

Office of the Inspector General

September 30, 1999

John R. Dyer
Principal Deputy Commissioner
of Social Security

Acting Inspector General

Performance Measure Review: Periodic Full Medical Continuing Disability Review
Data Collection (A-01-98-94003)

Attached is a copy of the subject final report. The objective of this evaluation was to assess the process used by the Social Security Administration (SSA) to accumulate and report periodic full medical continuing disability review (CDR) workload data to Congress. SSA is required to provide Congress with the number of periodic CDRs performed each year to: (1) meet annual reporting requirements established by legislation, and (2) report on workload performance measures established by both SSA and the Congress. Under the Government Performance and Results Act, SSA chose to report the number of periodic CDRs performed annually as a performance measure.

You may wish to comment on any further action taken or contemplated on our recommendations. If you choose to comment, please provide your comments within the next 60 days. If you wish to discuss the final report, please call me or have your staff contact Daniel R. Devlin, Acting Assistant Inspector General for Audit, at (410) 965-9700.

James G. Huse, Jr.

Attachment

**OFFICE OF
THE INSPECTOR GENERAL**

SOCIAL SECURITY ADMINISTRATION

**PERFORMANCE MEASURE REVIEW:
PERIODIC FULL MEDICAL
CONTINUING DISABILITY REVIEW
DATA COLLECTION**

September 1999

A-01-98-94003

**EVALUATION
REPORT**



EXECUTIVE SUMMARY

OBJECTIVE

The objective of this evaluation was to assess the process used by the Social Security Administration (SSA) to accumulate and report periodic full medical continuing disability review (CDR) workload data to Congress.

BACKGROUND

A periodic CDR is a review routinely conducted to determine if a disabled individual is still medically eligible to receive benefits under the Disability Insurance or Supplemental Security Income programs. SSA conducts periodic CDRs using one of two methods: full medical reviews or questionnaires. Full medical reviews are primarily conducted by a Disability Determination Services (DDS) office located in each State. Once a DDS medical examiner makes a decision as to whether or not an individual is still disabled, an electronic record showing the results of the review is transmitted to the National Disability Determination Services System (NDDSS), which is maintained by SSA. This data base maintains information on all full medical CDRs conducted nationwide.

SSA is required to report to Congress the number of periodic CDRs performed each year to meet two legislative requirements. The Social Security Act requires SSA to report to Congress annually on the results of periodic CDRs, and the Contract with America Advancement Act of 1996 requires that SSA provide an annual status report on the number of periodic CDRs performed. In addition, under the Government Performance and Results Act, SSA chose to report the number of periodic CDRs performed annually as a performance measure. Finally, periodic CDRs is one of the workload measures reported to Congress to gauge SSA's progress in meeting workload goals proposed in its budget. Although SSA performs both periodic and work CDRs, the above listed reporting requirements focus specifically on periodic CDRs, which account for the majority of SSA's total CDR workload each year.

RESULTS OF REVIEW

Overall, SSA's process to accumulate aggregate full medical CDR workload data is adequate, but the NDDSS does not have the capability to fully distinguish periodic CDRs from other workloads for congressional reporting. As a result, SSA could not ensure that 12.5 percent of full medical CDRs reported in Fiscal Year (FY) 1997 were correctly classified as periodic CDRs. SSA had not reported on the full medical CDRs

for FY 1998 at the time of our review. These NDDSS classification problems have increased the risk that SSA is over-reporting to Congress the number of periodic CDRs performed.

Classification Codes in the NDDSS

SSA does not solely rely on the NDDSS to report the number of CDRs conducted, but has established separate tracking systems to adjust NDDSS totals prior to reporting these workload numbers to Congress. SSA is not able to identify all of its workload using this approach, since these systems cannot monitor the “other” category to ensure that periodic CDRs are properly separated from work CDRs. The NDDSS uses the CDR classification codes entered by DDS staff to sort the CDR workload for reporting purposes. However, some periodic CDRs lack adequate classification and, hence, are placed in the “other” CDR category of the primary workload report, where they are assumed to be periodic CDRs. Proper classification has been hampered by: (1) cases arriving at the DDS offices without accurate identification; (2) DDS staff overusing the “miscellaneous” code on CDRs; and/or (3) DDS staff leaving key classification fields blank.

Coding Guidance Provided to DDS Offices

Although the CDR classification codes are key to SSA’s attempt to categorize CDR workloads, SSA has not provided consistent guidance on these codes to the DDS offices. Also, the multiple software programs and computer systems used by DDS offices have made coding problems difficult to monitor and correct. We found six out of the seven DDS offices that we contacted lacked a complete, up-to-date list of codes in their NDDSS interface software programs.

SSA’s Attempts to Improve DDS Coding

SSA officials have recognized some of the problems related to ensuring valid classification codes are used. DDS offices are now required to place two classification codes on every case. In addition, SSA added case classification information to the systems used by the DDS offices in order to better identify incoming CDR cases. However, the NDDSS continues to accept invalid classification codes. Also, five of seven DDS offices did not use the new CDR classification feature on incoming cases for a variety of reasons, including: (1) DDS staff did not trust the CDR classification code and/or (2) the CDR classification code was not available.

RECOMMENDATIONS

To assist DDS offices with their CDR workload and to improve the accuracy of CDR data reported to Congress, we recommend that SSA:

- provide guidance to SSA and DDS offices explaining the importance of completed transmittal sheets and proper coding to differentiate the specific workloads;
- provide SSA components and DDS offices with a single source of authoritative and updated CDR classification codes to ensure all offices are using the proper codes;
- coordinate with DDS offices to update their software programs to ensure the proper classification codes are maintained in their systems; and
- update the edits in the NDDSS so that all incoming records with invalid "why review was made" codes are rejected and returned to the DDS offices for correction.

AGENCY COMMENTS

In response to our draft report, SSA agreed with all of our recommendations, except to update the edits in the NDDSS. SSA indicates that subsequent to our exit conference, the Office of Systems Requirements verified that this edit is in place. (See Appendix E for the full text of SSA's comments to our draft report.)

OFFICE OF THE INSPECTOR GENERAL RESPONSE

At the time of our audit, the NDDSS accepted invalid codes, as we found specific cases where invalid codes were accepted. In future audits, we will test whether SSA's recent changes corrected this condition.

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INTRODUCTION

OBJECTIVE

The objective of this evaluation was to assess the process used by the Social Security Administration (SSA) to accumulate and report periodic full medical continuing disability review (CDR) workload data to Congress.

BACKGROUND

Since 1980, SSA has been required to conduct periodic CDRs on individuals receiving Disability Insurance (DI) benefits. Periodic CDRs relate to reviews performed from time to time to determine if an individual is still medically eligible to receive benefits, as compared to work issue CDRs related to reviews initiated when work activity is reported for an individual. Legislation enacted since 1994 has also required CDRs and redeterminations on Supplemental Security Income (SSI) recipients (see Appendix B). For both the DI and SSI programs, SSA is required to annually report to Congress the number of periodic CDRs completed, the cost to perform these reviews, and the expected program cost savings that will result from these reviews.

The Government Performance and Results Act of 1993 (GPRA) requires SSA to establish performance measures for its major business functions (see Appendix C). SSA chose the number of periodic CDRs performed annually as a performance measure under GPRA. SSA has also committed to Congress that it will report on: (1) the number of periodic CDRs conducted; and (2) the number of childhood redeterminations conducted under the Welfare Reform law.² Information on both of these workload measures was promised to Congressman Porter, Chairman of the Labor, Health and Human Services, Education and Related Agencies Subcommittee, who wanted to gauge SSA's progress in meeting workload goals proposed in its annual budget.³ The workload goals for Fiscal Year (FY) 1997 through 1999 are shown in Table 1.

¹ This requirement applies to Fiscal Years 1996 through 2002.

² References to the Welfare Reform law relate to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

³ These performance goals are often called the "Porter Commitments."

Table 1: Workloads Under GPRA and the Porter Commitments

Periodic CDRs Processed	FY 1997	FY 1998	FY 1999
Planned	603,000	1,245,000	1,637,000
Actual	690,478	1,391,889	NA

CDR Workloads

CDRs are conducted through one of two methods: full medical reviews or CDR mailers. Full medical reviews are primarily conducted by Disability Determination Services (DDS) offices located in each State,⁴ whose administrative costs are funded by SSA. The DDS offices' responsibilities related to CDRs include reviewing an individual's medical evidence, developing medical evidence if unavailable or insufficient, and rendering a determination as to whether the individual is still disabled.

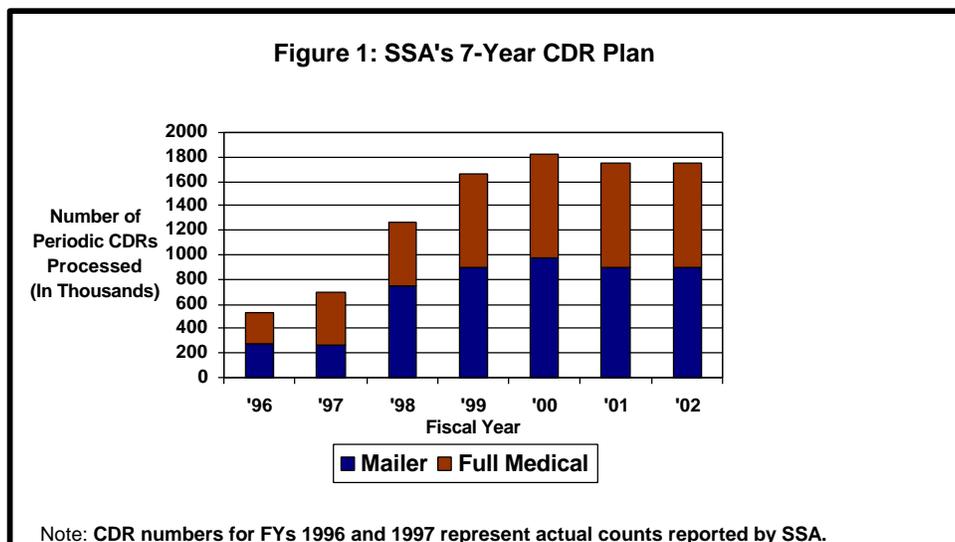
CDR mailers⁵ are questionnaires sent to disabled individuals asking whether: (1) they have performed any work; (2) their medical condition has changed; and (3) they are interested in receiving vocational rehabilitation services. If the answers to the questions indicate the individual's condition may have improved, the case is referred to a DDS office for a full medical CDR to determine whether the individual is still disabled.

In its most recent Annual Report on CDRs, submitted to Congress on August 25, 1998, SSA stated that it processed 690,478 periodic CDRs during FY 1997.⁶ SSA also stated that the cost to process these CDRs was \$330 million. Over the next four years, the number of CDRs performed is expected to increase as SSA eliminates its backlog. In a March 1998 report to Congress, SSA updated its 7-year plan to eliminate the backlog of periodic CDRs by FY 2002. The CDRs performed or planned through FY 2002 are shown in Figure 1.

⁴ DDS offices shown in SSA's workload reports are located in all 50 States, the District of Columbia, Guam, and Puerto Rico.

⁵ SSA noted in its FY 1996 Annual Report on CDRs that the profiling system used to determine who receives the mailer questionnaire ". . . has proven to be an efficient and cost-effective means for identifying beneficiaries who, because their disabling impairments have not improved, do not require full medical reviews in the [DDSs]."

⁶ The 690,478 CDRs consisted of 420,863 full medical CDRs and 269,615 CDR mailers.

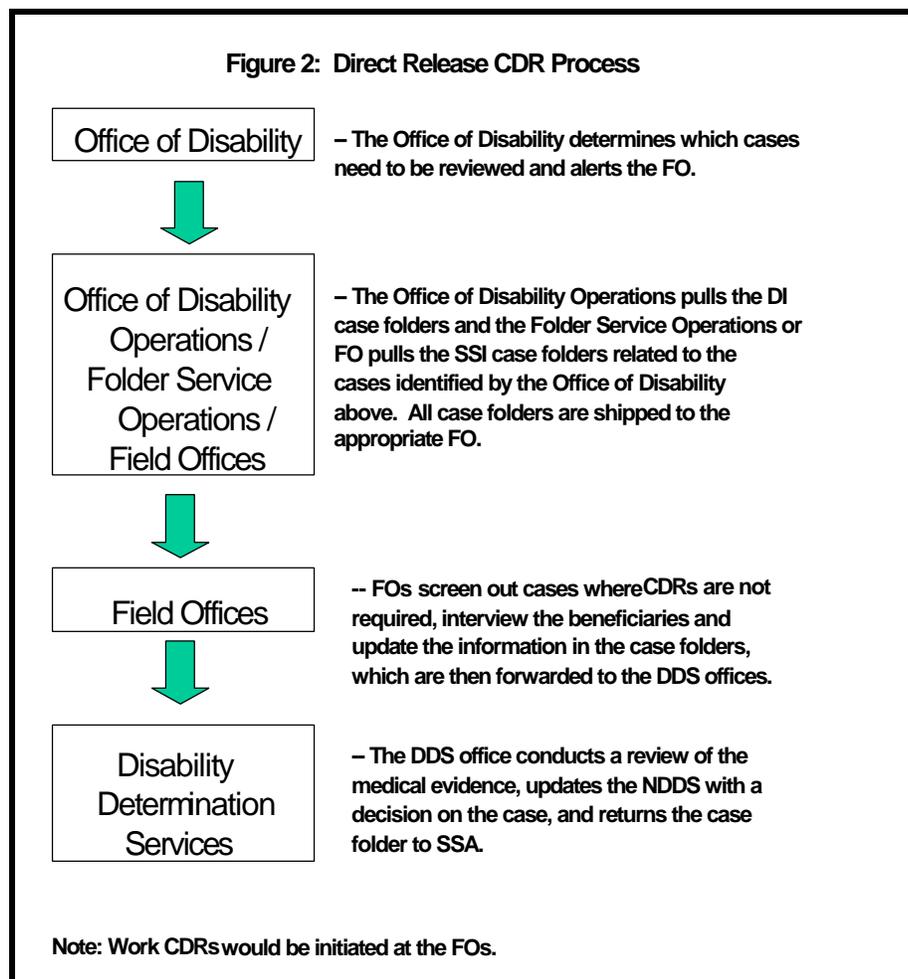


CDR Reporting Process at the DDS Offices

SSA's field offices (FO) send CDR cases to the DDS offices throughout the year for processing. SSA initiates these CDRs for various reasons, including: (1) routine scheduling of a medical review (this is sent out as a "direct release");⁷ (2) responses to a CDR mailer indicate that the individual's medical condition has improved; (3) receipt of information that an individual's condition has improved and/or the individual has been working (this is sent out as a "work CDR"); or (4) testing the reliability of SSA's systems and/or verifying assumptions through a full medical review.

SSA's folder processing centers send the case folders (which contain background and medical information on the individual) selected for a CDR to the appropriate FO for development. FO personnel review the information in the case folders, interview the individuals, and update pertinent facts in the folders prior to sending the cases onto the DDS offices for full medical reviews. DDS medical examiners, using information in the case folders, determine if additional tests are necessary. Based on this information, a determination is made as to whether the individual is still disabled according to current medical criteria. The DDS office prepares a *Cessation or Continuance of Disability or Blindness Determination and Transmittal* at the end of each review to provide information on the medical review, including a decision as to whether the individual is still disabled. An electronic version of this form is transmitted daily to the National Disability Determination Services System (NDDSS), which is maintained by SSA. This data base maintains information on all full medical CDRs conducted nationwide. See Figure 2 for a flow chart of the CDR direct release process.

⁷ SSA classifies medical impairments into one of three periodic CDR categories: Medical Improvement Expected, which generally necessitates a review every 6 to 18 months; Medical Improvement Possible, which generally necessitates a review every 3 years; and Medical Improvement Not Expected, which generally necessitates a review every 5 to 7 years.



SSA has also developed a CDR tracking system, the CDR Control File (CDRCF), to assist the Office of Disability (OD) in managing the increasing number of CDRs mandated by legislation. This system is used to notify FOs that a routine CDR is due, track the progress of the CDR, and interface with other SSA systems to update the recipient's records. The CDRCF also shares information with the NDDSS. Although the CDRCF currently covers SSI CDRs only, SSA is in the process of expanding the capability of the system, so it can handle DI and concurrent CDR cases as well.⁸

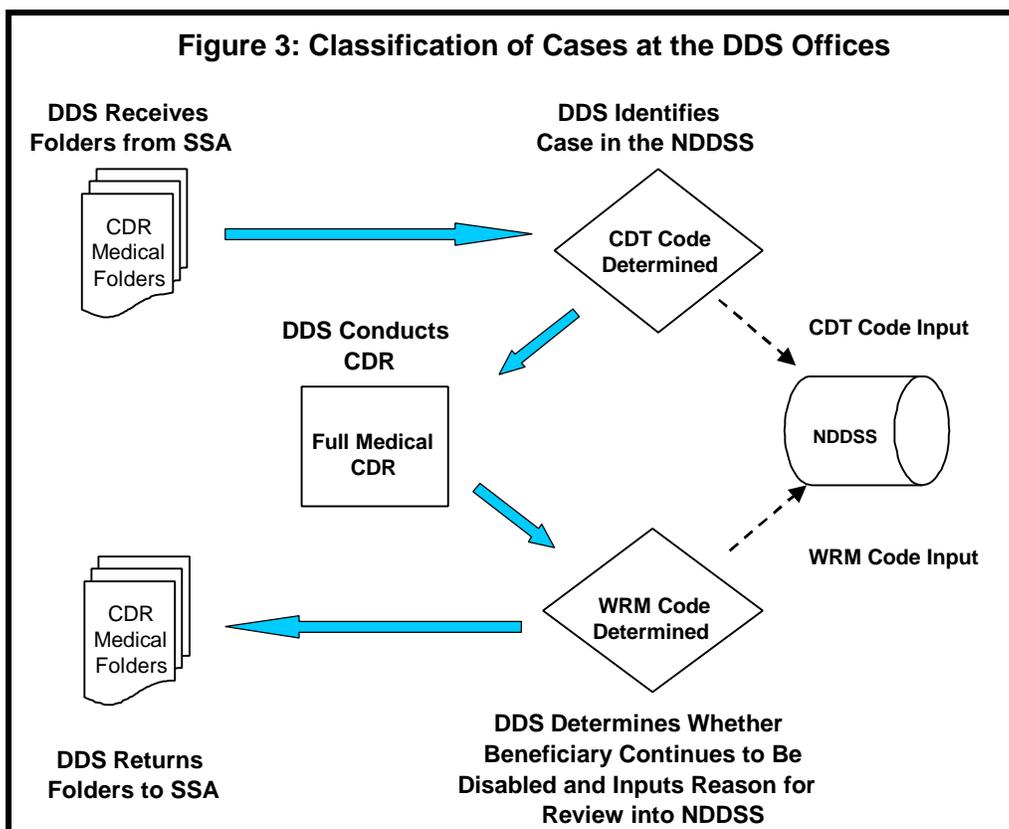
State Agency Operations Report

The NDDSS produces the State Agency Operations Report (SAOR), which provides workload data for each DDS office. The SAOR report tracks the DDS workload on a weekly basis.⁹ DDS staff identify incoming and outgoing CDR cases through specific

⁸ Concurrent cases relate to individuals receiving both DI and SSI benefits.

⁹ The NDDSS data base also captures other types of information, such as the number of initial

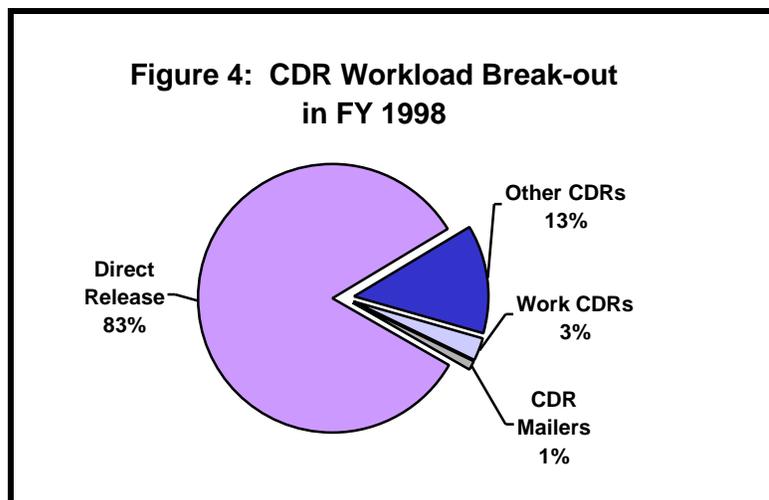
classification codes. One of the codes used on incoming cases, the Continuing Disability Review Type (CDT) code, is used by the NDDSS to initially classify the CDR workload into four categories: (1) direct release; (2) mailers; (3) work; and (4) other. SSA considers all of these to be periodic CDRs except work CDRs. A second code, the Why Review Was Made (WRM) code, is later entered into the same system and determined by medical examiners at the end of the CDR process. Although both codes are expected to identify the CDR cases in the same way, the WRM code supercedes the CDT code in the NDDSS and becomes the final identification of the CDR case. Appendix D provides a complete listing of the CDT and WRM codes used by DDS offices. See Figure 3 for a flow chart of the coding process at DDS offices.



According to SSA's FY 1998 SAOR, the majority of the cases coming into DDS offices were coded as direct releases. In FY 1998, approximately 83 percent of the CDRs performed at the DDS offices were identified as part of the direct release process. The next largest groups were the "other" CDRs, initiated by the FOs or centrally by SSA; and work CDRs initiated by FOs. These groups represented about 13 percent and

determinations on individuals applying for disability benefits for the first time, reconsiderations of previous DDS determinations, and staffing levels at the DDS offices. We only reviewed the CDR workloads in this report.

3 percent of the FY 1998 workload, respectively. Finally, CDR mailer cases forwarded to DDS offices for a medical review were about 1 percent of the total. This breakout is shown in Figure 4.



SCOPE AND METHODOLOGY

To accomplish our objective, we:

- visited three DDS offices and telephoned four DDS offices to assess their process for inputting CDR information into the NDDSS;
- interviewed SSA regional officials in five regions to discuss the CDR reporting process at the DDS level and to obtain information on particular coding problems;
- interviewed SSA officials in the Office of Information Management (OIM), the Office of Systems Requirements and OD in Baltimore, Maryland, on the operations of the NDDSS, the availability of CDR processing guidance, and the uses of information provided by the DDS offices;
- reviewed the Program Operations Manual Systems (POMS) instructions, the Management Information Manual (MIM), and other guidance available to DDS offices explaining how CDR cases should be processed;
- analyzed information available in the SAOR for FYs 1996 through 1998;
- analyzed CDR data available in the NDDSS for FYs 1997 and 1998; and
- reviewed SSA's recent efforts to make classification codes more reliable, such as the CDRCF download and new WRM field edits in the NDDSS.

This is our third CDR report in a series of reviews. In our first CDR report, we reviewed SSA's FY 1996 Annual Report on CDRs for compliance with congressional reporting requirements.¹⁰ In our second report, we reviewed the cost allocation process used by SSA when assigning administrative costs to CDRs and redeterminations.¹¹

We did not verify the accuracy of individual CDR entries, but focused our efforts on specific coding issues that could impact the reliability of CDR entries as they are sorted and utilized by SSA in reports to Congress. We performed our review in Baltimore, Maryland, and Boston, Massachusetts, between May and December 1998. The review was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

¹⁰ SSA/OIG A-01-97-91007, "Review of the Social Security Administration's Fiscal Year 1996 Annual Report on Continuing Disability Reviews," March 18, 1998.

¹¹ SSA/OIG A-01-98-51001, "The Social Security Administration's Process to Segregate Continuing Disability Review Costs," August 27, 1998.

RESULTS OF REVIEW

Overall, SSA's process to accumulate aggregate periodic full medical CDR workload data is adequate. However, the NDDSS does not have the capability to fully distinguish periodic CDRs from other workloads. As a result, SSA has developed additional tracking methods for specific workloads to accommodate congressional reporting requirements. This separate tracking allows SSA to identify most of its periodic CDR workload in FY 1997. However, SSA could not ensure that the 12.5 percent of periodic CDRs (some 52,604 CDR's) reported in FY 1997 were correctly classified as periodic CDRs. As a result, NDDSS classification problems have increased the risk that SSA is over-reporting to Congress the number of periodic CDRs performed.

To meet congressional reporting requirements, SSA must have an accurate and complete measure of all CDRs performed and must be able to specifically identify the CDR workload from all other work performed. Cases in the NDDSS are classified based on the coding determined by staff in the DDS offices. Based on discussions with DDS officials, we found that some DDS offices have trouble classifying portions of their CDR workload and do not have an authoritative and updated listing of CDR classification codes. Also, our analysis of the information in the NDDSS found that DDS staff are coding CDR cases with miscellaneous codes, invalid codes, or leaving the classification field blank. Cases coded in this manner are classified as periodic CDRs for reporting purposes. Coding problems can be attributed in part to: (1) incomplete or incorrect information on the case folders received by the DDS offices; (2) inconsistent SSA guidance to the DDS offices regarding CDR codes to be used in the NDDSS; and (3) the variety of computer software programs at the DDS offices. Although SSA has made some changes in an attempt to resolve the classification problems, these changes to date have been inadequate.

CLASSIFICATION CODES IN THE NDDSS

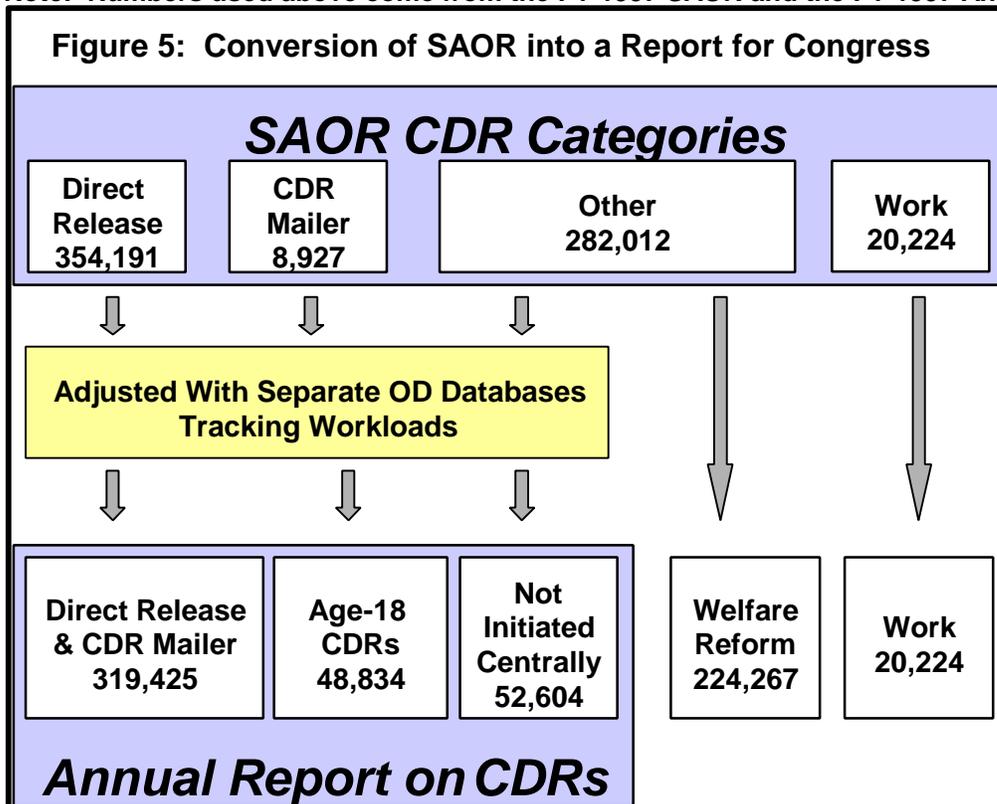
SSA does not use the NDDSS workload report, but has established separate tracking systems to adjust NDDSS totals prior to reporting these workload numbers to Congress. Hence, SSA is not able to identify all of its workload using this approach since these systems cannot monitor the "other" category to ensure that periodic CDRs are properly separated from work CDRs. The NDDSS uses the CDR classification codes entered by DDS staff to classify the CDR workload for reporting purposes. However, some periodic CDRs lack adequate classification and, consequently, are placed in the "other" CDR category of the primary workload report, where they are assumed to be periodic CDRs. Proper classification has been hampered by (1) cases arriving at the DDS offices without accurate identification; (2) DDS staff overusing the

“miscellaneous” code on CDRs; and/or (3) DDS staff leaving key classification fields blank.

SSA’s Reliance on NDDSS Classifications

Although the SAOR is SSA’s key CDR workload report, OD staff told us that all of the categories shown on the SAOR, with the exception of work CDRs, are not used when reporting CDR results to Congress because OD has established separate data bases to track direct release and mailer CDR workloads. Both the direct release and mailer workloads are monitored centrally by OD staff. OD also monitors childhood redeterminations under the Welfare Reform law through a separate data base that shows the Social Security numbers of cases released to FOs. This data base is periodically updated as the NDDSS shows that a CDR on a specific case has been completed. The year-end totals for direct release and mailer CDRs shown in these separate data bases are what will be reported to Congress rather than the category totals in the SAOR. See Figure 5 for a diagram showing the process used to adjust FY 1997 SAOR category totals for the FY 1997 Annual Report on CDRs.

Note: Numbers used above come from the FY 1997 SAOR and the FY 1997 Annual



Report on CDRs. The Report did not segregate direct release CDRs from CDR mailers. Both Welfare Reform childhood redeterminations and age-18 CDRs are included in the "other" category on the SAOR.

While SSA's separate data bases allow monitoring of direct release and mailer CDRs, SSA is not able to identify work CDRs and "other" CDRs, since it is the FO that has made a determination that a CDR is necessary and not OD. As a result, SSA used the work CDR count from the SAOR for its FY 1997 Annual Report on CDRs. In addition, SSA had to note in its FY 1997 Annual Report on CDRs that another 52,604 periodic CDRs were "not initiated centrally," without being able to say any more about these cases. However, SSA's inability to monitor the contents of this category increases the risk that SSA is inappropriately combining work CDRs and periodic CDRs in its reports to Congress, especially since only the FOs initiate both work CDRs and periodic CDRs. As a result, SSA still must be able to rely on CDR classifications in the NDDSS to accurately report all full medical CDRs. A better understanding of the "other" category in the SAOR, as well as DDS coding problems, may explain some of the unidentified CDRs.

Classification Codes and "Other" CDRs

Vague or invalid classification of cases by DDS staff can overstate the "other" CDR category of the SAOR while understating the remaining three categories. The purpose of the NDDSS classification scheme is to place each CDR in one of four categories in the SAOR. According to this classification scheme, CDRs are categorized based on their CDT and/or WRM codes. Improperly coded CDRs are placed by default in the "other" category of the SAOR. Since the "other" category is considered to be a periodic CDR category, any work CDRs with vague or invalid coding will be misreported in the SAOR as periodic CDRs.

The FY 1997 Annual Report on CDRs shows that 52,604 CDRs, or about 12.5 percent of the national workload, were not direct releases, mailers or work CDRs. Although, these 52,604 CDRs include a number of legitimate CDRs initiated by FOs, such as voluntary reports of medical improvement, an OD official noted that this number appears unusually large to cover just the groups legitimately classified as "other." We could not determine the extent of the "other" CDRs for FY 1998 since the Annual Report on CDRs covering this period had not been released at the time of our review.

In our attempt to understand the size of the "other" category, we analyzed data in the NDDSS for FYs 1997 and 1998 to determine the extent of vague and/or invalid classification coding. We found that DDS offices had used the "miscellaneous" CDT code on 9 percent of their workload in FY 1997 and 11 percent of their total CDR workload in FY 1998. However, a review of specific DDS coding in the FY 1998 NDDSS data shows that 87 percent of the "miscellaneous" codes were represented by 10 DDS offices, even though these DDS offices make up only 21 percent of the national CDR workload. For example, in FY 1998 the South Carolina DDS office used the "miscellaneous" code for 81 percent of its incoming CDR cases. Table 2 shows the 10 States with the highest percentage of "miscellaneous" codes in their CDT field.

Table 2: Top 10 States with “Miscellaneous” Codes in the CDT Field

State	FY 1998 Total Workload	FY 1998 Workload Coded as “Miscellaneous”	“Miscellaneous” as a Percentage of FY 1998 Workload
Alabama	16,739	4,127	24.7
Florida	38,331	9,778	25.5
Illinois	33,338	26,512	79.5
Indiana	10,610	2,015	19.0
Louisiana	17,779	7,297	41.0
Montana	2,476	551	22.3
Nevada	2,697	381	14.1
New Jersey	13,927	4,750	34.1
South Carolina	10,753	8,747	81.3
Utah	3,478	913	26.3
Totals	150,128	65,071	43.3

We also found that in FY 1997 approximately 5,960 of the CDR cases had a blank or invalid CDT code and about 11,840 CDR cases had a blank or invalid WRM code. In FY 1998, about 40,330 of the CDR cases had a blank or invalid CDT code and approximately 9,580 CDR cases had a blank or invalid WRM code. Although every DDS office had blank or invalid WRM codes, 5 States make up 52 percent of the blank or invalid WRM codes even though they represent only 15.7 percent of the national workload.¹² The CDT code has always been a mandatory field on records entered into the NDDSS, and SSA made the WRM field mandatory as well at the end of FY 1998.

Classification Issues at the DDS Offices

Classification problems can lead to delays in processing, the wrong criteria being used, or higher numbers of CDRs being placed in the “other” CDR category. The CDR classification process at the DDS offices is dependent on the quality of the CDR information provided to the office, as well as the ability of the DDS staff to make distinctions between workloads. We found several reasons why DDS staff had difficulty classifying CDR cases. In some cases, the transmittal sheet information on incoming medical folders was missing or had errors. In addition, the DDS staff were often: (1) making assumptions about incoming cases that led to vague or erroneous coding; (2) were classifying whole groups of cases as “miscellaneous;” or (3) misunderstood how codes should have been used.

Transmittal Sheet Problems

SSA's components are tasked with identifying the type of CDR being forwarded to DDS offices. The Boston Regional Office has a *CDR Transmittal Form* that accompanies the

¹² The five States with the highest number of blank or invalid WRM codes in FY 1998 are Alabama, New York, Ohio, Wisconsin, and Wyoming.

CDR case from the FO to the DDS office and indicates whether the case is a DI, SSI or concurrent case. It also identifies the CDR as “mailer,” “direct release,” “work issue,” or “other.” Similar transmittal sheets are prepared by the Office of Disability Operations (ODO) and the Folder Service Operations (FSO) when sending cases to FOs. However, both SSA and DDS officials told us that these forms are sometimes missing, incomplete, or have errors.

DDS officials noted that transmittal sheets have fallen off the CDR case folders as they are being sent from the FO to the DDS office. In other cases, the information on the transmittal sheet has been in error. For instance, two DDS offices noted that transmittal sheets from the FSO were classifying age-18 CDRs as “miscellaneous” CDRs, even though a specific CDT code had been created for these CDRs. In another case, coding errors at SSA in early FY 1998 caused CDR case identification problems. On December 9, 1997, SSA issued an Emergency Message to the FOs noting that 225,000 DI CDRs had erroneously been labeled as “medical improvement not expected” cases.¹³ This message noted that “a programming change to allow for the conversion to the year 2000 resulted in the erroneous labeling of approximately 225,000 [DI] direct release CDRs being sent to [FOs] starting in late October 1997.”¹⁴ DDS officials noted that the uncertainty related to coding of incoming cases leads to skepticism throughout the DDS offices as to the true identity of the case, causing additional reviews of the case and delays in the processing of the CDR. In addition, uncertainty related to certain incoming cases, such as age-18 CDRs, could lead to the wrong criteria being used in conducting the CDR.

DDS’s Use of the Classification Codes

At two of the seven DDS offices we contacted, the staff responsible for incoming cases said that they classify most incoming cases as “medical improvement possible,” regardless of the transmittal form content, just to be conservative. Another DDS office coded most of the incoming cases as “miscellaneous” regardless of the information on the flag, while a fourth DDS office actually devised its own transmittal sheet that blurred the categories and classified almost all of the workload as “miscellaneous.” When asked about this process, both regional and DDS officials noted that the large volume of incoming cases makes it difficult for the clerical staff to sort through all of the cases. Instead, as the cases go forward, the medical examiners are expected to make the determination later in the process, and put in the right WRM code. However, given the fact that the classification system uses dual-coding in order to better identify cases, such short-cuts can compromise the accuracy of the classification process.

¹³ See Emergency Message (EM)-97-197.

¹⁴ Later guidance in EM-98-042 noted that the error specifically related to the CDT coding on the transmittal sheet.

Vague coding guidance creates the risk that work CDRs classified as “miscellaneous” will be reported in the “other” category on the SAOR and thereby, be included in the periodic CDR count. Some of the vague coding related to confusion about the CDT code used for work CDRs. For example, four of the DDS offices told us that they used the “miscellaneous” code on SSI CDRs because they believed the CDT code for work CDRs related only to “DI work” CDRs. However, our review of the POMS guidance shows that “SSI work” CDRs are supposed to use the same CDT code used for “DI work” CDRs.¹⁵ The problem is related to the wording in the guidance for the code which defines it in terms of DI CDRs only. The transmittal sheets from ODO/FSO add to this confusion by placing the “SSI work” CDRs under the miscellaneous category rather than with the “DI work” CDRs.

CODING GUIDANCE PROVIDED TO DDS OFFICES

Although the CDR classification codes are key to SSA’s attempt to categorize CDR workloads, SSA does not provide consistent guidance on these codes to the DDS offices. Also, the decentralized nature of DDS operations, including computer programs, makes coding problems difficult to monitor and correct.

Out-of-Date Guidance

While an OD official told us the MIM is the most up-to-date list of valid CDT and WRM codes; yet each of the DDS offices we visited said that they used POMS guidance to set up the CDR codes in their computer systems.¹⁶ When we reviewed the POMS sections the DDS offices used that addressed the coding process and compared them to the MIM, we found that many of the codes were either missing or incomplete in the POMS sections cited.¹⁷

In particular, we found inconsistent guidance on the CDT and WRM codes. The POMS section entitled *How to Complete the Receipt Data Input Screen*,¹⁸ intended to assist DDS personnel with the NDDSS codes used for initial CDR case input, did not address CDT codes related to the Welfare Reform law, such as CDRs on maladaptive children

¹⁵ POMS SM 06006.073.

¹⁶ SSA defines POMS as “. . . the single authorized means for issuing official written program policy and operating instructions in SSA, whether issued by central office, regional office or a program service center.” and “. . . a single repository of all operational information relevant to a particular subject.”

¹⁷ We were able to find a POMS reference that matched the Management Information Manual, POMS SM 06002.200 – Parts of a Full Query Response, but none of the DDS offices we spoke to cited this section when asked about coding guidance.

¹⁸ POMS section SM 06001.120.

and individuals attaining age 18. Similar problems were found with instructions for WRM coding. In the POMS sections specifically addressing the WRM code,¹⁹ we found that neither the Welfare Reform law categories, nor the CDR mailer categories, were mentioned in either set of guidance.

We requested copies of the CDT and WRM codes being used by seven DDS offices in their software packages that upload information into the NDDSS. Six out of seven DDS offices contacted lacked a complete, up-to-date listing of codes in their systems (see Appendix D).

Decentralized Computer Systems

The variety of software programs and computer systems used by the DDS offices has made the correction of coding problems all the more difficult. Currently, DDS offices are using different private sector software packages, depending on the type of computers used at the office (e.g., IBM, Wang, Unisys, etc.) and the preference of the State. In addition, each DDS office is responsible for maintaining its own list of CDT, WRM and additional codes in the software package used to interface with the NDDSS.

SSA officials told us that although the DDS offices are reimbursed by SSA for procuring interface packages, the software is the property of each DDS office. One regional official told us that, because SSA does not own the software, the regional office does not have the authority to monitor the use of the software. As a result, the quality of the information maintained within the system at each DDS office can vary widely.

SSA's ATTEMPTS TO IMPROVE DDS CODING

SSA officials have recognized some of the problems related to ensuring valid classification codes are used. DDS offices are now required to place two classification codes on every case. In addition, case classification information was added to SSA's systems used by DDS offices to better identify incoming CDR cases. However, the NDDSS continues to accept invalid classification codes and the majority of DDS offices we contacted were not utilizing the new case classification feature on incoming cases.

New Guidance on Classification Codes

Although CDT codes must be completed for each CDR record entered into the NDDSS, the WRM codes were not mandatory in the NDDSS until the end of FY 1998. New guidance instructed DDS offices to update their software packages by September 12, 1998, so that a WRM code is required for each CDR processed. The guidance states, "this modification will enable OD and OIM to provide useful responses to litigation and

¹⁹ POMS section DI 28085.020 and DI 28086.020.

legislative requests related to the review of CDRs.” SSA expected the DDS offices to update their systems.

An OIM official said that the NDDSS was also updated so only a certain range of valid WRM codes can be accepted. If such an update works properly, fields that are left blank or filled with an invalid WRM code should be rejected by the NDDSS and sent back to the DDS office for correction. However, in a later discussion with an OIM official we found that the allowable range of WRM codes included invalid codes. As a result, invalid WRM codes were still being accepted by the NDDSS in FY1999.

Automated Codes Available at the DDS Offices

During FY 1998, an NDDSS feature was put in place to assist DDS personnel with CDR case identification. However, our review found that this new feature does not cure SSA’s classification problems. The NDDSS now provides an automatic download of key CDR information from SSA’s CDRCF when the DDS office logs incoming cases into the NDDSS. Upon entering the Social Security number of an individual scheduled for a CDR, the NDDSS download provides information such as the individual’s name, address, telephone number, gender, and date of birth. Although the CDRCF currently covers SSI CDRs only, it is being expanded to eventually cover DI and concurrent CDR cases. The automatic download to the NDDSS also includes a CDT code put into the system by the SSA prior to the folder going to the DDS offices.

While such an electronic file including the CDT code should assist the DDS offices in identifying incoming cases, five of the DDS offices we spoke to either: (1) did not use the download information; (2) did not trust the CDT code, even if they used other information from the download; or (3) did not have a CDT code in their automatic download. For example, one DDS official noted that the data entry clerks at the DDS office have not used the download because the CDT codes are not reliable. In addition, we visited a DDS office to watch the download process and noted that the download was missing a CDT code. When we later spoke to SSA officials about the DDS comments, the officials said that some of the DDS offices may have been slow to utilize the new download feature, but noted that SSA was now receiving positive feedback on this CDRCF feature.

It is also worth noting that although SSA created the CDRCF to manage an increasing number of CDRs mandated by legislation, the current CDRCF is unable to identify CDR cases that originate at the FOs. As SSA states in its POMS guidance, “This CDRCF is for CDRs established by the Office of Disability (OD). . . It is NOT intended for Field Office initiated CDRs.”²⁰ As such, the CDRCF cannot, at this time, assist SSA in monitoring work and “other” CDRs.

²⁰ POMS DI 40503.004.

CONCLUSIONS AND RECOMMENDATIONS

SSA's plans to process and report on increasing numbers of CDRs over the next few years necessitates a clear and understandable classification system at all levels of the organization. Only in this way can SSA's CDR workload be accurately measured and reported to Congress. Although the NDDSS provides reliable aggregate information, our review has shown that the NDDSS and other data bases developed by SSA can not ensure the accurate classification of periodic CDR cases from other CDR workloads. In addition, SSA's attempts to resolve the classification problems have been inadequate.

To assist the DDS offices with their CDR workload and improve the accuracy of CDR data reported to Congress, we recommend that SSA:

1. provide guidance to SSA and DDS offices explaining the importance of completed transmittal sheets and proper coding to differentiate the specific workloads;
2. provide SSA components and DDS offices with a single source of authoritative and updated CDR classification codes to ensure all offices are using the proper codes;
3. coordinate with DDS offices to update their software programs to ensure the proper classification codes are maintained in their systems; and
4. update the edits in the NDDSS so that all incoming records with invalid WRM codes are rejected and returned to the DDS offices for correction.

AGENCY COMMENTS

In response to our draft report, SSA agreed with all of our recommendations except to update the edits in the NDDSS so that all incoming records with invalid WRM codes are rejected and returned to the DDS offices for correction. SSA stated that subsequent to our exit conference, the Office of Systems Requirements verified that invalid codes are not accepted by the NDDSS.

OFFICE OF THE INSPECTOR GENERAL RESPONSE

At the time of our audit, the NDDSS accepted invalid codes, as we found specific cases where invalid codes were accepted. In future audits, we will test whether SSA's recent changes corrected this condition.

APPENDICES

LIST OF ACRONYMS

CDT	Continuing Disability Review Type
CDR	Continuing Disability Review
CDRCF	Continuing Disability Review Control File
DAA	Drug Addiction and/or Alcoholism
DDS	Disability Determination Services
DI	Disability Insurance
EM	Emergency Message
EPE	Extended Period of Eligibility
FO	Field Office
FSO	Folder Service Operations
FY	Fiscal Year
GPRA	Government Performance and Results Act
MIE	Medical Improvement Expected
MIM	Management Information Manual
MINE	Medical Improvement Not Expected
MIP	Medical Improvement Possible
NDDSS	National Disability Determination Services System
OD	Office of Disability
ODO	Office of Disability Operations
OIM	Office of Information Management
P.L.	Public Law
POMS	Program Operations Manual Systems
SAOR	State Agency Operations Report
SSA	Social Security Administration
SSI	Supplemental Security Income
VR	Vocational Rehabilitation
WRM	Why Review was Made

RELEVANT SSA CDR LEGISLATION

LEGISLATION	DATE ENACTED	PROVISIONS	PROGRAM INVOLVED
Section 221(i) of the Social Security Act	Act amended on June 9, 1980 by Public Law (P.L.) 96-265; on January 12, 1983 by P.L. 97-455, and on November 10, 1988 by P.L. 100-647	<ol style="list-style-type: none"> 1) Report to Congress annually on the results of periodic continuing disability review (CDRs) required to be performed on a beneficiary at least once every 3 years. 2) Report to Congress annually with respect to determinations that the Commissioner has made, on a State-by-State basis, to waive the requirement that the continuing eligibility of disability beneficiaries with nonpermanent disabilities be reviewed at least once every 3 years. 	<p style="text-align: center;">Disability Insurance (DI)</p> <p style="text-align: center;">DI</p>
Social Security Independence and Program Improvements Act of 1994 (P.L. 103-296)	August 1994	<ol style="list-style-type: none"> 1) Conduct medical reviews on at least one-third of individuals attaining age-18 each year during fiscal year (Fys) 1996 through 1998. Report to Congress by October 1, 1998. (Note A) 2) Conduct at least 100,000 CDRs annually on SSI recipients for the period October 1995 through September 1998. Report to Congress by October 1, 1998. 	<p style="text-align: center;">Social Security Income (SSI)</p> <p style="text-align: center;">SSI</p>
Contract with America Advancement Act of 1996 (P.L. 104-121) (Note B)	March 1996	<ol style="list-style-type: none"> 1) Conduct redeterminations by January 1, 1997 for beneficiaries for whom Drug Addiction and/or Alcoholism (DAA) is a contributing factor material to the finding of disability and who timely appealed their termination based on DAA. 2) Report to Congress annually for FYs 1996 through 2002 on the amount of money spent on CDRs, the number of reviews conducted by category, the results of such reviews by program and the estimated savings by program over the short-, medium- and long-term. 	<p style="text-align: center;">DI/SSI</p> <p style="text-align: center;">DI/SSI</p>

LEGISLATION	DATE ENACTED	PROVISIONS	PROGRAM INVOLVED
Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) (Note C)	August 1996	<ol style="list-style-type: none"> 1) Redetermine eligibility for children considered disabled based on the comparable severity standard and/or maladaptive behavior. (Note D) 2) Conduct CDRs once every 3 years for recipients under age 18 with nonpermanent disabilities. 3) Conduct CDRs not later than 12 months after birth for low birth-weight babies. (Note D) 4) Redetermine eligibility during the individuals 18th year using the adult initial eligibility criteria. (Note D) 	<p style="text-align: center;">SSI</p> <p style="text-align: center;">SSI</p> <p style="text-align: center;">SSI</p> <p style="text-align: center;">SSI</p>
Balanced Budget Act of 1997 (P.L. 105-33)	August 1997	<ol style="list-style-type: none"> 1) Extends current 12-month period to 18 months for redetermining the disability of children under age-18 under the new comparable severity standard and/or maladaptive behavior standards. 2) Permits SSA to schedule a CDR for low birth-weight babies at a date after the first birthday if the Commissioner determines the impairment is not expected to improve within 12 months of the child's birth. 3) Provides SSA with the authority to make redeterminations of disabled childhood recipients who attain age-18, using the adult eligibility criteria, more than 1 year after the date such recipient attains age-18. 	<p style="text-align: center;">SSI</p> <p style="text-align: center;">SSI</p> <p style="text-align: center;">SSI</p>

- Notes:**
- (A) Repealed by P.L. 104-193.
 - (B) The legislation also authorized funds to be spent on performing the required periodic CDRs in addition to the normal workload: for FY 1996, \$260 million; for FY 1997, \$360million; for FY 1998, \$570 million; and for FY 1999 though FY 2002, \$720 million annually.
 - (C) The legislation authorized \$150 million in FY 1997 and \$100 million in FY 1998 in additional funds to assist with these mandates. The legislation also requires eligibility redeterminations for non-citizens.
 - (D) Provisions modified by the Balanced Budget Act of 1997.

SUMMARY OF GOVERNMENT PERFORMANCE AND RESULTS ACT OF 1993

The Government Performance and Results Act (GPRA) of 1993 was signed into law after the U.S. Congress concluded:

1. waste and inefficiency in Federal programs undermine the confidence of the American people in the Government and reduces the Federal Government's ability to address adequately vital public needs;
2. Federal managers are seriously disadvantaged in their efforts to improve program efficiency and effectiveness, because of insufficient articulation of program goals and inadequate information on program performance; and
3. congressional policymaking, spending decisions and program oversight are seriously handicapped by insufficient attention to program performance and results.

The purposes of GPRA are to:

1. improve the confidence of the American people in the capability of the Federal Government, by systematically holding Federal agencies accountable for achieving program results;
2. initiate program performance reform with a series of pilot projects in setting program goals, measuring program performance against those goals, and reporting publicly on their progress;
3. improve Federal program effectiveness and public accountability by promoting a new focus on results, service quality, and customer satisfaction;
4. help Federal managers improve service delivery, by requiring that they plan for meeting program objectives and by providing them with information about program results and service quality;

5. improve congressional decision making by providing more objective information on achieving statutory objectives, and on the relative effectiveness and efficiency of Federal programs and spending; and
6. improve internal management of the Federal Government.

The GPRA requires Federal agencies to develop:

1. strategic plans, which contain a comprehensive mission statement, general goals and objectives, and descriptions of how the goals and objectives are to be achieved;
2. annual performance plans, which contain objective and quantifiable performance indicators and goals that measure the relevant outputs, service levels, and outcomes of each program activity; and
3. annual performance reports, which review the success of achieving the performance goals of the previous fiscal year, explain why any goals have not been met, and what plans are in place to foster goal achievement.

To date, the Social Security Administration (SSA) has fulfilled the main requirements of GPRA. It provided Congress and the Office of Management and Budget with its strategic plan, "Keeping the Promise," in September 1997. "Keeping the Promise" presented the strategic goals and objectives the Agency intended to meet over the next 5 years. GPRA requires strategic plans to cover a period of not less than 5 years and that they be updated at least every 3 years. SSA released its first annual performance plan in February 1998 and reported on these indicators in its FY 1998 Accountability Report. The first annual performance plan, released as part of SSA's budget justification, detailed the Agency's performance goals for FY 1999. SSA has since released its second annual performance plan which details the performance goals it plans to achieve in FY 2000.

CDR CODES PROVIDED IN SSA'S GUIDANCE COMPARED TO THE CODES USED BY THE DDS OFFICES VISITED

Continuing Disability Review Type Code and Description Per the Management Information Manual	POMS (1)	DDS Office #1	DDS Office #2	DDS Office #3
01- Periodic Review Case (MIE)	Y	Y	Y	Y
02- Childhood Disability Redetermination (2)	D	Y	Y	Y
03- Periodic Review Case (MIP)	Y	Y	D	Y
04- Age-18 Disability Determination	D	Y	Y	Y
05- Reserved for Future Use	D	D	D	Y
06- Named Litigant	Y	Y	Y	N
07- Reserved for Future Use	D	D	D	Y
08- Reopened Mental Impairment	Y	Y	Y	N
09- Permanent Disability	Y	Y	Y	Y
10- Reserved for Future Use	D	D	D	D
11- Reserved for Future Use	D	D	D	Y
12- Extended Period of Eligibility (EPE) (2)	Y	Y	Y	Y
13- Miscellaneous	Y	D	Y	Y
34- CDR Mailer Released FY 1994	Y	N	Y	N
35- CDR Mailer Released FY 1995	Y	N	Y	N
36- CDR Mailer Released FY 1996	Y	N	Y	N
37- CDR Mailer Released FY 1997	Y	N	Y	N
38- CDR Mailer Released FY 1998	Y	Y	Y	N
39- CDR Mailer Released FY 1999	Y	N	Y	N
40- CDR Mailer Released FY 2000	Y	N	Y	N
41- CDR Mailer Released FY 2001	Y	N	N	N
42- CDR Mailer Released FY 2002	Y	N	N	N
43- CDR Mailer Released FY 2003	Y	N	N	N
44- CDR Mailer Released FY 2004	Y	N	N	N

Legend: Y = Code being used in same way as defined in the Management Information Manual
N = Code not being used at all
D = Code being used but for a different purpose

Notes: (1) Program Operations Manual System (POMS) Section SM 06001.120 – How to Complete the Receipt Data Input Screen

(2) Code 12 is used for work CDRs. Code 02 is used for Welfare Reform redeterminations.

The remainder are considered by SSA to be periodic CDRs.

WRM Code and Description Per the Management Information Manual	POMS (1)	DDS Office #1	DDS Office #2	DDS Office #3
- Vocational Rehabilitation Diary (Not "301" Case)	Y	N	Y	Y
- Court Remand (Based on Social Security Disability Reform Act of 1984)	Y	N	Y	Y
02- Reopened Mental Impairment Case (Based on Social Security Disability Reform Act of 1984)	Y	N	Y	Y
03- Reserved for Future Use	Y	Y	D	Y
04- MIE (Medical Reexamination Diary)	Y	Y	D	Y
05- MIP (3-Year Periodic Review Diary)	Y	Y	Y	Y
06- MINE (5-Year Periodic Review Diary)	Y	Y	Y	Y
07- MINE (7-Year Periodic Review Diary)	Y	Y	Y	Y
08- EPE Medical Review (2)	Y	Y	Y	Y
09- Adoption Issue	Y	Y	Y	Y
10- Trial Work Period Diary Matured (2)	Y	N	Y	Y
11- Voluntary Report of Medical Improvement	Y	Y	Y	Y
12- Earnings Posted – MIE (2)	Y	Y	Y	Y
13- Earnings Posted – MIP or MINE (2)	Y	Y	Y	Y
14- Voluntary Report of Work – MIE (2)	Y	Y	Y	Y
15- Voluntary Report of Work – MIP or MINE (2)	Y	Y	Y	Y
16- Third Party Report	Y	Y	Y	Y
17- State VR Report	Y	Y	Y	Y
18- Court Order (Other than Medical Improvement – Individual or Class Member)	Y	N	Y	Y
19- Post Transplant End-State Renal Disease	Y	N	Y	Y
20- Special (Use only when specifically instructed.)	Y	N	Y	Y
21- Other	Y	Y	Y	Y
22- "301" Case Review Diary	Y	N	Y	Y
23- 1619(a) – Initial Eligibility CDR (2)	Y	Y	D	D
24- 1619(b) – Initial Eligibility CDR (2)	Y	Y	D	D
25- 1619 Status Change CDR (2)	Y	Y	D	D

WRM Code and Description Per the Management	POMS (1)	DDS	DDS	DDS
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Information Manual		Office #1	Office #2	Office #3
26- 1619 CDR – Concurrent title II Determination (2)	N	Y	D	N
27- Individualized Functional Assessment Disability Redetermination (2)	N	Y	D	Y
28- Maladaptive Behavior Disability (2)	N	Y	D	Y
29- Age-18 Disability Redetermination	N	Y	D	Y
30- Reserved for Future Use	Y	Y	D	Y
31- Reserved for Future Use	Y	Y	D	Y
34- CDR Mailer Released FY 1994	N	N	Y	N
35- CDR Mailer Released FY 1995	N	N	Y	N
36- CDR Mailer Released FY 1996	N	N	Y	N
37- CDR Mailer Released FY 1997	N	Y	Y	N
38- CDR Mailer Released FY 1998	N	N	Y	N
39- CDR Mailer Released FY 1999	N	N	Y	N
40- CDR Mailer Released FY 2000	N	N	Y	N
41- CDR Mailer Released FY 2001	N	N	N	N
42- CDR Mailer Released FY 2002	N	N	N	N
43- CDR Mailer Released FY 2003	N	N	N	N
44- CDR Mailer Released FY 2004	N	N	N	N

Legend: Y = Code being used in same way as defined in the Management Information Manual
N = Code not being used at all
D = Code being used but for a different purpose

Notes: (1) POMS Section DI 28085.020 – Why Review Was Made.
(2) Codes 08, 10, 12, 13, 14, 15, 23, 24, 25 and 26 are used for work CDRs. Codes 27 and 28 are used for Welfare Reform redeterminations. The remainder are considered by SSA to be periodic CDRs.

AGENCY COMMENTS

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