ICN: 31179-23-176

SOCIAL SECURITY

Office of the Inspector General

MEMORANDUM

Date: June 28, 2001 Refer To:

To: Larry G. Massanari
Acting Commissioner
of Social Security

From: Inspector General

Subject: Medical Evidence of Record Collection Process at State Disability Determination Services (A-07-99-21003)

The attached final report presents the results of our audit. Our objectives were to: (a) review and assess the efficiency of the medical evidence of record collection process at State Disability Determination Services (DDS), and (b) assess the DDS' ability to provide the Social Security Administration with management data.

Please comment within 60 days from the date of this memorandum on corrective action taken or planned on each recommendation. If you wish to discuss the final report, please call me or have your staff contact Steven L. Schaeffer, Assistant Inspector General for Audit, at (410) 965-9700.

James G. Huse, Jr.

Attachment

OFFICE OF
THE INSPECTOR GENERAL

SOCIAL SECURITY ADMINISTRATION

MEDICAL EVIDENCE OF RECORD COLLECTION PROCESS AT STATE DISABILITY DETERMINATION SERVICES

June 2001 **A-07-99-21003**

AUDIT REPORT

Mission

We improve SSA programs and operations and protect them against fraud, waste, and abuse by conducting independent and objective audits, evaluations, and investigations. We provide timely, useful, and reliable information and advice to Administration officials, the Congress, and the public.

Authority

The Inspector General Act created independent audit and investigative units, called the Office of Inspector General (OIG). The mission of the OIG, as spelled out in the Act, is to:

- Conduct and supervise independent and objective audits and investigations relating to agency programs and operations.
- Promote economy, effectiveness, and efficiency within the agency.
- Prevent and detect fraud, waste, and abuse in agency programs and operations.
- Review and make recommendations regarding existing and proposed legislation and regulations relating to agency programs and operations.
- Keep the agency head and the Congress fully and currently informed of problems in agency programs and operations.

To ensure objectivity, the IG Act empowers the IG with:

- Independence to determine what reviews to perform.
- Access to all information necessary for the reviews.
- Authority to publish findings and recommendations based on the reviews.

Vision

By conducting independent and objective audits, investigations, and evaluations, we are agents of positive change striving for continuous improvement in the Social Security Administration's programs, operations, and management and in our own office.

Executive Summary

OBJECTIVE

Our objectives were to: (a) review and assess the efficiency of the medical evidence of record (MER) collection process at State Disability Determination Services (DDS); and (b) assess the DDS' ability to provide the Social Security Administration (SSA) with management data.

BACKGROUND

SSA is responsible for establishing the policies on developing disability claims under the Disability Insurance (DI) and Supplemental Security Income (SSI) programs. Disability determinations under SSA's DI and SSI programs are performed by each State's DDS in accordance with Federal regulations. DDSs are responsible for obtaining adequate medical evidence to support the disability decision. In doing so, DDSs may purchase consultative examinations (CE) to supplement the MER obtained from claimants' treating sources. SSA reimburses DDSs for 100 percent of allowable expenditures.

SSA instructs DDSs to make every reasonable effort to obtain MER from claimants' treating sources. SSA's instructions define every reasonable effort as: (1) making an initial request for MER from the treating source; (2) making a follow-up request any time between 10 and 20 calendar days after the initial request if the MER has not been received; and (3) allowing a minimum of 10 calendar days from the follow-up request for the treating source to respond. If MER is not received within 10 calendar days from the follow-up request, the DDS can purchase a CE—an expensive and time-consuming process.

RESULTS OF REVIEW

The current MER collection times account for a considerable portion of overall disability claims processing times because the processes of requesting and receiving MER are slow and labor-intensive for both the DDS and the claimant's treating source. First, the DDS sends a MER request letter to the treating source(s) identified by the claimant on his/her disability application. The treating source photocopies the MER and returns it to the DDS via mail or, in some cases, facsimile. Timeliness of MER receipt is dependent on the treating source's workload and cooperation. As such, the time it takes treating sources to respond to DDS requests for MER can vary from a few days to several weeks.

We calculated the time it took eight DDSs to receive MER from claimant treating sources during Fiscal Year 1998. For the 663,293 MER purchased by the 8 DDSs, 64.8 percent of the MER were received within 30 days from the date of request. For the remaining 35.2 percent, the 8 DDSs waited more than 30 days to receive the MER.

This represented 233,300 MER at a cost to SSA of almost $3 million. Six of the eight DDSs received 76 percent to 88 percent of their MER within 30 days. However, the North Carolina and Oklahoma DDSs received MER within 30 days for only 39 percent and 53 percent of their requests, respectively.

Our review also disclosed that delays in receiving MER from treating sources resulted in SSA paying for MER that was not received by the DDS until after the disability decision was made. The 8 DDSs in our review expended over $1 million to purchase 78,709 MER that were not received until after the DDS made the disability decision. The North Carolina DDS accounted for 60 percent of these MER purchases. Delays in DDSs receiving MER from treating sources can, but do not necessarily, result in the DDSs purchasing costly CEs in order to obtain medical evidence to support the disability decision. Due to insufficient management data, we were unable to determine whether delays in receiving these 78,709 MER resulted in the DDSs purchasing unnecessary CEs.

We found that the DDS' ability to provide SSA with management data related to MER collection times varied. This variance was attributed to DDSs using different computer systems to collect MER data and to SSA not providing DDSs with uniform MER data collection requirements.

SSA is currently involved in the Specialized MER Professional Relations Officer project. This project dedicates a professional or medical relations officer solely to activities related to MER collection and is expected to last 2 years. There are six DDSs participating in the project: Puerto Rico, Florida, Illinois, Louisiana, Nebraska, and Idaho. The project is in the initial stages and to date there are no reportable results. The purpose of the project is to determine whether assigning one professional relations officer in each DDS to duties solely to MER retrieval will promote the timely receipt of quality MER and ultimately decrease CE costs.

In collecting medical evidence, SSA must consider standards implemented as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt national uniform standards to be followed by health plans, health care providers, and health insurers in disclosing medical information. Although HHS may not regulate SSA's disclosure of medical information, the new regulations will have a significant impact on SSA's ability to obtain MER from medical sources.

RECOMMENDATIONS

We recommend that SSA:

- Pursue options for improving MER collection times at DDSs experiencing problems in receiving MER within 30 days from the date of the request. This should include sharing best practices of DDSs that have been innovative in obtaining MER timely.

- Conduct a study to determine whether savings in CE costs could be realized by providing a financial incentive to medical providers who submit MER within 30 days from the date of the request.

- Improve its oversight of the DDS MER collection process by: (a) developing uniform MER data collection requirements for DDSs; and (b) performing periodic evaluations of MER collection processes and times at DDSs to develop best practices.

AGENCY COMMENTS

SSA agreed with our first recommendation, but did not agree with our second and third recommendations. With regard to our second recommendation, SSA stated that an internal focus group determined that the fee paid for MER is not a critical issue, and that a financial incentive would raise the total cost of obtaining evidence without improving compliance by the providers. SSA also disagreed with the third recommendation, stating that uniform data collection requirements would impose a burden on DDSs to make software and processing adjustments or to undertake a prohibitive manual process. (See Appendix D for SSA's comments.)

OIG RESPONSE

In its comments to our second recommendation, SSA stated that raising the fee for MER would simply raise the total cost of obtaining evidence without improving compliance by the providers. Our recommendation was not intended to imply an increase in MER payment amounts; nor, was it intended to provide an incentive payment to providers who do not comply with timely submission of MER. Rather, the study should consider paying the current fee to providers who submit MER within 30 days, and paying a lesser fee to providers who exceed the 30-day submission date.

With regard to our third recommendation, we acknowledge SSA's concern that software and processing adjustments may provide an initial burden on DDSs. However, we do not believe that software modifications or processing adjustments are insurmountable problems given the importance of management information to SSA's oversight of the disability determination process. Furthermore, as DDSs are converted to the IBM AS/400 computer system, we would expect improvements in the DDS' ability to collect electronic data accurately and timely.

Table of Contents

Acronyms

BAH	Booz-Allen & Hamilton
CE	Consultative Examination
CY	Calendar Year
DDS	Disability Determination Services
DI	Disability Insurance
EDI	Electronic Data Interchange
FY	Fiscal Year
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
MER	Medical Evidence of Record
NDDSS	National Disability Determination Services System
OIG	Office of the Inspector General
POMS	Program Operations Manual System
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number

Introduction

OBJECTIVE

Our objectives were to: (a) review and assess the efficiency of the medical evidence of record (MER) collection process at State Disability Determination Services (DDS); and (b) assess the DDS' ability to provide the Social Security Administration (SSA) with management data.

BACKGROUND

SSA is responsible for establishing the policies on developing disability claims under the Disability Insurance (DI) and Supplemental Security Income (SSI) programs. Disability determinations under SSA's DI and SSI programs are performed by each State's DDS in accordance with Federal regulations.[1] DDSs are responsible for obtaining adequate medical evidence to support the disability decision. In doing so, DDSs may purchase consultative examinations (CE) to supplement the MER obtained from claimants' treating sources.[2] SSA reimburses DDSs for 100 percent of allowable expenditures.

In making disability determinations, the DDS develops a claimant's complete medical history for a 12-month period based on the earliest of: (1) the application filing date; (2) the date last insured; (3) the prescribed period ending date; or (4) the attainment of age 22. If the disability is alleged to have begun during the 12 months preceding the application date, then the medical history is developed based on the alleged disability onset date. To develop the claimants' medical history, DDSs obtain and review MER from claimants' treating sources. MER includes, but is not limited to, copies of laboratory reports, prescriptions, x-rays, ancillary tests, operative and pathology reports, consultative reports, and other technical information that documents the claimant's health condition.

SSA instructs DDSs to make every reasonable effort to obtain MER from claimants' treating sources. SSA's instructions define every reasonable effort as: (1) making an initial request for MER from the treating source; (2) making a follow-up request any time between 10 and 20 calendar days after the initial request if the MER has not been received; and (3) allowing a minimum of 10 calendar days from the follow-up request for the treating source to respond.[3] If MER is not received within 10 calendar days from the follow-up request, the DDS can purchase a CE—an expensive and time-consuming process.

---

[1] States may turn this function over to the Federal government if they no longer are able to make disability determinations. [20 C.F.R. §§ 404.1503(a) and 416.903(a)]

[2] CEs include medical and psychological examinations, x-rays, and laboratory tests.

[3] SSA Program Operations Manual System DI 22505.001B.4, "Every Reasonable Effort." This instruction implies that 30 days is a reasonable timeframe for DDSs to receive MER from treating sources.

Congress authorized SSA to pay for MER under the SSI program since its inception in 1974 because it was considered unreasonable to expect a claimant to pay for MER under a needs-based program.[4] In 1980, Congress authorized SSA to pay for MER under the DI Program. In doing so, Congress believed that MER would be received more timely if payment was made, and costs would be reduced since CEs may not be needed.[5]

SCOPE AND METHODOLOGY

To accomplish our objective we:

- Reviewed sections of the Social Security Act, the Code of Federal Regulations, and SSA's Program Operations Manual System (POMS).

- Randomly selected 10 DDSs for on-site field work and obtained electronic data files of MER and CE payments made during the period of October 1, 1997, through September 30, 1998.[6]

- Conducted site visits at SSA, Baltimore, Maryland; the Wisconsin DDS; and the Kansas DDS.

- Compared MER and CE payment amounts in the electronic data files obtained from the 10 DDSs to the MER and CE payment amounts reported to SSA on the Report of Obligations (Form SSA-4513) to validate the completeness of the data.

- Performed an analysis of MER receipt times for eight DDSs by calculating: (a) the time elapsed between the date the DDS requested MER and the date the MER was received by the DDS; and (b) the number and cost of MER received and paid for after the date the disability decision was made (see Appendix A).

- Obtained information from the 48 continental United States DDSs on their MER collection process.[7]

---

[4] Social Security Amendments of 1971, Pubic Law 92-603 (86 Stat. 1329); H.R. Rep. 92-231 at 148, reprinted at 1972 U.S. Code Cong. and Admin. News, p. 5134.

[5] Social Security Disability Amendments of 1980, Public Law 96-265 (94 Stat. 441), section 309 codified at section 223(d)(5) of the Social Security Act, 42 U.S.C. section 423(d)(5); S. Rep. 96-408 at 59, reprinted at 1980 U.S. Code Cong. and Admin. News, p.1337.

[6] DDSs selected were Delaware, Illinois, Iowa, Kansas, Massachusetts, North Carolina, Oklahoma, Utah, Virginia, and Wisconsin. The Illinois and Virginia DDSs were excluded from the review because they were unable to provide all of the requested data files. Therefore, our analysis was performed for eight DDSs.

[7] There are 54 DDSs; however, we excluded Hawaii, Alaska, District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

- Reviewed information on SSA and DDS pilot MER projects received from DDSs and SSA's Central and Regional Offices.

- Reviewed Booz-Allen & Hamilton's (BAH) *Report on the Use, Storage, and Exchanges of Electronic Medical Records and Documents in the Health Industry.*

- Reviewed the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- Reviewed SSA's 2010 Vision Plan dated August 2000.

We conducted our audit between June 1999 and January 2001 in Kansas City, Missouri. The entities reviewed were State DDSs and the Office of Disability under the Deputy Commissioner for Disability and Income Security Programs. Our audit was conducted in accordance with generally accepted government auditing standards.

Results of Review

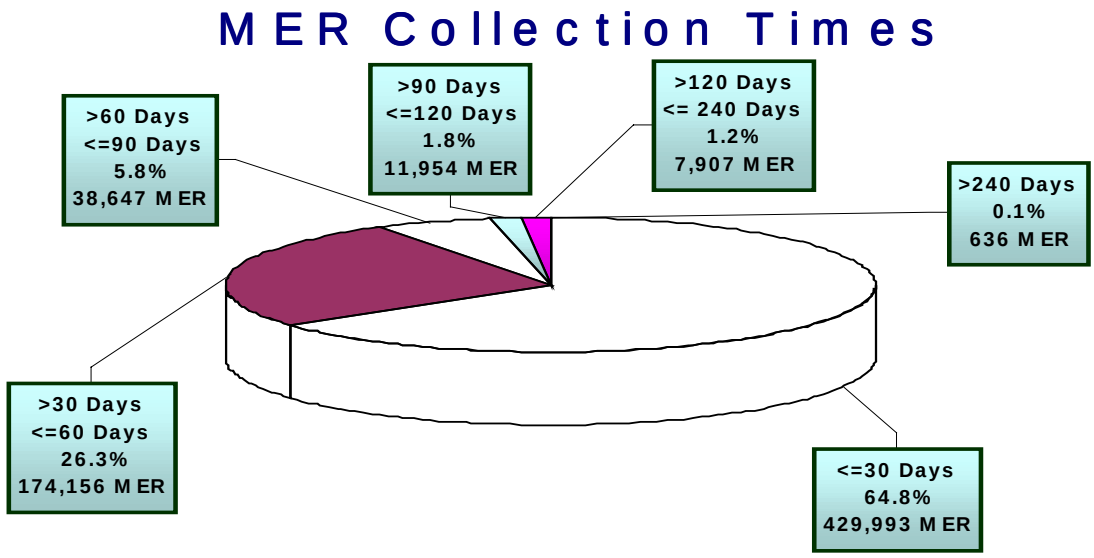
Our review showed that improvements are needed in MER collection times. Our analysis identified delays in DDSs receiving MER from treating sources. We found that these delays resulted in SSA paying for MER that was not received by the DDSs until after the disability decision was made. We also found that the DDS' ability to provide SSA with management data related to MER collection times varied. This variance was attributed to DDSs using different computer systems to collect MER data and to SSA not providing DDSs with uniform MER data collection requirements.

THE CURRENT MER COLLECTION PROCESS

The DDS sends a MER request letter to the treating source(s) identified by the claimant on his/her disability application. The treating source photocopies the MER and returns it to the DDS via mail or, in some cases, facsimile. Timeliness of MER receipt is dependent on the treating source's workload and cooperation. As such, the time it takes treating sources to respond to DDS MER requests can vary from a few days to several weeks.

MER Collection for Eight DDSs

We calculated the time it took eight DDSs to receive MER from claimant treating sources during Fiscal Year (FY) 1998. For the 663,293 MER purchased by the 8 DDSs, 64.8 percent of the MER was received within 30 days from the date of request (see Appendix A). For the remaining 35.2 percent, the eight DDSs waited more than 30 days to receive the MER. This represented 233,300 MER at a cost of $2,964,615 to SSA. The following chart provides the MER collection times for the eight DDSs.



Six of the eight DDSs received 76 percent to 88 percent of their MER within 30 days. However, the North Carolina and Oklahoma DDSs, received MER within 30 days for only 39 percent and 53 percent of their requests, respectively. SSA should consider options for improving MER collection times at these DDSs.

MER Received After the Disability Decision

Our review also disclosed that delays in receiving MER from treating sources resulted in SSA paying for MER that was not received by the DDS until after the disability decision was made. The 8 DDSs in our review expended $1,011,772 to purchase 78,709 MER that were not received until after the DDS made the disability decision, as shown in the following table.[8]

State DDS	Number of MER Received After the Disability Decision	MER Expenditures	Average Number of Days from the Decision Date to the MER Received Date
Delaware	1,924	$ 26,291	24
Iowa	1,801	30,921	34
Kansas	3,654	46,856	23
Massachusetts	10,189	148,692	31
North Carolina	47,266	566,050	24
Oklahoma	9,536	130,165	22
Utah	888	11,536	47
Wisconsin	3,451	51,261	51
Total	78,709	$1,011,772	32

According to SSA's instructions, DDSs are to review MER received after the disability decision and determine whether it has an affect on the initial disability decision.[9] The DDS staff we interviewed stated that paying for MER received after the initial disability decision continues because: (1) the MER may be needed if the claimant appeals the initial decision; (2) the DDSs do not want to alienate treating sources by refusing to pay for untimely MER; and/or (3) payment is required by State law.

[8] The North Carolina DDS accounted for 60 percent of these MER. According to the North Carolina DDS, the MER receipt date provided to us in its data file was the same as the MER payment date which may not be the actual date the MER was received. The DDS does not record the actual date MER is received. If the North Carolina DDS was excluded from our analysis, the MER collection times for the remaining seven DDSs would be as follows: less than 31 days, 78.5 percent; 31 to 60 days, 16.5 percent; 61 to 90 days, 3.2 percent; 91 to 120 days, 1 percent; 121 to 240 days, 0.7 percent; and over 240 days 0.1 percent.

[9] POMS DI 22520.001, Disposition of Trailer Material.

THE ABILITY OF DDSs TO PROVIDE MER MANAGEMENT DATA

We found that the DDS' ability to provide SSA with management data related to MER collection varies. The variance exists because DDSs use different computer systems to collect MER data and SSA has not provided DDSs with uniform requirements for MER data collection.

DDS Computer Systems

We found that the ability of DDSs to provide information and the type of information DDSs can provide varies and this presented us with several problems in collecting and analyzing MER data for this review. The DDSs use multiple, disparate and incompatible computer systems and software to process disability claims. There are 54 DDSs that support a variety of software programs.[10] Currently, there are 26 DDSs using WANG computer systems. However WANG no longer provides technical support to these DDSs. SSA is in the process of converting these 26 DDSs to the IBM AS/400 computer system used by other DDSs. The conversion for the first DDS—Wisconsin—was scheduled to begin on October 1, 2000. However, as of January 2001, the conversion had not begun. See Appendix C for the DDS computer conversion timeline.

A March 1997 Office of the Inspector General (OIG) report, *The Social Security Administration's Payment for Medical Evidence of Record Obtained by State Disability Determination Services* (A-07-95-00833), recommended that SSA capture data on MER collection times to determine the extent to which MER is not being submitted timely. In its comments to the report, SSA agreed to perform an evaluation of MER collection times within 9 months of the date of the OIG report or by December 1997. Based on status of recommendation information obtained from SSA's Management Analysis and Audit Program Support staff in June 2000, the evaluation was not completed because of DDS backlogs and workload pressures caused by high application rates. Appendix B contains SSA's comments on A-07-95-00833 and the status of the report's recommendation.

SSA's Oversight of MER Collection

We found that SSA does not have adequate oversight of the MER collection process. SSA has not provided DDSs with uniform MER data collection requirements. As such, DDSs choose what MER information is collected resulting in inconsistent information being collected at DDSs.

Also, SSA does not monitor MER collection times. The MER information we requested from the DDSs for our review is essential management information that both the DDS and SSA should use to monitor the timeliness of MER requested from treating sources. For example, the Illinois DDS was unable to provide information on MER receipt times because the information is not captured by the DDS. Therefore, we question how or if the DDS determines the timeliness of MER receipt. Furthermore, without MER

[10] There are 28 DDSs that use Levy software; 15 DDSs that use Versa software; 2 DDSs that use MIDAS software; 6 DDSs that are to install either Levy, Versa, or MIDAS software in FY 2000; and 3 DDSs that use independent software.

collection time information, the DDS could prematurely purchase costly CEs instead of making every reasonable effort to obtain MER as outlined in SSA's instructions.

SSA's MER COLLECTION PILOT PROJECT

SSA's most recent MER initiative is the Specialized MER Professional Relations Officer project. This project dedicates a professional or medical relations officer solely to activities related to the collection of MER and is expected to last 2 years. There are six DDSs participating in the project: Puerto Rico, Florida, Illinois, Louisiana, Nebraska, and Idaho. The project is in the initial stages and to date there are no reportable results. The purpose of the project is to determine whether assigning one professional relations officer in each DDS to duties solely to MER retrieval will promote the timely receipt of quality MER and ultimately decrease CE costs.

MEDICAL EVIDENCE COLLECTION AND HIPAA

HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt national uniform standards to be followed by health plans, health care providers, and health insurers in disclosing medical information. Although HHS may not regulate SSA's disclosure of medical information, the new regulations may have a significant impact on SSA's ability to obtain MER from medical sources. SSA has assigned responsibilities for implementation of HIPAA and related electronic medical information activities to the Office of Disability and Income Support Programs.

According to SSA, there are three HIPAA standards that may impact the disability determination process: (1) electronic data standards; (2) security standards; and (3) privacy standards.

Electronic Data Standards

Electronic data interchange (EDI) is the electronic transfer of information. EDI allows entities within the health care system to exchange medical, billing, and other information, as well as process transactions in a fast and cost effective manner. The health care industry recognizes the benefits of EDI and many entities within the industry have developed their own EDI formats. HIPAA required HHS to adopt national standards for EDI formats for health care information transactions, as well as code sets to be used in those transactions. Code set means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes.

HHS published the final rule for the "standards for electronic transactions" in the Federal Register[11] on August 17, 2000. Most covered entities have 24 months to comply with the standards. SSA will be affected by these standards because medical providers may not be willing to provide medical records to SSA unless it is done electronically using a standardized coding system.

[11] 65 Fed. Reg. 50312 (Aug. 17, 2001).

Security Standards

The security of health information is especially important when the information can be directly linked to an individual. Confidentiality is threatened by the risk of improper access to electronically stored information and by the interception of the information during electronic transmission. Also, there is a potential need to associate signature capability with information being electronically stored or transmitted.

HIPAA requires HHS to establish security and electronic signature standards for health care information and individually identifiable health care information maintained or transmitted electronically. Health plans, health care clearinghouses, and health care providers would use the security standards to develop and maintain the security of electronically transmitted health care information.

The HHS Health Care Financing Administration is coordinating the development of standards for security and electronic signature. This effort involves staff from various Federal agencies including SSA. These standards will impact SSA if information has to be encrypted.

Privacy Standards

Individuals who provide sensitive information to health care professionals want assurance that the information will be protected during the course of their treatment and in the future. HIPAA requires HHS to establish standards to protect the privacy of individually identifiable health information maintained or transmitted by health plans, health care clearinghouses, and certain health care providers. The HHS has adopted comprehensive regulations that would prohibit the disclosure of most patient information except as authorized by the patient or as explicitly permitted by the legislation.

HHS published the final rule for the "standards for privacy of individually identifiable health information" in the Federal Register[12] on December 28, 2000 and it became effective on April 14, 2001. Most covered entities have 24 months to comply with the standards. SSA will be affected by these standards because providers may take a cautious, restrictive approach to implementing the privacy rules regarding disclosure of medical records.

[12] 65 Federal Register 82462 (December 28, 2000). In response to public comment on the final rules, on February 28, 2001, HHS published notice that it would accept further public comment for an additional 30 days. 66 Federal Register 12738 (February 28, 2001). The comment period closed on March 30, 2001. HHS specified that this additional comment period would not otherwise alter the effective date of the regulations. However, we are aware that the current standards for privacy of individual identifiable health information may be subject to amendment which could have further potential impact on the MER collection process.

Conclusions and Recommendations

In 1994, SSA announced its plans to redesign the disability determination process in a report titled *Plan for a New Disability Claims Process*. In this report, SSA attributed lengthy disability claims processing times, in part, to delays DDSs experienced in receiving MER from claimant treating sources. The report acknowledged the value of the treating sources' information and suggested the establishment of a national fee reimbursement schedule for medical evidence. Furthermore, the report suggested rewarding the treating source based on timeliness and quality of the medical evidence.

Our review shows that improvements are needed in the MER collection process. Our analysis of MER collection times at eight DDSs found that DDSs experienced delays in receiving MER from claimants' treating sources. As a result of these delays, SSA paid for MER that was not received until after the DDSs made the initial disability decision.

We also found that SSA does not have adequate oversight of the DDS MER collection process. SSA has not established uniform MER data collection requirements nor does it monitor MER collection times. Finally, SSA must continue to give attention to the implementation of HIPAA standards to ensure the DDS' ability to obtain timely and uniform electronic information from the health care community.

We recommend that SSA:

1. Pursue options for improving MER collection times at DDSs experiencing problems in receiving MER within 30 days from the date of the request. This should include sharing best practices of DDSs that have been innovative in obtaining MER timely.

2. Conduct a study to determine whether savings in CE costs could be realized by providing a financial incentive to medical providers who submit MER within 30 days from the date of the request.

3. Improve its oversight of the DDS MER collection process by: (a) developing uniform MER data collection requirements for DDSs; and (b) performing periodic evaluations of MER collection processes and times at DDSs to develop best practices.

AGENCY COMMENTS

SSA agreed with our first recommendation. Specifically, in June 2001, SSA plans to begin a 2-year pilot, "Specialized Medical Evidence of Record Professional Relations Officer" in six States. The purpose of the pilot is to determine whether assigning one professional relations officer in each DDS to duties related solely to MER retrieval will promote the timely receipt of quality MER and ultimately decrease CE costs.

SSA did not agree with our second recommendation and stated that an internal focus group determined that the fee paid for MER is not a critical issue. Furthermore, SSA stated that a financial incentive would raise the total cost of obtaining evidence without improving compliance by the providers. SSA also stated that current high priority workloads, and the differences among DDS' systems, make the recommended study problematic.

SSA also disagreed with third recommendation and stated that uniform data collection requirements would impose a burden on DDSs to make software and processing adjustments or to undertake a prohibitive manual process. SSA also stated that in order for it to perform periodic evaluations, most of the DDSs would have to manually track MER and the need for CEs in cases where MER is not received or is not received in a timely manner. (See Appendix D for SSA's comments.)

OIG RESPONSE

In its comments to our second recommendation, SSA stated that raising the fee for MER would simply raise the total cost of obtaining evidence without improving compliance by the providers. Our recommendation was not intended to imply an increase in MER payment amounts; nor, was it intended to provide an incentive payment to providers who do not comply with timely submission of MER. Rather, the study should consider paying the current fee to providers who submit MER within 30 days, and paying a lesser fee to providers who exceed the 30-day submission date.

With regard to our third recommendation, we acknowledge SSA's concern that software and processing adjustments may provide an initial burden on DDSs. However, we do not believe that software modifications or processing adjustments are insurmountable problems given the importance of management information to SSA's oversight of the disability determination process. Furthermore, as DDSs are converted to the IBM AS/400 computer system, we would expect improvements in the DDS' ability to collect electronic data accurately and timely.

We acknowledge SSA's concern regarding the MER collection times reported for the North Carolina DDS. However, we do not concur with SSA's position that the North Carolina DDS' data should be excluded from our report. We clearly state in footnote 8 that the North Carolina DDS' MER collection times are based on MER payment dates instead of receipt dates. Due to unavailable data, we do not know whether the timing differences in the two dates would result in a material difference in our MER collection time analysis. However, in consideration of SSA's comments, we added the MER collection times exclusive of the North Carolina DDS to footnote 8.

The MER collection process is a critical element of disability claims processing and we strongly believe that SSA needs to improve its oversight of this process. In doing so, SSA should establish uniform data collection requirements for claims processing information, including MER. Without uniform data collection requirements, SSA will encounter problems in analyzing MER data similar those found with the North Carolina

DDS data identified in this report. Although the North Carolina DDS had the ability to collect various electronic data information, the absence of uniform data collection requirements resulted in different information being collected by the DDS than what was collected by other DDSs in our review. In its comments to this report, SSA stated that the non-uniformity of data collection and different data systems make it difficult to conduct programmatic reviews of the DDSs. We believe this is further support for implementing our recommendation.

Appendices

Appendix A

Sampling Methodology and Data Analysis

SAMPLING METHODOLOGY

We randomly selected 10 Disability Determination Services (DDS) to provide electronic data on medical evidence of record (MER) and consultative examination (CE) payments issued during the period of October 1, 1997 through September 30, 1998. The 10 DDSs were Arizona, Delaware, Illinois, Massachusetts, New York, North Carolina, South Dakota, Tennessee, Virginia, and Wisconsin.

We experienced difficulties in obtaining data from the 10 randomly selected DDSs and dropped 4 DDSs from our review. The New York and Tennessee DDSs were dropped because of their participation in recent Social Security Administration (SSA), Office of the Inspector General audits. The South Dakota DDS was dropped because it could not provide electronic data files. The Arizona DDS was dropped because it could not electronically provide all data elements required for the audit. These four DDSs were replaced with the Iowa, Utah, Oklahoma, and Kansas DDSs.

Accordingly, we obtained electronic data on CE and MER payments from the Delaware, Illinois, Iowa, Kansas, Massachusetts, North Carolina, Oklahoma, Utah, Virginia, and Wisconsin DDSs. We also received supporting information including the claimant name and Social Security number (SSN). The Illinois and Virginia DDSs were excluded from the review because they were unable to provide all requested information.

MER COLLECTION TIMES ANALYSIS

The following table shows the MER records included in our analysis and the associated MER payments. We segregated the MER records into six categories based on the elapsed time between the MER request date and the MER receipt date. Our analysis included MER records with a received date between October 1, 1997 and September 30, 1998.

SUMMARY BY STATE DDS OF MER COLLECTION TIMES AND PAYMENTS

MER Receipt Times	Delaware DDS	Iowa DDS	Kansas DDS	Massachusetts DDS	North Carolina DDS	Oklahoma DDS	Utah DDS	Wisconsin DDS	Number of MER Payments	MER Payment Amount
30 days or less	13,001	51,762	45,084	81,105	89,482	35,640	23,552	90,367	429,993	$6,333,368
31 to 60 days	2,970	6,017	5,355	18,960	102,851	24,744	3,178	10,081	174,156	$2,219,956
61 to 90 days	567	917	870	4,321	25,004	4,782	532	1,654	38,647	$485,916
91 to 120 days	157	246	214	1,528	7,472	1,644	185	508	11,954	$150,989
121 to 240 days	111	113	111	1,169	4,835	1,150	131	287	7,907	$99,275
More than 240 days	13	12	6	279	89	208	17	12	636	$8,479
Totals	16,819	59,067	51,640	107,362	229,733	68,168	27,595	102,909	663,293	$9,297,983

MER RECEIVED AFTER THE DISABILITY DECISION DATE ANALYSIS

We obtained Calendar Year (CY) 1997, CY 1998, and Fiscal Year (FY) 1999 electronic versions of the National Disability Determination Services System (NDDSS). From the NDDSS we downloaded information on the claimant name, claimant SSN, filing date, decision date, and type of decision. We then matched information contained in the FY 1998 DDS data files to the NDDSS data.

The next step was to limit our review to those FY 1998 MER that contained a disability decision date after October 1, 1997. Once this step was complete, we compared the MER received dates to the disability decision dates and selected those MER with the latest disability decision date.

Status of Prior Recommendation

SOCIAL SECURITY

MEMORANDUM

Date: March 19, 1997

To: David C. Williams
Inspector General

From: John J. Callahan
Acting Commissioner of Social Security

Subject: Office of Inspector General Draft Report, "The Social Security Administration's Payment for Medical Evidence of Record Obtained by State Disability Determination Services" (A-07-95-00833)--INFORMATION

We appreciate the opportunity to comment on this draft audit report since evidence collection and related issues are so vital to disability processing time improvements.

SSA, in the Disability Process Redesign, plans to undertake a thorough reevaluation of policies and procedures relative to the collection of evidence in support of disability applications. This reevaluation will include a thorough study of the relative effects of multiple factors on such performance measures as processing time and consultative examination purchase rates (and dollar amounts). Untimely submission of medical evidence of record (MER) is but one factor in this complex of issues that SSA needs to consider. For example, at least some of the delay in MER development and receipt is mail time, from the DDS to the source, and from the source back to the DDS. Facsimile MER and other forms of electronic transmission of MER being pursued by SSA offer promise to reduce MER processing time within the current MER payment system.

While we concur with your view that payment for MER should serve as an incentive for timely and responsive submission of medical evidence, our evaluation, which should be completed within 9 months, is designed so as to take a broader view of MER; therefore, we are not prepared at this time to address your specific recommendation for statutory change. If the results of our evaluation show that statutory changes are needed, SSA will then propose the necessary legislation.

Our technical comments on the report are attached for your consideration. Staff questions may be directed to Dan Sweeney on extension 51957.

CIN:	***A-07-95-00833***
Report	The Social Security Administration's Payments for Medical Evidence of Record Obtained by State Disability Determination Services
Recommendation:	Re-evaluate its policy for paying for MER. As part of this re-evaluation, we suggest that SSA, for a specified time period, have selected DDSs capture the time between the initial MER request.
Status:	Status - June 2000 The Office of Disability (OD) planned to reevaluate policies and procedures on the collection of Medical Evidence of Record (MER), including payment for it and the amount of time involved. The study was originally designed to obtain: data on innovations by the Disability Determination Services (DDS) to obtain MER quickly; input from major medical organizations/stakeholders on their opinions regarding non-payment for MER received more than 30 days after request; statistics on the incidence of MER received more than 30 days after request; and Disability Examiners' analysis of individual cases to determine if MER received more than 30 days after request was material to the determination. The DDSs have been unable to participate in the latter two parts of the study due to backlogs and workload pressures caused by high application rates, Drug and Alcohol Addiction reevaluations, Continuing Disability Reviews, childhood reviews, and OIG installations. Parts one and two of the study are complete. OD planned to provide the OIG with the data they now possess by May 31, 1999. During the period just before OD was to report, OIG announced a new audit (21999045) that is examining the entire MER process. OD has been in contact with the IG staff and has learned that the IG has completed the data gathering phase of that audit; and current plans envision a December 2000 release of the audit report . The data collected for that audit is more current than that which OD could have provided. Given that OD does not want to duplicate OIG's efforts, OD will now attempt to evaluate the IG's findings and new recommendations when they are released and determine if an additional study is required at that time. See recommendation number 21995027-1 for related information. (Williams--50380).

Social Security Administration's (SSA) Computer Conversion Timeline for Disability Determination Services (DDS)

SSA Tier	Levy & Associates Group	DDS Number	DDS Client	Software Implementation Start Date	Software Implementation End Date
1	1	1	Wisconsin	October 2000	June 2001
1	1	2	Indiana	November 2000	August 2001
1	1	3	Georgia	December 2000	September 2001
1	1	4	Arkansas	December 2000	September 2001
1	2	5	Federal	April 2001	January 2002
1	2	6	Oklahoma	July 2001	April 2002
1	2	7	Iowa	August 2001	May 2002
1	2	8	North Carolina	September 2001	June 2002
1	2	9	Florida	September 2001	June 2002
2	3	10	Idaho	April 2002	January 2003
2	3	11	Arizona	June 2002	March 2003
2	3	12	Massachusetts	July 2002	April 2003
2	3	13	Kansas	July 2002	April 2003
2	4	14	Rhode Island	February 2003	November 2003
2	4	15	South Dakota	April 2003	January 2004
2	4	16	Connecticut	April 2003	January 2004
3	4	17	District of Columbia	March 2003	December 2003
3	4	18	Washington	March 2003	January 2004
3	5	19	Kentucky	November 2003	August 2004
3	5	20	New Mexico	February 2004	October 2004
3	5	21	Louisiana	February 2004	October 2004
3	5	22	Montana	January 2004	October 2004
3	6	23	Colorado	February 2004	October 2004
3	6	24	Vermont	September 2004	June 2005
3	6	25	Michigan	November 2004	August 2005
3	6	26	Puerto Rico	November 2004	August 2005

- This plan is based on starting the first step of the software migration in Wisconsin DDS on October 1, 2000.
- This plan assumes a "module (or group of modules) at a time" process and estimates an implementation and roll out period for each module for each DDS.
- The "Software Implementation Start Date" is the start of Levy & Associates consulting with the DDS.
- The "Software Implementation End Date" is the estimated completion for each DDS including roll out of the last module(s).
- Source of Timeline: Deputy Commissioner for Systems, Office of Systems Requirements.

Agency Comments

SOCIAL SECURITY

MEMORANDUM

June 8, 2001 Refer To: S1J-3

To: James G. Huse, Jr.
Inspector General

Larry G. Massanari
Acting Commissioner of Social Security

Subject: Office of the Inspector General Draft Report, "Review of Medical Evidence of Record Collection Process at the State Disability Determination Services" (A-07-99-21003)—INFORMATION

Thank you for the opportunity to review and comment on the subject report. We appreciate OIG's efforts in conducting this review. Our comments are attached.

Staff questions may be directed to Janet Carbonara on extension 53568.

Attachment:
SSA Response

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL (OIG) DRAFT REPORT, "REVIEW OF MEDICAL EVIDENCE OF RECORD (MER) COLLECTION PROCESS AT STATE DISABILITY DETERMINATION SERVICES (DDS)" (A-07-99-21003)

We appreciate the OIG's efforts in conducting this review. Before responding to the specific recommendations, we want to note our concern with the information presented in the section *"The Current MER Collection Process"* on pages 4 and 5 of the draft report. We believe that inclusion of the data from the North Carolina DDS results in an inaccurate representation of MER collection times. As the footnote on page 5 indicates, the North Carolina DDS reports the date the MER was paid for, not the date the MER was received. The subject draft report treats these dates as if they were the date the MER was received. Therefore, the North Carolina data should be excluded from the report with a potential increase in the percentage of MER received in 30 days from 64.8 percent to 78.5 percent.

Finally, in "Background" the OIG states, "If MER is not received within 10 calendar days from the follow up request, the DDS can purchase a CE—an expensive and time-consuming process." The North Carolina DDS has the lowest CE rate in the Atlanta Region, and at 33.2 percent for fiscal year 2000, ranks 37th among the States in terms of percentage of CEs requested for cases processed. This actual experience of the North Carolina DDS seems to further indicate that the data for that State should not be considered.

Our comments on the recommendations are provided below. Additionally, several technical comments are included that we believe will improve the accuracy and content of the report.

Recommendation 1

Pursue options for improving MER collection times at DDSs experiencing problems in receiving MER within 30 days from the date of the request. This should include sharing best practices of DDSs that have been innovative in obtaining MER timely.

Comment

We agree. In June 2001, SSA will begin conducting a 2-year pilot, "Specialized Medical Evidence of Record Professional Relations Officer." The following States will be participating: Puerto Rico, Florida, Illinois, Louisiana, Nebraska, and Idaho. The purpose of the pilot is to determine if assigning one professional relations officer in each DDS to duties related solely to MER retrieval will promote the timely receipt of quality MER and ultimately decrease consultative examination (CE) costs. Also, we already share best practices in many subject areas, including MER collection, with Professional Relations Officers at the annual National Professional Relations Conference and in the publication, "The National Professional Relations Bulletin."

Recommendation 2

Conduct a study to determine whether savings in CE costs could be realized by providing a financial incentive to medical providers who submit MER within 30 days from the date of the request.

Comment

We disagree. In calendar year 2000, an SSA focus group on improving MER collection determined that "The amount of the fee paid for MER is not a critical issue. While some physicians do feel their time is more valuable than the remuneration provided by SSA... by and large they view this as a necessary consequence of working with their patient."

The report should note that the rates SSA pays for MER are far below the amounts paid for such reports in the private market, so there is currently very little financial incentive for treating source provision of MER. Even so, much of the requested MER (over 78 percent in this review, as noted in our opening comment) is submitted within 30 days. The recommended approach could simply raise the total cost of obtaining evidence without improving compliance by the providers. If we raised the pay out to medical sources for MER for a study, it could prove difficult to return to today's reimbursement amounts. Additionally, current high priority workloads, which preclude the manual tracking required for such a study, and the differences among the DDS systems available to track the effects of any monetary incentives make conducting a study problematic.

Recommendation 3

Improve oversight of the DDS MER collection process by: a) Developing uniform MER data collection requirements for DDSs and b) performing periodic evaluations of MER collection processes and times at DDSs to develop best practices.

Comment

We disagree. As the OIG draft report notes, the DDSs use multiple, disparate and incompatible computer systems and software. Uniform data collection requirements would impose a burden on the DDSs to make software and processing adjustments or to undertake a prohibitive manual process. In addition, we do not believe that uniform data collection requirements will improve DDS efforts in obtaining timely MER. Knowing that a DDS waits an extra 10 to 20 days to receive evidence from a particular source is not helpful. It would be necessary to know why. The result would be a large data collection burden without indications that it would result in a significant payoff.

In order for SSA to perform periodic evaluations, most of the DDSs would have to manually track MER and the need for CEs in cases where MER is not received or is not received in a

timely manner. This tracking must be done by someone with intimate knowledge of the case included for study and cannot be automated or undertaken manually in the foreseeable future because of other workload pressures.

We believe that our efforts should instead continue to focus on obtaining timely MER. The DDSs are already required to make every reasonable effort to obtain MER from treating sources. Each DDS has treating sources who present unique challenges to their successfully meeting that requirement, and they have worked out various ways to get the best responses possible from these treating sources. We will continue to share their experience and best practices, regarding MER and many other subject areas, with Professional Relations Officers at the annual National Professional Relations Conference and through the publication, "The National Professional Relations Bulletin." In addition, the Specialized MER Professional Relations Officer Project may give us additional insight into the effects on overall processing time of devoting staff to obtaining MER.

OIG Contacts and Staff Acknowledgements

OIG Contacts

Rona Rustigian, Acting Director, Disability Program Audit Division (617) 565-1819

Mark Bailey, Deputy Director, (816) 936-5591

Acknowledgements

In addition to those named above:

Ron Bussell, Auditor-in-Charge

Ken Bennett, Auditor

For additional copies of this report, please contact the Office of the Inspector General's Public Affairs Specialist at (410) 966-5998. Refer to Common Identification Number A-07-99-21003.

DISTRIBUTION SCHEDULE

	No. of Copies
Commissioner of Social Security	1
Management Analysis and Audit Program Support Staff, OFAM	10
Inspector General	1
Assistant Inspector General for Investigations	1
Assistant Inspector General for Executive Operations	3
Assistant Inspector General for Audit	1
Deputy Assistant Inspector General for Audit	1
Director, Systems Audit Division	
Director, Financial Management and Performance Monitoring Audit Division	1
Director, Operational Audit Division	1
Director, Disability Program Audit Division	1
Director, Program Benefits Audit Division	1
Director, General Management Audit Division	
Issue Area Team Leaders	25
Income Maintenance Branch, Office of Management and Budget	1
Chairman, Committee on Ways and Means	1
Ranking Minority Member, Committee on Ways and Means	1
Chief of Staff, Committee on Ways and Means	1
Chairman, Subcommittee on Social Security	2
Ranking Minority Member, Subcommittee on Social Security	1
Majority Staff Director, Subcommittee on Social Security	2
Minority Staff Director, Subcommittee on Social Security	2
Chairman, Subcommittee on Human Resources	1
Ranking Minority Member, Subcommittee on Human Resources	
Chairman, Committee on Budget, House of Representatives	
Ranking Minority Member, Committee on Budget, House of Representatives	
Chairman, Committee on Government Reform and Oversight	
Ranking Minority Member, Committee on Government Reform and Oversight	
Chairman, Committee on Governmental Affairs	
Ranking Minority Member, Committee on Governmental Affairs	

Chairman, Committee on Appropriations, House of Representatives	1
Ranking Minority Member, Committee on Appropriations, House of Representatives	1
Chairman, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, House of Representatives	1
Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, House of Representatives	1
Chairman, Committee on Appropriations, U.S. Senate	1
Ranking Minority Member, Committee on Appropriations, U.S. Senate	1
Chairman, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate	1
Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate	1
Chairman, Committee on Finance	1
Ranking Minority Member, Committee on Finance	1
Chairman, Subcommittee on Social Security and Family Policy	1
Ranking Minority Member, Subcommittee on Social Security and Family Policy	1
Chairman, Senate Special Committee on Aging	1
Ranking Minority Member, Senate Special Committee on Aging	1
Vice Chairman, Subcommittee on Government Management Information and Technology	1
President, National Council of Social Security Management Associations, Incorporated	1
Treasurer, National Council of Social Security Management Associations, Incorporated	1
Social Security Advisory Board	1
AFGE General Committee	9
President, Federal Managers Association	1
Regional Public Affairs Officer	1
Total	**97**

Overview of the Office of the Inspector General

Office of Audit

The Office of Audit (OA) conducts comprehensive financial and performance audits of the Social Security Administration's (SSA) programs and makes recommendations to ensure that program objectives are achieved effectively and efficiently. Financial audits, required by the Chief Financial Officers Act of 1990, assess whether SSA's financial statements fairly present the Agency's financial position, results of operations, and cash flow. Performance audits review the economy, efficiency, and effectiveness of SSA's programs. OA also conducts short-term management and program evaluations focused on issues of concern to SSA, Congress, and the general public. Evaluations often focus on identifying and recommending ways to prevent and minimize program fraud and inefficiency.

Office of Executive Operations

The Office of Executive Operations (OEO) supports the Office of the Inspector General (OIG) by providing information resource management; systems security; and the coordination of budget, procurement, telecommunications, facilities and equipment, and human resources. In addition, this office is the focal point for the OIG's strategic planning function and the development and implementation of performance measures required by the Government Performance and Results Act. OEO is also responsible for performing internal reviews to ensure that OIG offices nationwide hold themselves to the same rigorous standards that we expect from the Agency, as well as conducting employee investigations within OIG. Finally, OEO administers OIG's public affairs, media, and interagency activities and also communicates OIG's planned and current activities and their results to the Commissioner and Congress.

Office of Investigations

The Office of Investigations (OI) conducts and coordinates investigative activity related to fraud, waste, abuse, and mismanagement of SSA programs and operations. This includes wrongdoing by applicants, beneficiaries, contractors, physicians, interpreters, representative payees, third parties, and by SSA employees in the performance of their duties. OI also conducts joint investigations with other Federal, State, and local law enforcement agencies.

Counsel to the Inspector General

The Counsel to the Inspector General provides legal advice and counsel to the Inspector General on various matters, including: 1) statutes, regulations, legislation, and policy directives governing the administration of SSA's programs; 2) investigative procedures and techniques; and 3) legal implications and conclusions to be drawn from audit and investigative material produced by the OIG. The Counsel's office also administers the civil monetary penalty program.