied approaches to collecting medical records. SSA regularly reviews DDSs' compliance with requirements for medical records collection as part of its quality assurance review of a sample of more than 30,000 DDS decisions each year.

These reviews take place before the DDS determination is communicated to the claimant, and SSA returns the claim to the DDS for additional work if SSA reviewers find that additional medical evidence or analysis is needed.³² These reviews assess both the accuracy of the DDSs' determinations and the sufficiency of the documentation the DDSs obtained. Decisional deficiencies occur when the DDS should have made a different determination, and documentation deficiencies occur when additional documentation is necessary in order to make the correct determination. Errors related to the collection of medical evidence include cases in which insufficient medical evidence was obtained to support the DDS determination, for example, to establish that the claimant's impairment is severe or expected to last at least 12 months or result in death.

SSA also requires DDSs to routinely report substantial budget, program operations, and management data to SSA. While these data help SSA oversee the DDSs, they may lack some key measures that SSA could use to evaluate the effectiveness of different DDSs' medical records collection practices. For example, not all DDSs' computer systems routinely track the total number of requests they send and the timeliness of provider responses. Of the 51 DDS directors we surveyed, 14 did not provide complete responses on the number of medical record requests they sent and received responses to, and others were able to provide only estimates. The lack of consistent data on receipts of medical records from providers limits SSA's ability to evaluate the effectiveness of different DDSs' medical records collection activities—evaluations which could lead to wider adoption of practices that are found to be successful and cost effective.³³

³²Although SSA considers such instances to be errors, it is possible that the DDS obtained sufficient medical evidence from other sources, such as a consultative exam, to support its determination. Not all errors identified in SSA quality assurance reviews indicate that the claim was incorrectly decided.

³³Obtaining consistent data on medical records and requests and receipts is key to ensuring that both DDS and SSA program managers have sufficient operational data to ensure efficient use of resources. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD00-21.3.1 (Washington, D.C., November 1999) (pp. 18-19).

Nationally consistent data could help SSA assess whether some DDSs' approaches are more effective than others or whether adoption of new approaches, such as incentive payments for prompt provider response, yields faster submission of records.

DDSs Face Challenges Recruiting and Retaining Qualified Consultative Exam Providers

Recruiting and retaining enough medical providers to conduct consultative exams was frequently cited by DDS representatives as one of the main challenges to medical evidence collection, in part because of provider concerns about missed appointments or DDS payment rates for consultative exams. Responses to these challenges include scheduling consultative exams with medical providers whose practices focus primarily on performing disability evaluations and adjusting payments, for example, by paying providers for the time they spend preparing for a consultative exam that a claimant fails to attend.

Recruitment and Retention of Consultative Exam Providers Is Difficult

We frequently heard from DDS directors, both during our site visits and in response to our survey, about their difficulty finding medical providers to conduct consultative exams. It is even difficult for DDSs to obtain consultative exams from claimants' treating physicians—the preferred source for consultative exams according to SSA guidance and regulations.³⁴ For example, 41 of the 51 DDS directors we surveyed reported that their offices routinely ask claimants' treating providers if they are willing to perform a consultative exam if needed, but 34 of these directors reported that claimants' treating providers are never or almost never willing to perform these exams. According to DDS officials and providers, reasons for this reluctance may include concern about disrupting the doctor-patient relationship through involvement in the disability claim and dissatisfaction with DDS payment rates. These inquiries often are included in the requests for medical records sent by the

³⁴SSA regulations governing the disability determination process note that when, in the judgment of the DDS examiner, a claimant's treating source is qualified, equipped, willing to perform consultative examinations or tests for the fee schedule payment used by the DDS and generally furnishes complete and timely reports, a claimant's treating source will be the preferred source to conduct a consultative examination. The guidance to DDSs indicates that this is because the treating provider is usually in the best position to provide detailed longitudinal information about the claimant's condition. SSA provides options to the DDSs to determine the willingness of treating providers to perform consultative exams, including a general survey of providers in the state every 3 years, an inquiry on the letter requesting medical records, a telephone call to the treating provider at the time a consultative exam is ordered, or a combination of these.

DDSs to claimants' treating providers. For example, in our review of 100 claim files for initial disability determinations, 45 files contained one or more requests for medical records that included an inquiry about the providers' willingness to perform a consultative exam. However, only 2 claimants' files had records of consultative exams conducted by the treating provider. In many cases, DDSs make this request in the form of a yes or no question that accompanies their requests for medical records or by asking providers to contact them if they would be interested in performing a consultative exam. Often providers either indicate they are not willing to perform a consultative exam or leave the question blank. In some cases, the requests for records indicate that the absence of a response will be interpreted as an indication that they are not interested.

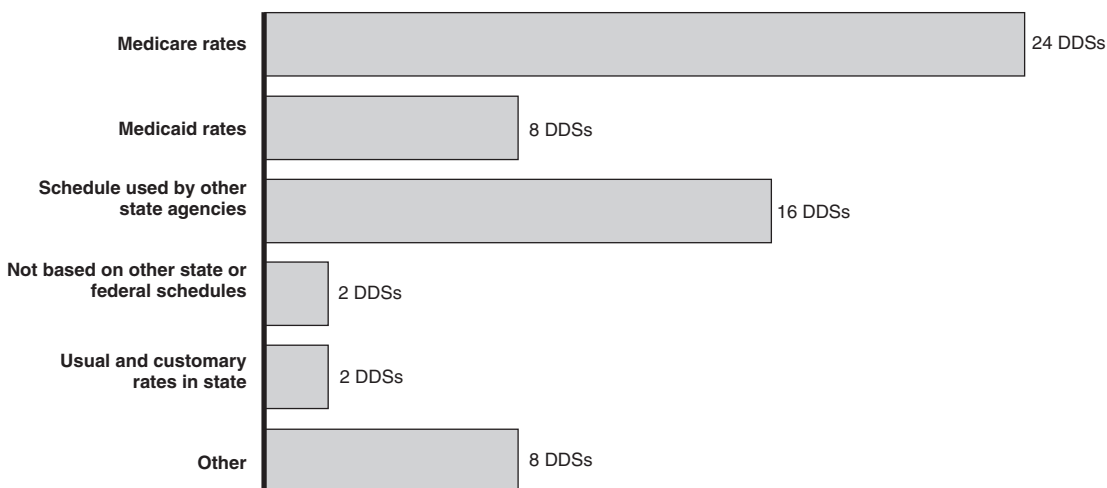
One reason why the DDSs may face difficulty recruiting and retaining consultative exam providers is the frequency with which disability claimants miss their consultative exam appointments. DDS directors reported in our survey that claimants fail to attend approximately 16 percent of consultative exam appointments on average, with 40 of the 51 directors providing this information. When asked the reason why claimants fail to attend these appointments, DDS directors reported that claimants sometimes miss appointments for reasons including transportation challenges, unmet needs for someone to accompany the claimant to the appointment, reluctance to take part in the exam, or inability to attend due to a mental or physical health condition. Regardless of the reason for claimants' failure to attend scheduled exams, several DDS examiners we spoke with identified missed consultative exams as a major problem which may affect providers' willingness to participate. If a claimant misses an appointment, providers lose revenue if they are unable to substitute another patient and cannot bill the DDSs for the missed exam. When asked to what extent provider concerns about missed consultative exam appointments posed challenges, almost half of DDS directors (24 of 51) reported that such concerns posed challenges to a great or very great extent, although some DDSs (20) reimburse providers for time spent preparing for missed consultative exams.

Current payment rates also may contribute to the DDSs' challenges recruiting and retaining consultative exam providers who submit high-quality reports. Almost all DDS directors (50 of 51) reported that DDS fee schedules posed a challenge, at least to some extent, to recruiting and retaining a panel of highly qualified consultative exam providers. Several DDS officials told us current consultative exam payment rates affect their ability to recruit and retain consultative exam providers in their states. For example, California DDS officials commented that current consultative

exam payment rates are below prevailing payment rates in the state. Wyoming DDS officials also told us that payment rates pose challenges to the recruitment of providers for Wyoming’s consultative exam provider pool.

Consultative exam payment varies among DDSs nationwide. SSA regulations require that payments to providers for consultative exams not exceed the highest rate paid by federal or other agencies in the state for the same or similar services. Within those parameters, DDSs vary in the type of payment rates they use as benchmarks for consultative exams. (See fig. 4.)

Figure 4: Sources of DDS Consultative Exam Payment Schedules



Source: GAO survey of DDS directors.

Note: Five of the responding DDSs reported that their consultative exam fee schedules were based generally on more than one of these sources.

Many DDS directors (17 of 51) also indicated that in their opinion current payment amounts in their states are not high enough to ensure that the DDS receives timely, high-quality consultative exam reports. For those DDSs, seven also reported that consultative exam reports only sometimes demonstrated sufficient familiarity with the claimants’ medical records and history to support the assessment.

Some DDSs Rely on High-Volume Consultative Exam Providers or Pay Providers for Preparing for Missed Appointments

Some DDSs have adopted responses to the challenge of recruiting and retaining consultative exam providers by (1) relying on high-volume providers whose practices focus primarily on performing disability evaluations and (2) adjusting consultative exam payments. As shown in figure 5, most DDSs (32 of 51) report they often use high-volume providers to conduct consultative exams for claimants in their state. Twenty-nine indicated that using these providers has a moderately positive or very positive effect on the quality of the consultative exam reports they receive.

Figure 5: States Reporting Frequent Use of High-Volume Consultative Exam Providers



Source: GAO survey of DDS directors.

At least one DDS has taken the concept of high-volume consultative exam providers one step further. The New York DDS expanded its use of high-volume consultative exam providers by hiring contractors to recruit consultative exam providers and manage claimants' appointments. New

York DDS officials reported that the majority of consultative examinations now are conducted through these contractors in areas of the state covered by contracts. As described to us by New York DDS officials, these contracts provide for extensive training of new consultative exam providers that can last several months, content and timeliness requirements for exam reports, and quality assurance including surveys of claimants and inspection of providers' facilities.

Some DDSs have adjusted their payments for consultative exams to address recruitment challenges in their states. For example, Wyoming currently pays usual and customary rates that providers receive for similar exams throughout the state. Wyoming DDS officials reported that they make use of such a structure due to the sparse population and small number of medical providers that service their state, approximately 1,000. According to Wyoming DDS officials, a relatively small portion of these providers are willing to perform consultative exams for the DDS and they believe that without usual and customary payment, even fewer providers would be willing to conduct them. In addition, many DDSs (20 of 51) pay consultative exam providers for the time they spend preparing for exams that claimants fail to attend, which may help DDSs retain their consultative exam provider pool. Among those 20 DDSs reporting that they offer such payments, the average payment provided was about \$44.

Finally, DDSs engage in various activities to facilitate claimant attendance at consultative exams. The most common activities reported are reminder letters and telephone calls and reimbursement for travel costs (see table 3). Examiners at two of the DDSs we visited described arranging for consultative exam providers to perform in-home evaluations for claimants whose impairments kept them confined to their homes. Examiners noted that "third parties"—family members or social workers listed as contacts on the application for benefits—may help facilitate consultative exam appointments, especially for claimants who are homeless or who have mental or developmental impairments.

Table 3: DDS Activities to Facilitate Claimant Attendance at Consultative Exams, Fiscal Year 2007

DDS activity	Frequency					
	Always or almost always	Very often	Often	Sometimes	Never or almost never	No answer
Send reminder letter	48	2	0	1	0	0
Place one reminder call	16	14	11	8	2	0
Place multiple reminder calls	0	2	5	25	19	0
Reimburse private transportation costs	14	10	9	10	6	2
Reimburse public transportation costs	15	3	4	7	21	1
Arrange for taxi or van service	4	8	5	13	20	1
Reimburse for taxi or van service	10	2	2	15	20	2
Provide sign or foreign language interpreters	18	5	7	21	0	0
Coordinate with third parties, such as family members or social workers	9	14	16	11	1	0

Source: GAO survey of DDS directors.

SSA Reviews Consultative Exams and DDS Decisions, but Does Not Evaluate DDS Practices to Address Recruitment and Retention Challenges

While SSA evaluates consultative exams as part of its quality assurance review process and collects data on spending for consultative exams, it has not evaluated the effectiveness of varied DDS responses to challenges related to recruiting and retaining consultative exam providers. SSA reviews consultative exams as part of its ongoing quality assurance reviews of more than 30,000 randomly sampled initial disability determinations. SSA reviewers assess the claim file for errors including unnecessary consultative exams; consultative exam from an improper source (such as failure to use a psychiatrist or psychologist to evaluate a mental disorder); or incomplete, inadequate, or unsigned consultative exam reports.

Despite these overall quality reviews, SSA officials indicated they were unable to locate any studies SSA has conducted to evaluate the effectiveness of varied DDS collection practices. By undertaking such studies, SSA program managers could identify promising DDS practices to recruit and retain consultative exam providers or evaluate their effectiveness and potential for wider adoption and thereby improve accountability by facilitating wider adoption of DDS practices with the potential to help the agency achieve its service delivery goals, such as making the correct decision early in the process. SSA currently does not collect some information, such as nationally comparable data on missed consultative exams, that could help SSA evaluate DDS practices that may

hold promise for improved recruitment and retention of consultative exam providers in other states.

SSA Has Made Progress in Moving to Electronic Collection of Medical Records, but Faces Challenges Shifting to the Use of Electronic Medical Records

SSA's transition from paper medical records to the use of electronic images of medical records has increased opportunities for program efficiencies and agency collaboration. SSA prefers and encourages providers to submit medical records online, but it continues to receive a little more than half of these records in paper form. SSA has only conducted limited studies of the problems related to electronic submission of medical records and has not taken additional steps necessary to facilitate greater use of online submission options. In anticipation of the medical community's replacement of paper with uniform electronic medical records, SSA is developing procedures to electronically request and receive electronic medical records and analyze them in ways that are expected to make the medical evidence collection process and disability decision making more efficient.

Use of Electronic Images Enables SSA and DDSs to Collaborate More Efficiently

As a step toward automating its disability process, SSA has successfully adopted the use of electronic images of medical records instead of paper copies for new claimants. Electronic images of medical records—records scanned, faxed, or uploaded into SSA's computer database—are an important step in SSA's transition to an automated process, as these images can be submitted, stored, and accessed electronically by authorized staff from distant locations. Electronic medical evidence—even in the form of electronic images—facilitates collaboration between SSA and DDSs. For example, electronic files have enabled SSA to implement a new process for resolving disagreements concerning DDS disability decisions reviewed by SSA before initial decisions are finalized. Rather than having SSA reviewers in each regional office review DDS decisions only in that region, electronic access to records enables staff in other regions and policy staff in SSA headquarters to review cases remotely. SSA introduced this process to promote more nationally consistent interpretations of SSA policy. Additionally, SSA and DDSs are able to shift workloads from office to office without mailing records, which takes time and increases the risk that records will be lost. However, SSA officials and DDS directors told us electronic image records have limitations in that they cannot be electronically analyzed and searched.

Almost all surveyed DDS directors (50 of 51) reported that having medical records in electronic folders has increased productivity, but some indicated that frustrations exist, such as some computer system usage

problems. For example, several DDS examiners told us they were frustrated by occasional data system interruptions, due in part to performance problems with SSA's computer system. The SSA system manages large amounts of data across multiple SSA and DDS computer systems. Over half of DDS directors (27 of 51) reported that one of the challenges to medical evidence collection was performance problems with SSA's integrated computer system, and most (38 of 51) reported that improvement in the stability or responsiveness of the system would add a great or moderate value to the DDSs' medical evidence collection efforts.³⁵

SSA Has Made Progress in Developing Options for Submitting Records Electronically, but More than Half Are Still Submitted on Paper

One of SSA's goals is to receive all medical records electronically.³⁶ SSA maintains several avenues for providers to submit medical evidence online, and nearly all DDS directors (48 of 51) reported that DDS outreach to providers very often addressed options for electronic submission.³⁷ Some providers, however, have told DDS officials they find SSA's online submission options inconvenient, difficult to use, or beyond their technical expertise. For example, many providers do not use SSA's Electronic Record Express Web site to submit records, although it was designed to provide an efficient option for submitting medical records. This Web site limits the number of files that can be sent at one time, which is problematic for large providers such as big hospitals or medical centers. Additionally, infrequent users must call a designated DDS official to reset expired passwords if too much time has passed between submissions.³⁸ SSA officials told us some providers opt to pay a commercial service to submit medical records, because the service provides for the submission

³⁵This included 20 directors that indicated it would add very great value, and 12 directors that indicated it would add great value.

³⁶SSA, E-Government Annual Report, Letter to OMB, Sept. 14, 2007. SSA regards fax as one of the options providers have for submitting records electronically. Providers may fax paper copies of the records or use a computer to send electronic files by fax.

³⁷This included 42 directors that indicated that outreach to providers always or almost always included this topic.

³⁸SSA designed the ERE Web site for small- to medium-volume providers, copy services, and consultative exam providers. To identify issues and obtain user suggestions for improving the ERE Web site, SSA held two meetings during fiscal year 2008, which also included DDS provider relations and information technology professionals. SSA obtained a list of almost 300 suggestions to improve its ERE Web site and is making enhancements based in large part on these provider suggestions. SSA noted that competing priorities and budgetary constraints limit the number of enhancements the agency can make in each fiscal year.

of many files at once, which can be a more efficient option for providers of large volumes of medical records.³⁹ SSA has recently deployed its own tool for submission of many files at once, called Webservices, but to use this option, medical providers must develop their own software interface to SSA's Web site. Although SSA provides some technical support, some providers may still find this option beyond their technical expertise. As of November 2008, only two medical record providers were using Webservices. SSA officials noted that additional providers have expressed interest in using WebServices but the agency temporarily limited its use to these two because of limits on the system's capacity that it intends to resolve after a planned upgrade.⁴⁰

DDS professional relations officers at a 2007 conference of the National Association of Disability Examiners noted various difficulties they face encouraging providers to use SSA's Web site for submitting evidence online. In order to use online options for submitting medical records to SSA, some providers with electronic medical record systems may either need to convert files or print and scan them. In some cases, providers may find this too time consuming to be feasible. Although some providers have registered as Web site users, the difficulties encountered were enough to make them stop using it. A DDS professional relations officer said that they were getting so many calls from providers having problems with the Web site that they had to designate someone to handle the calls. On the other hand, the Mississippi DDS had early success encouraging providers to use the Web site by contracting with a former SSA official who provided detailed "start to finish" guidance on how to use the Web site.

SSA held conferences in two cities in March 2008 to give its Web site users an opportunity to express their concerns, and made some modifications to the Web site in July 2008, but SSA has conducted only limited study of the problems with electronic submission of medical records or analyzed the barriers various groups of providers face using the site (such as small- and

³⁹To submit a large volume of requested records online to SSA, one release of information ("copy") service uses software called Connect:Direct, which is owned by Sterling Commerce, an AT&T company. SSA indicated that it developed WebServices to provide a lower-cost option for electronic submission of large numbers of medical records, and that the agency plans to upgrade WebServices in the first quarter of fiscal year 2009.

⁴⁰Both of these were copy services. After it completes its planned WebServices upgrade, SSA will work with a third high-volume provider to test the enhancements with the goal of allowing additional medical providers and copy services to use this technology in the near future.

medium-volume users), and they have not developed a strategy for overcoming these barriers. The agency has made progress responding to some user concerns, for example, by enabling claimants' representatives to view clients' folders online, but SSA has not developed a strategy to address the concerns of other user groups.

SSA's efforts to realize its electronic submission goal also are hindered by the uneven pace of the medical community's acceptance of electronic records. Despite a presidential call for widespread adoption of electronic health records by the year 2014, the Robert Wood Johnson Foundation estimated that less than one-fifth of responding U.S. physicians (17 percent) had at least basic electronic health records and only about 4 percent had fully functional electronic records systems.⁴¹

Nationwide, in September 2008, SSA received 52 percent of records for disability claims on paper, 21 percent through online submission, and 27 percent by fax.⁴² (See fig. 6.) One large provider accounts for most of the records SSA receives online. In September 2008, 57 percent of online submissions came from this large medical record copy service. We found variation among the DDSs in the percentages of records received online. In September 2008, 13 DDSs received more than 25 percent of records online while another 11 DDSs received less than 10 percent. DDSs varied in the percentage of records received by electronic fax, with 10 DDSs receiving less than 15 percent of records by fax, and 5 DDSs receiving more than 50 percent.⁴³ Although providers have submitted an increasing share of records via fax and online over the last few years, the growth in

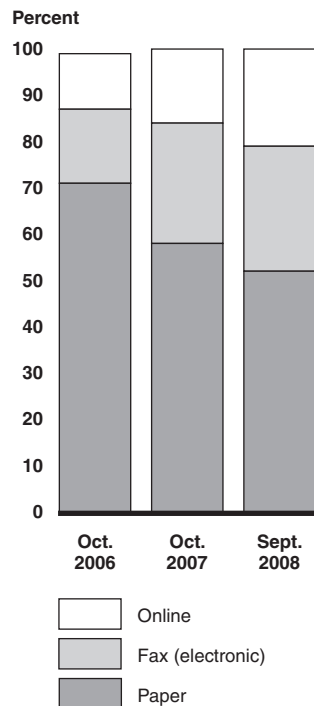
⁴¹David Blumenthal et al., eds., *Health Information Technology in the United States: Where We Stand, 2008* (Princeton, N.J., Robert Wood Johnson Foundation, 2008). These estimates were based on analysis of data from selected surveys of medical providers. They also found that 17 percent of those that were not using electronic health records had purchased such systems, but had not yet implemented them. Another 26 percent indicated that they intended to acquire an electronic health record system within 2 years.

⁴²In contrast, during the same month, SSA received only 6 percent of consultative examination reports on paper, 26 percent through online submissions, and 68 percent by fax.

⁴³These results do not include data from the New York DDS; data from New York were not available.

nationwide use of online submission options has slowed in recent months.⁴⁴

Figure 6: SSA Still Receives About Half of Records on Paper



Source: GAO analysis of DDS data compiled by SSA.

SSA Is Beginning to Transform Its Process with Computer-to-Computer Requests and Receipts of Records in Uniform Formats

While encouraging providers to submit medical records electronically speeds the collection of medical evidence, SSA is participating in preliminary tests of new computer processes that are expected to bring substantial additional efficiencies. With these new procedures, SSA computers request and receive electronic medical records directly from providers' computers—records in uniform formats that SSA's computer system can search and use to begin analysis of the claimant's condition. The electronic images of medical records they currently use are not as suited for analysis as are electronic medical records in uniform formats.

⁴⁴Online submissions increased from 12 percent of submissions in October 2006 to 20 percent in March 2008, then rose slowly to 21 percent in September 2008. Over this recent period, 19 DDSs saw a decline in the proportion of records submitted online.

For example, currently, DDS examiners cannot electronically search a record or file for particular diagnoses and test results. Instead they must review all the medical records—hundreds of pages of records in some cases—in order to find the pertinent evidence. Most surveyed DDS directors (32 of 51) reported that options for submitting medical evidence in these new formats would be of great or very great value.⁴⁵ In its strategic plan for fiscal years 2008 to 2013, SSA established a goal to transform its medical evidence collection process by automatically requesting and receiving electronic medical records through a nationwide health information network.⁴⁶ This network is expected to enable medical providers to securely exchange electronic medical records in uniform formats. This will enable SSA to automatically search and analyze the records at the start of the disability determination process.⁴⁷ Software will flag medical records that contain references to diagnoses and tests specified in SSA’s medical listings, and thus help examiners promptly determine whether claimants have impairments that qualify as disabilities.

To help encourage the use of these processes, SSA is working with other agencies and health providers to develop electronic methods to request, receive, and analyze electronic medical records. For example, SSA and a Boston hospital have launched a prototype effort by which SSA electronically queries the hospital’s computer and retrieves the hospital’s electronic medical records for specific claimants.⁴⁸ SSA plans to expand the Boston initiative to additional providers in the future. However, industry standards and protocols need to be further developed before this process can be replicated widely. For example, standards have only recently been developed for the document format used in the Boston initiative called the “continuity of care document.” This format is an

⁴⁵Medical evidence in these formats provides coded information as uniform structured data, as opposed to electronic images. They enable SSA and DDSs to electronically search and analyze records, not just view them on a computer screen.

⁴⁶The Department of Health and Human Services is leading the effort to develop a nationwide health information network for the purpose sharing health care information over a secure, cost-effective communication system.

⁴⁷Although SSA has participated in the development of this nationwide health information network as well as the standards that support it, SSA has no direct control over these or their acceptance, as the Department of Health and Human Services is the federal agency leading the effort.

⁴⁸These efforts are initiatives under the Department of Health and Human Services’ plans to achieve health information technology infrastructure to improve the quality and efficiency of health care.

electronic exchange standard for sharing patient summary information. In addition, challenges remain in electronic authorization procedures designed to protect the privacy of patients' health records, as we have reported in previous reports and testimonies.⁴⁹

Conclusions

The collection of medical evidence in the disability determination process poses many challenges. The DDSs are operating in a high-volume environment and must balance reasonable efforts to obtain complete medical information with the need for timely determinations. Medical providers have constraints on their time and resources as well, and typically focus on diagnosis and treatment rather than assessment of functional ability. The difficulties some DDSs have in obtaining requested medical records and ensuring that claimants attend consultative exams suggest opportunities for continued improvement in the medical evidence collection process. Some DDSs have independently developed varied approaches to respond to these challenges; and all DDSs might benefit from learning from one another and testing and adopting some of these approaches, as appropriate. SSA, however, currently lacks some important data necessary to evaluate these approaches and identify promising practices, which might be shared to promote more timely and complete collection of relevant medical evidence by all DDSs.

Meanwhile, SSA efforts to improve the use of consultative examinations and the collection of medical records proceed as the medical community undertakes a major transformation from paper to computer records. With a presidential goal of widespread adoption of electronic medical records by 2014, increasing numbers of providers may have certified electronic records systems capable of fulfilling DDS records requests in electronic formats. As a high-volume user of these records, SSA has incentives to keep pace with industry standards. As such, the prospect of electronically requesting and receiving medical records being explored by SSA and a Boston hospital, and in the development of the nationwide health information network, among other projects, holds promise for achieving

⁴⁹GAO, *Health Information Technology: HHS Has Taken Important Steps to Address Privacy Principles and Challenges, Although More Work Remains*, [GAO-08-1138](#) (Washington, D.C.: Sept. 17, 2008); *Health Information Technology: Early Efforts Initiated but Comprehensive Privacy Approach Needed for National Strategy*, [GAO-07-238](#) (Washington, D.C.: Jan. 10, 2007); and *Health Information Technology: Efforts Continue but Comprehensive Privacy Approach Needed for National Strategy*, [GAO-07-988T](#) (Washington, D.C.: June 19, 2007).

even greater efficiencies in medical evidence collection for disability cases in the long run. In the near term, SSA has opportunities to realize greater efficiencies in the collection of medical evidence by encouraging providers to submit records online, saving both time and money by dispensing with inefficient copying and scanning. SSA has taken measures to improve its online submission options, but some providers continue to face difficulties using them and utilization remains limited. Reasons for this are unknown, even to SSA. An evaluation that studies the utilization of SSA's online submission options, identifies barriers to wider usage, and develops strategies to address these barriers, may help SSA identify cost-effective ways to encourage wider use of online submission methods, especially as more providers begin to use electronic medical records.

Recommendations for Executive Action

To foster timely and effective collection of medical evidence for disability determinations, we recommend that the Commissioner of SSA identify DDS medical evidence collection practices that may be promising, evaluate their effectiveness, and encourage other DDSs to adopt effective practices where appropriate. As a part of these evaluations, the Commissioner should work with the DDSs to find cost-effective ways to gather consistent data on the effectiveness of DDS medical evidence collection activities. Such data should include key indicators, such as the proportion of requests that yield medical records, the timeliness of medical record receipts, and how frequently claimants fail to attend consultative exams.

To achieve a more timely and efficient collection of medical records by encouraging medical evidence providers to submit records electronically, until the nationwide health information network is in operation, we recommend that the Commissioner of SSA conduct an evaluation of the limited utilization of its online submission options. This evaluation should include an analysis of the needs of small, medium, and large providers; identify any barriers to expanded use; and develop strategies to address these barriers.

Agency Comments

We provided a draft of this report to officials at SSA for their review and comment. In its comments, SSA agreed with our findings and recommendations. Specifically, SSA noted the need for consistent nationwide data but indicated that this is complicated by fact that each DDS uses one of 5 separate case processing systems. To address this limitation, SSA plans to include consistent management data in its common disability case processing system, currently in the planning stage

with implementation to begin in 2011. The agency also described current and planned activities to identify and address barriers to electronic submission of data. SSA's comments are reproduced in appendix IV.

We are sending copies of this report to the Commissioner of SSA and others who are interested. The report is also available at no charge on GAO's Web site at <http://www.gao.gov>.

Please contact me on (202) 512-7215 if you or your staffs have any questions about this report. Other major contributors to this report are listed in appendix V.



Daniel Bertoni
Director, Education, Workforce,
and Income Security Issues

Appendix I: Scope and Methodology

To determine how Disability Determination Services (DDS) and the Social Security Administration (SSA) collect medical evidence, we used four primary sources of information: (1) a survey of the 51 DDSs including all 50 states and the District of Columbia; (2) in-depth interviews and site visits with 5 states; (3) a review of 100 randomly selected initial claims files and 50 claim files at the appeals level; and (4) analysis of SSA data concerning disability determinations. To assess progress in moving from paper to electronic collection of medical evidence, we reviewed SSA documents concerning SSA and the health industry's efforts and analyzed data compiled by SSA's computer system regarding receipts of evidence and discussed efforts to encourage electronic submission with SSA and DDS officials, as well as several medical providers.

GAO Survey of DDS Directors on Collection of Medical Evidence for Initial DDS Disability Decisions

Our survey of DDSs addressed the timeliness of provider responses to DDS requests for medical records, practices and challenges associated with collecting medical records, practices and challenges associated with obtaining consultative exams, outreach to the medical provider community, and SSA and DDS initiatives associated with medical evidence collection. We pretested the complete survey questionnaire at four of the five DDSs we visited during our site visits and tested selected questions during our fifth DDS site visit. We revised our questionnaire following these pretests, incorporating suggestions and feedback from DDS and SSA regional office officials who reviewed the draft questionnaire during these pretests. In May 2008, we sent confidential access information to each of the 51 DDS directors in the 50 states and the District of Columbia. We received a response from all 51 of these directors, for a 100 percent response rate.

We analyzed the survey responses and present selected results in our report. In a few instances, we include results only from DDSs that submitted complete responses and computed national totals from DDS-supplied information. For example, we limited our analysis of DDS responses to questions about receipt of requested medical records to the 37 DDSs that provided the numbers of requested records received within 10 days, 11 to 20 days, 21 to 30 days, more than 30 days, and the number not received. Several DDSs responded to some, but not all of these questions, and other DDSs did not respond to any of these questions. Some of the DDSs estimated their responses while others indicated they were able to compute the information about medical record requests and receipts from their database. One DDS director indicated that the number of records not received included provider responses indicating that the requested records were not available. Another indicated that the number

the DDS provided for records not received included instances in which the DDS received records for which no payment was due. Checking with DDS directors in our site visit states, we determined that some of these DDSs used these same approaches, but others did not. In addition, we enforced skip patterns that were published in the survey.

State DDS Site Visits

We visited DDS in five states—California, Mississippi, New York, Vermont, and Wyoming—to gain a more detailed understanding of the medical evidence collection process, related challenges, and the availability of relevant data. At each of the DDSs we visited, we typically met with the DDS Director, Professional or Medical Relations Officer, and the Information Technology Specialist(s). SSA regional office representatives joined us for some meetings as well. We also met individually with several experienced claims examiners selected by the DDS directors in each state. In addition to describing their collection practices and challenges, DDS officials provided valuable feedback on the content and organization of our questionnaire on medical evidence collection in advance of its release to DDS directors in all 50 states and the District of Columbia. In California and New York, we visited two of those states' multiple DDS branch offices: Sacramento and Oakland, California; and Albany and Manhattan, New York. During each of these branch office visits we also spoke with experienced claims examiners. The information we obtained from each DDS we visited provided useful context to DDS operations and detailed examples of DDS responses to challenges, but information from these site visits is not intended to describe the operations of all DDSs.

We consulted a variety of factors in determining which DDSs to visit including geographic diversity, size, type of administrative computer processing system used, and SSA-provided performance data. These performance data included productivity, accuracy, percentage of claims with at least one invoiced medical record, percentage of all medical records received electronically, and percentage of claims with at least one consultative exam. We selected DDSs with both high and low indicators on these measures to illustrate examples of states with a variety of different medical evidence collection practices. The information we obtained at our site visits is illustrative and not intended to reflect the experiences of DDSs in other states. Table 4 presents some of the indicators we consulted in selecting the five DDSs to visit.

Table 4: Selected SSA Data for Five DDSs

DDS	Filing rate ^a	Allowance rate ^b	Productivity ^c	Accuracy ^d	Invoiced medical record rate ^e	Electronic receipt of medical records ^f	Consultative examination rate ^g
California	7.0	40.7%	249.9	92.3%	64.5%	28.3%	46.1%
Mississippi	15.0	23.4	277.0	93.0	70.5	88.2	44.2
New York	8.2	41.5	199.6	93.5	81.3	N/A	62.6
Vermont	6.8	51.0	185.9	96.3	93.9 ^h	26.4	25.3
Wyoming	5.5	44.3	253.4	94.5	87.8	27.6	42.8
United States	N/A	34.6	248.9	93.6	78.9	41.7	41.4

Source: SSA and SSA compilations of DDS data.

^aThe filing rate is the number for fiscal year 2005 of initial claims for Supplemental Security Income (SSI) or SSDI filed divided by state resident population.

^bThe allowance rate for initial claims in fiscal year 2007 is the number of initial claims in which the DDS made a determination of disability divided by the total number of decisions on initial claims.

^cProductivity is an SSA-generated measure for fiscal year 2007 of DDS performance, obtained by dividing the total number of cases cleared by the number of full-time-equivalent work years by employees at each DDS.

^dAccuracy rate is an SSA-generated measure for initial claims in the fiscal year 2005-2007 period of how each DDS performs derived from SSA's ongoing quality assurance reviews.

^eThe invoiced medical record rate is a DDS-reported rate for initial claims in fiscal year 2007 calculated by dividing the number of claims for which the DDS has obtained at least one medical record for which it received (or expected) an invoice by the total number of claims cleared by the DDS during the year.

^fElectronic receipt of medical records is a DDS-reported rate for September 2007 calculated by dividing the number of records received through electronic means—including by fax and online methods, such as via SSA's Web site—by the total number of medical records received by that DDS.

^gConsultative examination rate is a DDS-reported rate for initial claims in fiscal year 2007 calculated by dividing the number of claims with at least one consultative exam by the total number of claims cleared by that DDS during the year. A higher rank indicates a greater percentage of claims with at least one consultative exam.

^hBecause Vermont state law prohibits providers (or other custodians of medical records) from charging for health care records requested to support a claim or an appeal under any provision of the Social Security Act, none of the medical records the DDS receives are expected to include an invoice for providing records, but the Vermont DDS provides an "expedite" fee for records received sent within 16 days.

Reviews of Random Samples of Claimants' Folders

To obtain more detailed information about the medical evidence collection process, we reviewed two sets of randomly selected, but not projectable, samples of case files: (1) 100 initial disability claims files—electronic folders containing documentation of the disability determination for individual disability claimants and (2) 50 folders for claims decided at the administrative law judge level (ALJ) or appeal. For results from these reviews, see appendixes II and III.

To select these 100 initial disability claims folders, we reviewed all DDS decisions during fiscal year 2007 for Supplemental Security Income (SSI) and Disability Insurance (DI) disability benefits and excluded reconsiderations, continuing disability reviews, reopenings, and informal remands. For administrative purposes, we also excluded records that SSA maintained using paper records, rather than certified electronic folders. In order to avoid overrepresentation of claimants who filed for both SSI and DI simultaneously (30 percent of DDS initial decisions in fiscal year 2007), we eliminated duplicate listings of these claimants in our data set. We then randomly selected 100 cases from among the approximately 2.3 million cases in the selected data set.

These folders contained copies of SSA and DDS forms used in the development of the case including documentation for both DI and SSI claims. These documents often included medical evidence received from physicians and other providers, claimant and third-party assessments of the claimant's functional abilities, reports from providers of consultative exams of the claimant, forms providing evaluations of the evidence by DDS medical consultants, DDS forms for obtaining medical source statements from providers, forms and letters used to request medical and nonmedical evidence, evidence submitted by the claimant or his or her authorized representatives, and documents related to the disability determination such as SSA form 831, and Personal Decision Notices and similar notices for denied claims.

Similarly, to select a sample of cases decided by SSA ALJ hearings offices, we obtained from SSA an extract of SSA's Case Processing and Management System data set managed by SSA's Office of Disability Adjudication and Review. We selected records for decisions by the ALJ hearing offices during the first 6 months of fiscal year 2008 concerning initial claims for SSI and DI disability benefits that had been denied at the DDS initial level.¹ Some had been appealed to the DDS (a "reconsideration") or to the federal reviewing official, while others were appealed directly to the SSA ALJ hearing office. We also excluded records

¹As claimants appealing to an ALJ typically wait months for a hearing, many of the cases decided in fiscal year 2007 relied on paper records. Using the first 6 months of fiscal year 2008 rather than fiscal year 2007 as the more recent period gave us a larger population of ALJ decisions with electronic folder cases from which to draw our sample.

for which SSA had paper records, rather than certified electronic folders.² We randomly selected 50 of these records. SSA staff prepared a CD for each case folder. These electronic folders provided documents compiled by SSA and the DDS during the initial determination, as well as additional documents compiled subsequently, including those obtained during reconsideration of the initial decision by the DDS, documents provided by authorized representatives of the claimant, copies of medical evidence concerning treatment and examinations after the initial determination, medical source statements, an interrogatory, a deposition, and ALJ decision documents.

Analysis of SSA Data

To obtain more detailed data concerning DDS collection practices and to examine variations among DDSs, we obtained from SSA and analyzed a variety of computerized data. These included data for

- initial and reconsideration filings received, decided, and pending at year end;
- filings approved and denied;
- filings for which one or more medical evidence of record was purchased;
- filings for which one or more consultative exam was requested;
- expenditures for purchase of medical records and consultative exams;
- errors in DDS initial determinations identified by SSA quality assurance reviewers;
- the results of evaluations of medical records collected and consultative exam reports by SSA quality assurance reviewers; and
- responses to medical records obtained via methods, including paper and faxed submissions, and online submission options such as SSA's Electronic Records Express Web site.

²We identified 82,080 cases that met our criteria. A total of 194,896 cases met our other sample selection criteria before applying the certified electronic folder criteria. Whether the 42 percent of records that had certified electronic folders were representative of all cases that otherwise met our study criteria is not clear. We nonetheless concluded that this sample selection was sufficiently reliable for the purpose of providing illustrative examples of the ALJ hearing-level medical evidence collection process.

We used these data to summarize and compare how DDSs display these data graphically. We also used these data to provide additional information concerning the initial claim case files described above. To conduct limited tests of the reliability of these data we obtained copies of 831 data and Case Processing Management System data from SSA and compared results provided by SSA with results from our analysis of these data sources.

Appendix II: Selected Results from Analysis of 100 Randomly Selected Initial Disability Cases

The following tables provide selected findings from our review of 100 randomly selected cases for claimants with initial DDS determinations in fiscal year 2007.¹

Table 5: Characteristics of Medical Evidence Collection in 100 Cases of Initial DDS Disability Determinations, Fiscal Year 2007

Characteristic of evidence collection process	Approvals	Denials	Total cases
Number of claimants ^a	35	65	100
How SSA received the claim:			
Face-to-face interview	20	23	43
Telephone	9	27	36
No direct contact with the claimant (for example, Internet claim or parent interviewed without child claimant present)	6	15	21
No medical records received from any of the providers identified by the claimant	0	3	3
Claimant did not cite any medical providers	1	1	2
One or more provider asked for medical records indicated they had no records or no records for the specified time period	11	23	34
Medical records sought from providers that had not been identified by claimant when they filed ^b	7	13	20
One or more consultative exam report	20	37	57
Consultative exam provided by claimant's own physician or other treating source	1	1	2
One or more missed consultative exam ^c	0	11	11
Most common bases of decision	Met criteria set by medical listing in SSA regulations (15) Medical and vocational considerations (17)	Capacity for substantial gainful activity, either resuming relevant past work or other work (43) ^d	
Personal decision notice (or similar notice) indicated that the DDS decision was based on one or more reports from medical sources that had not provided medical records ^e	Not applicable ^f	10	10

Source: GAO review of initial claims files.

^aConcurrent filings for benefits under Title II and Title XVI are treated here as a single case.

^bExcludes medical evidence obtained from schools and excludes evidence sought after initial decision.

^cClaimant failed to appear for the exam.

¹See app. I for details concerning our selection of these cases. We included only cases for which SSA had electronic folders, versus documentation in paper form.

Appendix II: Selected Results from Analysis of 100 Randomly Selected Initial Disability Cases

^dThis includes specific SSA codes H1, H2, J1, J2, N1, N2, N31, N32, N42, N43, N33. Other codes indicate capacity for SGA in other specific circumstances.

^ePersonal decision notices or similar notices are sent to claimants denied benefits to describe in understandable language the basis and evidence for the decision.

^fPersonal decision notices (or similar notices describing the evidence used in making the decision) are not required in approved cases.

Table 6: Legibility of Records in 100 Cases of Initial DDS Disability Determinations, Fiscal Year 2007

Characteristics of medical records or consultative exam reports collected	Total cases
One or more medical records included handwritten evidence	82
One or more medical records included illegible or barely legible evidence	68
One or more consultative exam reports included handwritten evidence	8
One or more consultative exam reports included illegible or barely legible records	1

Source: GAO review of initial claims files.

Table 7: Characteristics of the Collection Process for Medical Records from Claimants' Providers in 100 Cases of Initial DDS Disability Determination, Fiscal Year 2007

Characteristics of records collection process	Number of requests in 100 cases
Total number of requests	332
Medical record provided	261
Requested record not obtained by date of initial decision	71
Providers indicated for example that they did not have a medical record for the claimant or did not have a claimant record for the time period specified	43
No evidence of response from provider ^a	28
DDS request for medical records included either a detailed or general request for a medical source statement ^b	68
One or more DDS request for medical records included an inquiry about the provider's willingness to perform a consultative exam if needed ^c	45

Source: GAO review of initial claims files.

^aThis includes one case in which the mailed request was returned as undeliverable.

^bIn 22 cases, the copies of medical records requests in the folder did not include such a request; in other cases, no copy of the request sent to provider was available.

^cIn 42 cases, copies of the medical records requests did not include such an inquiry; in other cases, no copy of a request was available.

**Appendix II: Selected Results from Analysis
of 100 Randomly Selected Initial Disability
Cases**

**Table 8: Time Periods for Receipt of Medical Records and Disability Determinations
in 100 Initial DDS Disability Decisions, Fiscal Year 2007**

Time period	Number of days			
	Minimum	Median	Average	Maximum
From date medical records requested to date medical records received	1	15	22	182
From date appointment made for consultative exam to date of exam ^a	4	24	26	63
From date of consultative exam to date consultative exam report received	0	9	12	40
From date of DDS receipt of claim to date DDS initial decision ^b	13	81	90	354

Source: GAO review of initial claims files.

^aThese figures are calculated, for cases with two or more consultative exams, using the longest time period between appointment and exam.

^bBased on date of receipt recorded on disability worksheet and date of decision recorded on SSA form 831.

Appendix III: Medical Evidence Collection Process at the Administrative Hearing Level

The process for collecting medical evidence at the administrative hearing level typically differs from the process at the DDS level. If the claimant for disability benefits is dissatisfied with the DDS's initial decision, he or she can appeal. In many cases the initial appeal is a request for a reconsideration by the DDS. Then, if the claimant is not satisfied with the DDS decision, he or she can appeal and request a hearing before an administrative law judge (ALJ), who will review the case in light of the evidence gathered by the DDS as well as additional evidence obtained.¹ The responsibility for providing evidence to support the appeal falls on the claimant. A claimant may be represented by an attorney or other representative, to collect the additional evidence on his or her behalf. If necessary evidence is not provided, the ALJ must attempt to fully and fairly develop the evidence. Most claimants who appeal to an SSA hearings office are represented by attorneys or others who enter into agreements with SSA providing payment to the representative, which may be from a specified proportion of awarded retroactive disability benefits in cases where claimants win their appeal.

SSA requires ALJs to conduct a prehearing review of all evidence and determine whether additional development is needed. Claimants' representatives may submit updated medical records. If the ALJ is unable to obtain adequate evidence, the ALJ also can request consultative exams or tests. Similarly, if additional evidence is needed, the ALJ may have an independent medical expert review the file and answer written interrogatories, or testify at the hearing. Some ALJs ask the DDS to gather additional evidence on their behalf.² Others have SSA hearings office staff gather evidence for the hearing. ALJs have additional options to obtain opinion evidence from claimants' providers, including sending interrogatories or questionnaires, requesting testimony at the hearing, and, under certain circumstances, issuing administrative subpoenas. Claimants' representatives told us that letters describing the possibility of such subpoenas are sometimes sent, but subpoenas are rare.

As part of SSA's continuing efforts to reduce the backlog of claims at the hearing level, it has implemented the Medical Expert Screening Initiative Business Process. This is a new pre-hearing initiative to identify disability

¹This includes evidence obtained by the DDS at the reconsideration level of appeal. In several states, however, appeals of DDS decisions go directly to the hearings offices.

²During fiscal year 2007, the DDSs provided assistance in collection of evidence for hearings offices in about 59,000 cases.

claimants whose impairments are most likely to meet the requirements for disability with a pre-hearing interrogatory sent to medical experts. If the medical expert responses to the interrogatories show that a fully favorable decision may be made on the record, without the need for additional evidence or a hearing, the case is referred to an attorney adjudicator in that hearing office to issue the decision, if warranted.

ALJs and DDSs use the same definition of disability, but use different administrative guidance. SSA guidance for DDSs is included in SSA's Program Operations Manual System. Its counterpart for ALJs is called the Hearings, Appeals, and Litigation Law Manual.

To obtain information on how medical evidence is collected at the ALJ hearing level, we reviewed electronic copies of 50 claims that were decided at the appeals level during the first half of fiscal year 2008. Claims were randomly selected from all decided initial disability claims nationwide which had a certified, fully electronic folder. The small sample size means that the information we obtained from these selected cases cannot be considered representative of all cases at the appeals level, but it provides examples of how medical evidence is collected at the appeals level. These included 34 fully favorable decisions, 1 partially favorable decision (a changed date for onset of the claimant's disability), and 10 unfavorable decisions. In 4 cases, the case was dismissed or the claimant withdrew. The tables below summarize results from our review of these cases:

Table 9: Characteristics of the Medical Evidence Collection Process for 50 Cases at the Initial DDS Decision Level and at the Hearings Office Appeal Level

Characteristic	Initial DDS Level	Hearings Office Level
Number of cases for which no medical records added	3	8
Number of cases for which DDS obtained medical records	47	4
Medical source statement added ^a	13	20
Consultative exam report(s) added	30	1
Claimant was represented	6	45

Source: GAO review of appealed disability claims.

Note: This table shows how many of the 50 cases had each characteristic at either the initial DDS or the hearings level.

^aA medical source statement is a medical source's opinion on what the claimant can still do despite his or her impairments. In other cases, evidence of a medical source was unclear or not present.

Table 10: Additional Examples of Medical Evidence Collection at Hearings Office Level

Example	Number of cases identified
Representative obtained medical source statement from a source that had provided records, but not a medical source statement at the initial DDS level	10
Representative obtained a medical source statement from a new medical source	5
Evidence indicates that the claimant's condition worsened after initial decision	12
Evidence indicates that the claimant died after initial decision, but before hearing was held	1
Claimant was initially denied because the disability was not expected to last 12 months, but new evidence indicated it did and received a fully favorable decision at the ALJ level	6
ALJ's decision gives "little weight" to state agency medical opinions provided at initial DDS level ^a	16a
ALJ's decision gives "no weight" to state agency medical opinions provided at initial DDS level	1
ALJ dismissed the case because claimant did not appear at the hearing	2
Claimant withdrew the appeal to ALJ level	2

Source: GAO review of appealed disability claims.

^aFor example, one ALJ writes, "The state agency medical opinions are given little weight because other medical opinions are more consistent with the record as a whole and evidence received at the hearing level shows that the claimant is more limited than determined by the state agency consultants." Another ALJ uses similar language and adds that, "Because the examiners did not have access to additional evidence submitted subsequent to the opinions, the opinions were not a full and accurate assessment of the claimant's condition."

ALJs often gather nonmedical as well as medical evidence to reach a decision. They typically observe the claimant during the hearing, in-person, or by video conference. One ALJ wrote, for example, "Furthermore, the state agency consultants did not adequately consider that the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are generally credible." Hearings also sometimes involve evidence from vocational experts—experts in assessing a claimant's ability to perform various jobs. In 3 of the 50 cases reviewed, the ALJ cited medical-vocational rules as the basis of their decision. By the time the cases we reviewed were decided by the SSA hearings office, medical evidence had typically been added that was not available at the time of the initial DDS decision. In most of these cases, the claimant's representative collected the new evidence and submitted it to SSA. Often

this included evidence from sources that had not provided medical records at the initial DDS level. In several cases the representative obtained a medical source statement from a source that had not previously submitted one, but had provided medical records.³ In 12 cases, evidence indicated that the claimant's condition proved more prolonged than the DDS expected.

³Why the representatives were able to obtain medical source statements while the DDSs were not is not clear based on the evidence in the case folder.

Appendix IV: Comments from the Social Security Administration



SOCIAL SECURITY

The Commissioner

December 9, 2008

Mr. Daniel Bertoni
Director, Education, Workforce, and
Income Security Issues
U.S. Government Accountability Office
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Bertoni:

Thank you for the opportunity to review and comment on the draft report, "Social Security Disability: Collection of Medical Evidence Could Be Improved with Evaluations to Identify Promising Collection Practices" (GAO-09-149).

Enclosed are our detailed comments to the draft report recommendations along with suggested technical revisions.

If you have any questions, please contact Candace Skumik, Director, Audit Management and Liaison Staff, at (410) 965-4636.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Astruc".

Michael J. Astruc

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS ON THE GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT, "SOCIAL SECURITY DISABILITY: COLLECTION OF MEDICAL EVIDENCE COULD BE IMPROVED WITH EVALUATIONS TO IDENTIFY PROMISING COLLECTION PRACTICES" (GAO-09-149)

Thank you for the opportunity to review and comment on the draft report. In general, your report provides accurate background information and accurate explanations of our disability process and policy, and Disability Determination Services (DDS) development. As the report indicates, there are many factors that contribute to the challenges the DDSs face in acquiring necessary medical evidence. The report accurately highlights issues such as: 1) claimants not showing up for scheduled appointments with medical providers; thus the medical providers lose revenue; 2) claimants not identifying all medical providers when applying for benefits; 3) medical providers skepticism about sending information because of the Health Insurance Portability and Accountability Act of 1996; and 4) medical providers assigning a low priority to sending medical evidence to the DDSs.

We will share methods of dealing with these challenges which were developed by one or more of the DDSs. In our new Agency Strategic Plan, we commit to transform our medical evidence collection process by automatically requesting and receiving electronic medical records through a nationwide health information network. The Department of Health and Human Services has the lead to develop this network. Developing new methods for the collection of medical evidence should decrease processing time considerably. Additionally, we are exploring options that would allow a custodian of records to disclose relevant personal information to us, when we make a request on behalf of an individual who files an application for initial or continuing benefits, without the use of paper authorization forms. This option will also relieve health care institutions and professionals from legal concerns about making the requested disclosure. These approaches will also enable us to reduce the burden on all parties involved and provide more timely decisions to disabled individuals while respecting the confidentiality of their personal information. However, these approaches will likely require legislation to be enacted.

We are in the process of building a common system, the Disability Claims Processing System, that will: 1) reduce transactions and simplify the interconnections, thereby improving systems responsiveness; 2) build in electronic receipt of medical evidence of record; 3) consider a national "vendor" source list; 4) consider national fiscal (bill paying) options; 5) address case analysis (medical source opinion) concerns; and 6) consider "contacting" external databases to obtain medical evidence.

We will continue in our efforts to improve the collection of medical evidence; however, limited budget and resources constrain our efforts to implement enhancements to resolve the identified barriers.

Our responses to the recommendations are as follows.

Recommendation 1

To foster timely and effective collection of medical evidence for disability determinations, the Social Security Administration (SSA) should identify DDS medical evidence collection practices that may be promising, evaluate their effectiveness, and encourage other DDSs to adopt effective practices where appropriate. As a part of these evaluations, SSA should work with the DDSs to find cost-effective ways to gather consistent data on the effectiveness of DDS medical evidence collection activities. Such data should include key indicators such as the proportion of requests that yield medical records, the timeliness of medical record receipts, and how frequently claimants fail to attend consultative exams.

Comment

We agree, below is a summary of actions we took to address medical evidence collection issues at the DDSs:

- Conducted various User Needs Analysis (UNA) meetings with DDS staff to identify issues and obtain user suggestions for improvement.
- Held annual national meetings with DDS systems staffs and DDS Professional Relations Officers to discuss issues and to share best practices.
- Conducted conference calls with the Regional Offices and DDS offices on a quarterly, monthly, biweekly, and weekly basis, depending on the specific subject and audience of the call, to discuss issues and best practices.
- Encouraged the DDSs to notify their Regional Office contacts with issues and best practices that include medical evidence collection.
- Conducted pilots of new business processes to evaluate their effectiveness, and if successful, encouraged other DDSs or Regions to implement these business practices. One example of this collaboration is the adoption of software programs developed by the Florida and Ohio DDSs to locate medical evidence that a medical provider submitted, but for various reasons, were not placed in the claimant's electronic folder. After determining the effectiveness of these software applications in locating medical evidence, we are now using them in all of the DDSs. In addition, we added functionality to the Electronic Records Express Website to accompany the functionality of these software applications (these enhancements are known as Track Status of Submissions and Customer Status Inquiries and were implemented in July 2008.)

We also agree that we should find ways to gather consistent data on the effectiveness of DDS medical evidence collection activities. However, because there are five separate DDS case processing systems, it is virtually impossible to gather consistent national data at this time. In an effort to obtain consistent national management information, we will continue our initiative to develop a common disability case processing system which is intended to be used by all of the DDSs. In November 2008, we began the planning and analysis efforts to identify the requirements for the common system. We and the DDSs have agreed to the need for consistent management information to be built into the common system. The new system will include medical evidence collection practices.

We have also scheduled the project plan for the common system. That plan spans several years with a “Phase 1” implementation scheduled for fiscal year 2011.

Recommendation 2

To achieve a more timely and efficient collection of medical records by encouraging medical evidence providers to submit records electronically, until the nationwide health information network is in operation, SSA should conduct an evaluation of the limited utilization of its online submission options. This evaluation should include an analysis of the needs of small, medium, and large providers, identify any barriers to expanded use, and develop strategies to address these barriers.

Comment

We agree. We are currently evaluating the methods used by medical providers and copy services to submit medical records electronically and have identified barriers to the use of these methods. In an effort to address their barriers, we have:

- Participated in two UNA meetings that included DDS staff and medical providers and copy services to identify issues and obtain user suggestions for improvement.
- Compiled and prioritized the identified issues and user suggestions and requested systems enhancements to resolve the issues and improve usability.
- Conducted Joint User Review conference calls to obtain user input on upcoming enhancements to various systems.
- Attended multiple medical community conferences, including the American Health Information Management Association, Medical Group Management Association, American Academy of Child and Adolescent Psychiatrists, and American Speech and Hearing Association. At these conferences, we and DDS staff discuss the various methods of submitting medical evidence electronically with the medical community.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Daniel Bertoni (202) 512-7215 or bertonid@gao.gov

Staff Acknowledgments

In addition to the contact named above, Michael J. Collins, Assistant Director; Benjamin P. Pfeiffer; Susan L. Aschoff; Alexander G. Galuten; Catherine M. Hurley; Karen A. Jarzynka; Katherine N. Laubacher; Jennifer R. Popovic; Suzanne C. Rubins; Meghan H. Squires; Vanessa R. Taylor; Rachael C. Valliere; and Walter K. Vance, made key contributions to this report.

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