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STATEMENT OF

JOSEPH F. DELFICO, ASSOCIATE DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS AND HUMAN RESOURCES

HOUSE COMMITTEE ON GOVERNMENT OPERATIONS

ON THE

SOCIAL SECURITY ADMINISTRATION'S MANAGEMENT OF THE CONSULTATIVE EXAMINATION PROCESS

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss the Social Security Administration's management of the consultative examination process in its disability programs. SSA will spend about $200 million this year on consultative examinations. These consultative examinations or CEs are purchased from private medical sources when additional evidence is needed to evaluate disability claims. The actual purchase of these examinations is carried out by the various state Disability Determination Services (DDSs) following SSA guidelines and instructions.

In July 1983, you asked us to review the consultative examination process and SSA's use of volume providers--physicians or medical practices devoted largely or exclusively to performing CEs. You expressed concerns about the quality of consultative examinations, especially those performed by volume providers, and the adequacy of SSA's system for monitoring the quality and costs of CEs.

Our work focused specifically on SSA initiatives implemented since 1981 congressional hearings on CEs and volume providers. We visited all 10 SSA regional offices to determine how well they were guiding and monitoring state agency management of the CE process. We also obtained CE management plans submitted by 52 state agencies between 1982 and 1985, and sent questionnaires to those agencies to elicit more specific information on their monitoring activities. In addition, we visited state agencies in California, New York, Texas, Ohio, Virginia, Indiana, and Kentucky.

To develop information on volume providers, we identified all providers with more than $100,000 in CE billings in fiscal year 1983, and sent them a questionnaire to obtain information about their methods of operation, perceptions about the CE process, and opinions on the adequacy of SSA guidance and standards. To elicit more detailed information than could be

obtained through the questionnaire, we visited the facilities of 11 volume providers in 7 states. We also reviewed SSA and state agency reports of visits to volume providers.

Although we did not attempt to independently measure the quality of CE reports, we reviewed the results of a 1983 SSA study comparing the quality of reports purchased from volume and non-volume sources. We also obtained opinions about CE report quality from more than 200 people involved with the disability decisionmaking process, including state agency personnel, SSA regional office personnel, administrative law judges, and legal aid representatives.

Our findings are detailed in our December 10 report to you, "SSA Consultative Examination Process Improved; Some Problems Remain" (GAO/HRD-86-23). In the interest of time, I will not go into the details of each issue discussed in the report. I will highlight major findings and use the rest of my time to answer questions you and members of the Subcommittee may have.

EARLIER CONCERNS ABOUT CEs AND VOLUME PROVIDERS LEAD TO IMPROVED CE MANAGEMENT

In the early 1980s, the increasing use of CEs in making disability determinations and the DDSs' use of volume providers to supply CEs became the subject of congressional and public concern. Court actions and adverse media publicity raised questions about the operations of several volume providers, the validity of their examinations, and the reliability of their reports.

The Subcommittees on Social Security and Oversight, of the House Committee on Ways and Means, held hearings on volume

providers in 1981 and 1982. SSA was criticized for not being knowledgeable enough about the effectiveness of DDSs' CE management or the quality of services performed by volume providers.

Since 1981, SSA has taken several steps to improve its CE management. SSA developed and issued several policy directives and guidelines covering CE management responsibilities, CE report content and signature requirements, and consulting physician qualification and independence standards.

Our review indicated that SSA's efforts have yielded beneficial results. Through its issuance of new policies and procedures, SSA has provided better direction on physician standards and CE report requirements, and established more formal CE management and oversight. State agencies have, as a result, increased their monitoring of CE providers and generally strengthened the CE process. Also, through our discussions with many people involved in the disability area, and through SSA's study of CE report quality, quality of examinations or of reports has not surfaced as a significant problem.

Despite this progress, however, we found several areas where SSA and the states could further improve the CE management process. Without improvements in these areas, we concluded that SSA lacked reasonable assurance of securing quality medical examinations and reports and for preventing the purchase of unnecessary examinations.

SSA SHOULD CONTINUE TO STRENGTHEN ITS MANAGEMENT OF THE CE PROCESS

SSA could further improve states' management of the CE process and better assure that quality medical examinations and

reports are purchased by: (1) establishing specific standards for certain important elements of DDSs' CE management systems, and (2) ensuring that SSA regional office oversight is effectively conducted nationwide.

Moreover, SSA could realize its goal of preventing fiscal fraud and abuse of CE funds by establishing appropriate controls over CE ordering. Several studies conducted by SSA regional offices and DDSs have found significant rates of premature and inappropriate CE purchasing in several states.

The Need for Scheduling Control Standards

A major concern expressed during the 1981 and 1982 congressional hearings was the brief amount of time that some CE providers spent examining claimants. Witnesses called on SSA to set standards governing the number of examinations to be performed by CE physicians on an hourly or daily basis.

Following the hearings, SSA instructed the states to establish scheduling controls to prevent "overscheduling." These guidelines, however, did not specify how to prevent overscheduling.

We found that most states' CE management plans do not adequately describe how CE appointment scheduling is controlled. Also, according to our questionnaire survey, 30 of the 52 DDSs have not established scheduling standards. The standards states do have vary widely.

Based on our evaluation of the states' CE management plans and our visits to states, we believe that many states'

scheduling procedures do not provide reasonable assurance that the type of scheduling practices which caused much public controversy in 1981 and 1982 will not reoccur when DDS workloads increase again with the resumption of continuing disability reviews. We believe that SSA should, at a minimum, require states which use volume providers to establish standards for controlling appointment scheduling and/or examination duration. To prevent the type of controversy about volume provider examination practices which occurred during the initial implementation of continuing disability reviews, we believe it is preferable that SSA establish these standards before resuming continuing disability reviews, or soon after their resumption.

Additional Guidance Also Needed on DDS CE Report Quality Review

Another major concern expressed during the 1981 and 1982 hearings was the method with which certain volume providers prepared reports of consultative examinations. Critics charged that through the use of word processing equipment and "canned language," some volume providers generated reports for DDSs' use that were more extensive and comprehensive than the examinations they performed, and did not accurately represent claimants' medical conditions.

After the hearings, SSA issued guidelines instructing states to establish procedures for reviewing new providers' reports and for maintaining an "on-going review of CE reports." SSA did not specify how the states were to structure their review systems, such as the method for selecting reports, or designate who was to perform the function. SSA central office staff told us they intended to have DDSs establish report review systems separate from the routine adjudicative process.

Our work found that 32 of the 52 state plans indicate that the states continue to rely primarily on examiners and medical consultants to review CE reports as part of the case development process for their "ongoing review" of CE reports. Examiners in most of the states we visited told us, however, that case processing pressures inhibited their willingness to inform DDS management about deficient CE report.

We believe SSA should clarify its intent concerning ongoing report review in its instructions to the states, and should require the larger DDSs to establish an independent report review system.

SSA Regional Offices' Oversight Is Often Inadequate

SSA's 10 regional offices are responsible for guiding, supporting, and monitoring the states' CE management efforts. We visited all 10 SSA regional offices to assess their effectiveness in carrying out these oversight responsibilities. We found wide variance in regional office CE oversight efforts. Reviews of states' CE management plans were not adequately performed by some regions; many deficient state plans were approved. Also, some regional offices had not reviewed states' CE management plan implementation and had not conducted annual comprehensive reviews of states' overall CE management, as required.

Our visits and the DDSs' responses to our questionnaire showed that, as of the summer of 1984, many states were not implementing certain important provisions of their CE management plans. For example, SSA guidelines require states to conduct at least one on-site visit to each key (volume) provider annually

and to obtain and evaluate claimants' reactions to being examined by key providers. Through our questionnaires and DDS visits, we found that:

-- On-site visits were not always done. Eight DDSs reported they had not visited any of their key providers and 19 other DDSs reported they had visited some but not all of their key providers as required by SSA. Six of the 96 volume providers which responded to our questionnaire survey reported that they had not been visited by any DDS (the largest received about $600,000 in CE payments in fiscal year 1983).

-- Claimant reaction surveys are not being conducted by some states. Eleven DDSs reported they had no procedures for obtaining claimant reactions. Four of the seven states we visited did not routinely perform these surveys.

We believe the lack of systematic regional oversight of DDS CE management increases the risk of questionable provider practices and unnecessary CE purchasing.

Too Many CEs May Have Been Purchased

We surveyed all SSA regions and DDSs to determine if any recent studies of the appropriateness of CE purchases had been conducted. We found six studies conducted by SSA regional office and DDS staff in four states (Arizona, Delaware, New Jersey, and New York) between 1981 and 1984. All of the studies noted high rates of premature and inappropriate CE purchasing. They found deficiencies in examiners' efforts to obtain treating source records, and CE purchases which were inappropriate in

terms of program evidentiary requirements. These studies show that between 13 and 43 percent of CEs purchased were determined to be premature and/or inappropriate.

In addition to the findings of unnecessary examinations, two studies found high rates of unnecessary supplemental laboratory diagnostic procedures. The 1981 New Jersey DDS study found that 74 percent of the cases with supplemental procedures contained at least one unnecessary test. The 1984 Arizona DDS study found that 46 percent of tests and 60 percent of x-rays purchased were unnecessary.

We discussed with SSA officials the need for a national study to determine how large a problem unnecessary CE purchasing may be. SSA officials agreed with us on the need for a special study, and said they would conduct a study of the necessity of CE purchasing in fiscal year 1986.

SSA needs to determine optimal timing for obtaining CEs

SSA guidelines stipulate that CEs be purchased only when sufficient evidence of impairment is unavailable from claimants' treating sources, and state that CEs should not be routinely purchased. While SSA requires that claimants' treating sources be contacted for evidence in most cases, it has not established a minimum period which examiners must wait to receive treating source records before ordering CEs.

To assure better development of medical evidence, the 1984 Disability Reform Act, which SSA is now in the process of implementing, requires that SSA issue regulations to establish standards for the purchase of CEs. It also requires that SSA

make "every reasonable effort" to obtain treating source records, and develop a complete medical history covering at least the 12 months preceeding any determination that an individual is not disabled.

In its proposed regulations, SSA defines "every reasonable effort" as an initial contact with every treating source and a 10-day follow-up contact with all non-responding sources. SSA also will require that examiners wait 20 days after follow-up contact with treating sources before using consultative evidence in making determinations.

While SSA's proposed regulations require that examiners wait 30 days for treating source evidence before using CEs, they do not prevent DDSs from purchasing CEs (having CE reports in hand) before the end of the treating source evidence waiting period. Thus, the potential still exists for DDSs to purchase CEs which could ultimately be made unnecessary because of the timely (within the 30-day waiting period) receipt of adequate treating source evidence.

We believe SSA should closely monitor the implementation of its new requirements to pursue treating source evidence to determine if DDSs are purchasing CEs prematurely. If SSA finds they are, it should change its regulations (now in draft) to require specifically that CE appointments be set at a time no earlier than the end of the proposed 30-day treating source evidence waiting period unless there are no relevant treating sources, or they are known to not have needed evidence, or they are known to be unresponsive or unreliable. Such a change would allow sufficient time to receive treating source evidence and to cancel CEs if adequate treating source evidence is received, and in many cases could result in more appropriate purchases of examinations and supplemental tests.

SSA also needs to determine if more physician involvement in CE ordering is warranted

SSA guidelines state that medical consultant or supervisory approval of examiners' CE purchase requests should be "encouraged."

In the states we visited, the extent of supervisory and medical consultant review of examiners' CE purchase requests varied. The effect of staff physician review on the necessity and appropriateness of CE purchases is unclear. Some DDS officials we interviewed said that requiring staff physicians to review all CE ordering would probably result in increased purchases of diagnostic tests because modern medical practice generally involves over-ordering of tests. However, many DDS staff physicians we interviewed said that requiring their review of examiners' CE requests would reduce unnecessary and inappropriate CE purchases.

In light of the inconsistency in states' CE request review practices and the evidence of premature and inappropriate CE purchases, we believe SSA should conduct a study to determine the effect of medical staff review of CE requests on the appropriateness of CE purchases, and if it is found to be beneficial, require that such review be mandatory for all DDSs.

CHARACTERISTICS OF VOLUME PROVIDERS

In addition to assessing SSA's management of the CE process, Mr. Chairman, as you requested, we also developed some information about volume providers. As you know, little information about volume providers' operating characteristics has been available.

Through questionnaire surveys, we identified 108 volume providers nationwide earning more than $100,000 for performing CEs in 1983. They range from individual physicians, clinics, and hospitals, to group practices devoted largely or exclusively to performing CEs. About half (27) of the states used them. While they are small in number, representing less than one half of one percent of the approximately 25,000 active providers available to perform CEs in those states, as a group they received $38 million, or about 26 percent of CE funds expended by those states. A detailed description of the operating characteristics of these providers and DDSs' perspectives on the advantages and disadvantages of using them is included in the appendix of our report.

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Mr. Chairman, that concludes my statement. We will be pleased to answer questions.

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