OFFICE OF
THE INSPECTOR GENERAL

SOCIAL SECURITY ADMINISTRATION

UNNECESSARY MEDICAL DETERMINATIONS FOR SUPPLEMENTAL SECURITY INCOME DISABILITY CLAIMS

February 2012 **A-01-10-20120**

AUDIT REPORT

Mission

By conducting independent and objective audits, evaluations and investigations, we inspire public confidence in the integrity and security of SSA's programs and operations and protect them against fraud, waste and abuse. We provide timely, useful and reliable information and advice to Administration officials, 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

We strive for continual improvement in SSA's programs, operations and management by proactively seeking new ways to prevent and deter fraud, waste and abuse. We commit to integrity and excellence by supporting an environment that provides a valuable public service while encouraging employee development and retention and fostering diversity and innovation.

SOCIAL SECURITY

MEMORANDUM

Date: February 21, 2012 Refer To:

To: The Commissioner

From: Inspector General

Subject: Unnecessary Medical Determinations for Supplemental Security Income Disability Claims (A-01-10-20120)

OBJECTIVE

The objective of our review was to determine the extent of unnecessary medical determinations for Supplemental Security Income (SSI) disability claims, which incur additional costs to the Social Security Administration (SSA).

BACKGROUND

SSI is a nation-wide, Federal cash assistance program administered by SSA that provides a minimum level of income to financially needy individuals who are aged, blind, or disabled.[1] To be eligible for SSI, individuals must meet certain non-medical criteria, such as income and resource limitations, and requirements for living arrangements/residency, and citizenship or qualified alien status.[2]

When a claimant files an SSI disability claim, SSA obtains and reviews the claimant's non-medical information to determine whether he or she meets the non-medical criteria for SSI payments. If not, SSA processes a non-medical denial. If it appears the claimant meets the non-medical criteria for SSI, SSA generally forwards the claim to the disability determination services (DDS) in the State or other responsible jurisdiction for a medical determination. In 2009, SSA processed 515,048 non-medical denials for SSI claims without referring the claims to the DDS.

If the claimant disagrees with the initial disability determination, he or she can file an appeal within 60 days from the date of notification of the determination. In most cases, an individual may request up to three levels of administrative review:
(1) reconsideration by the DDS, (2) hearing by an administrative law judge (ALJ),

[1] *Social Security Act* § 1601 *et. seq.*, 42 U.S.C. § 1381 *et. seq*.

[2] SSA, POMS, SI 00501.001 (January 18, 2005).

and (3) review by the Appeals Council. If a claimant is dissatisfied with the Appeals Council's decision, he or she may appeal to the Federal Courts.

When the SSI claim results in a non-medical denial after the medical determination, critical resources are unnecessarily expended. Obtaining unnecessary medical determinations costs the Agency valuable personnel time and resources. In Fiscal Year (FY) 2009, the cost for SSA to process a non-medical denial was $16.70 per claim. The cost for a DDS to make a medical determination was $519 per claim, and the cost for a hearing was $1,690 (this includes the $519 DDS medical determination cost plus the cost of an ALJ decision, which is $1,171 per claim).

During a prior review, *Disability Insurance and Supplemental Security Income Claims Approved in 2006 But Not Paid*,[3] we found that DDSs received claims for a medical determination in cases where the individuals were ineligible for SSI payments because of non-medical reasons. We initiated this review to determine the extent of this issue.

We obtained a file of SSI-only claims for Calendar Year (CY) 2009 with a medical determination made by the DDS that contained a non-medical denial. Our analysis of this file identified 19,395 claims that SSA appeared to have unnecessarily sent to the DDS for a medical determination. In addition, these individuals were not receiving benefits as of March 2011. We randomly selected 250 cases from this population for detailed analysis.

We also obtained a file of SSI-only claims with ALJ decisions made in CY 2009 that contained a non-medical denial.[4] Our analysis of this file identified 519 claims that appeared to have unnecessarily received an ALJ decision. In addition, these individuals were not receiving benefits as of August 2011. We randomly selected 50 cases from this population for detailed analysis. (See Appendix B for our scope, methodology, and sample results.)

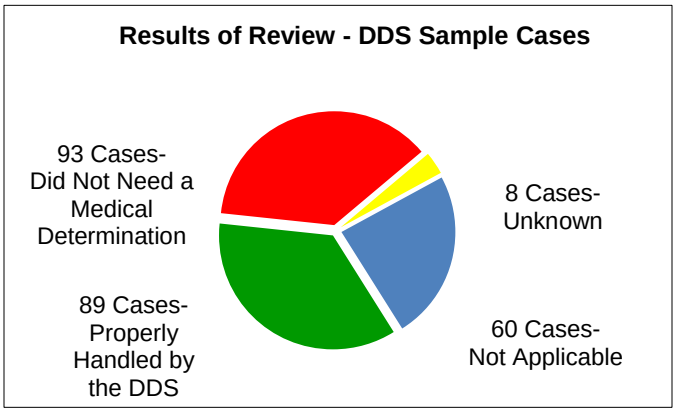
[3] SSA OIG, *Disability Insurance and Supplemental Security Income Claims Approved in 2006 But Not Paid* (A-01-10-11009), July 2010.

[4] Though DDSs make medical *determinations* and ALJs make medical *decisions*, for purposes of this audit report, we will call determinations and/or decisions "medical determinations."

RESULTS OF REVIEW

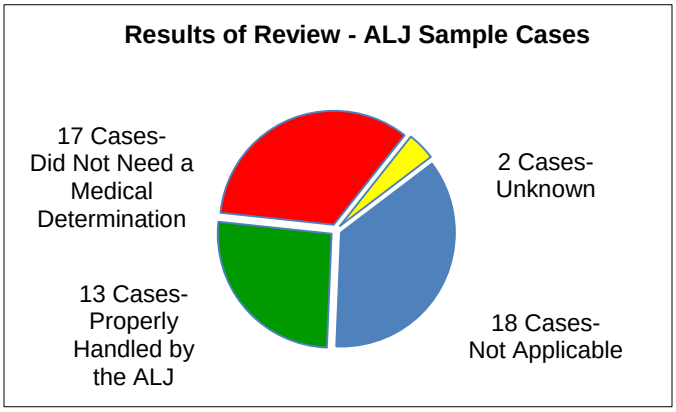
SSI disability claims received medical determinations even though the claimants did not meet the non-medical criteria for SSI. Based on our review, we estimate that 7,391 SSI claims unnecessarily received a medical determination in 2009. As a result, SSA spent approximately $3.8 million on unnecessary medical determinations.[5]

Of the 250 DDS cases in our sample,



- 93 (37 percent) did not need a medical determination of disability;
- 89 (36 percent) were properly referred to the DDS based on information provided by the claimant;
- 60 (24 percent) were not applicable because they had another claim that needed a medical determination; and
- 8 (3 percent) were unknown because we were unable to determine what information the claimant provided at the time of application.

In addition, of the 50 ALJ cases in our sample,



- 17 (34 percent) did not need a medical determination of disability;
- 13 (26 percent) were properly referred to the ALJ based on information provided by the claimant;

[5] We based our $3.8 million estimate by projecting the 89 cases unnecessarily sent to the DDS for a medical determination (as described on page 4 under "DDS Sample Cases That Did Not Need a Medical Determination") and 14 cases that were unnecessarily sent to an ALJ for a hearing decision (as described on page 6 under "ALJ Sample Cases Not Needing a Medical Determination"). We did not include four cases that SSA should have recalled from the DDS because the Agency was aware that the claimant did not qualify based on non-medical criteria, or three cases that SSA should have recalled from the ALJ because, although these cases incurred some costs at the DDS/ALJ, we were not able to quantify the total costs involved.

- 18 (36 percent) were not applicable because they had another claim that needed a medical determination; and
- 2 (4 percent) were unknown because we were unable to determine what information the claimant provided at the time of application.

DDS SAMPLE CASES THAT DID NOT NEED A MEDICAL DETERMINATION

Of the 93 claims that did not need a medical determination by the DDS,[6]

- 89 should not have been sent to the DDS for a determination because information provided on the application indicated the claimant did not qualify for SSI based on non-medical criteria, and
- 4 should have been recalled from the DDS before a determination was made because SSA became aware that the claimant did not qualify based on non-medical criteria. (See Table 1 for the reasons SSA denied these cases.)

Table 1: Reasons for Denial for Claims with an Unnecessary Medical Determination from DDS

Reason	Number of Cases	Portion
Income was too high	50	54%
Resources were too high	24	26%
Not a citizen or qualified alien	14	15%
In a public institution	4	4%
Fugitive felon status	1	1%
Total cases with unnecessary medical determinations	**93**	**100%**

Note: Table 1 details our actual sample findings. Separate random samples or further expansion of our sampling effort may or may not provide similar results.

Claims Unnecessarily Sent to the DDS

In 89 cases, SSA should not have sent the claim to the DDS for a medical determination because information provided on the application indicated that the claimant did not qualify for SSI based on the non-medical criteria at the time of application. In addition, in 6 of the 89 cases, SSA issued a non-medical denial notice before the DDS made the medical determination, yet DDS staff continued working on the claim because the Agency did not share this information. Had these claims not been referred to the DDS, SSA would have saved $46,191 and could have used these resources for other workloads.

For example, a man from California applied for SSI disability payments in January 2009. When he filed the claim, the claimant reported that he was not a U.S. citizen. SSA did not develop his alien status, even though the Agency denied a prior claim filed in

[6] Of these 93 cases, the DDS medically allowed 78 and denied 15.

2003 because he was not a citizen or qualified alien. SSA staff erroneously sent his claim to the DDS for a medical determination. The DDS worked on this claim for 4 months, requesting medical information from several sources, and even purchasing an examination to obtain more information. In April 2009, the DDS medically allowed this claim, but SSA denied the claim because the claimant was not a U.S. citizen or qualified alien.

In another example, in December 2008, a man filed for SSI disability payments for his 15-year-old son. At that time, the man reported he had over $5,000 of earned income per month. Even though this is over the income limits for SSI, SSA still sent the claim to the DDS for a medical determination. The DDS medically allowed this claim in April 2009, but SSA denied the claim because of the man's excess income.

Of these 89 cases, 8 also received a medical decision on appeal at either the reconsideration or ALJ level.[7] These cases incurred additional costs to the Agency.

For example, in September 2008, a woman from Louisiana applied for SSI payments for her 1-year-old son. On the application, she reported that she and her husband owned stock, but left the value blank. SSA did not confirm the value of stock and sent her claim to the DDS for a medical determination. The DDS medically denied the claim at both the initial and reconsideration levels, and the woman appealed and requested a hearing before an ALJ. In July 2010, the ALJ medically approved the claim, but a few months later, SSA denied the claim because of excess resources. When SSA verified the resources, the Agency found that the stock was worth over $8,000, making the claimant ineligible for SSI payments. Had the Agency obtained the value of the stock before sending the claim to the DDS, SSA would have saved valuable personnel time and resources. As of August 2011, this claimant is still not receiving SSI.

Recalling Claims from the DDS

In four cases, although SSA properly sent the claims to the DDS based on the information the claimants provided at the time of application, the Agency should have recalled the cases. In these cases, SSA became aware that the claimants did not qualify for SSI based on non-medical criteria and sent a denial notice to the claimant before the DDS made the medical determination. DDS staff continued to work on these cases and made medical determinations that were unnecessary.

For example, on February 6, 2009, a woman applied for SSI disability payments for her 7-year-old son. She did not report income for him at that time. On February 21, 15 days later, the woman notified SSA that her son was receiving over $1,500 a month in child support payments, which was over the income limits. SSA issued a non-medical denial notice on March 25, 2009, but did not notify the DDS that this child was not eligible for SSI. The DDS continued working the case and medically allowed the claim on April 24, 2009 after SSA processed the non-medical denial.

[7] All eight of these cases received a medical allowance as the final determination.

Claims Properly Handled by the DDS

Of the 250 cases in our sample, DDS staff properly handled 89 based on the information the claimant provided at the time of application. In some of these cases, the claimants did not disclose information that resulted in a non-medical denial. In other cases, SSA did not fully develop the non-medical criteria. In 46 of these 89 cases, SSA deferred the non-medical development. If SSA had fully developed the non-medical criteria for these 46 cases, the Agency should still have sent 43 of the cases to the DDS for a medical determination. However, SSA would have discovered that three of the cases should not have been referred to the DDS for a medical determination.

For example, a woman from Washington applied for SSI disability payments in December 2008. At that time, she reported that the only resources she and her husband owned were two vehicles, with values under the resource limit. SSA sent her claim to the DDS for a medical determination, and in April 2009, the DDS medically allowed the claim. After the allowance, the claimant admitted to owning property worth over $56,000, which made her ineligible for SSI. Had the claimant disclosed this information at the time of application, SSA would not have sent the claim to the DDS for a medical determination. As of August 2011, this claimant was still not receiving SSI.

In another example, a woman from Texas applied for SSI payments for her 14-year-old son in November 2008. At the time of the application, she alleged that she owned 2 acres of land worth $2,000. Based on this allegation, SSA sent the claim to the DDS for a medical determination, and in January 2009, the DDS medically allowed the claim. SSA then verified the value of the land and determined it was worth over $16,000, which made the child ineligible for SSI payments. Had SSA verified this information at the time of application, the Agency would not have sent the claim to the DDS for a medical determination.[8] As of August 2011, this claimant was still not receiving SSI.

ALJ SAMPLE CASES NOT NEEDING A MEDICAL DETERMINATION

Of the 17 claims that did not need a medical determination by an ALJ:[9]

- 14 should not have been sent to the ALJ for a determination because information provided on the application indicated the claimant did not qualify for SSI based on non-medical criteria, and
- 3 should have been recalled from the ALJ before a determination was made because SSA became aware that the claimants did not qualify based on non-medical criteria. (See Table 2 for the reasons SSA denied these cases.)

[8] SSA, POMS, DI 11055.035 (June 1, 2010).

[9] Of these 17 claims, the ALJ medically allowed 14 and denied 3.

Table 2: Reasons for Denial for Claims with an Unnecessary Medical Determination from the ALJ		
Reason	**Number of Cases**	**Portion**
Income was too high	7	41%
Resources were too high	7	41%
Not a citizen or qualified alien	2	12%
In a public institution	1	6%
Total cases with unnecessary medical decisions	**17**	**100%**

Note: Table 2 details our actual sample findings. Separate random samples or further expansion of our sampling effort may or may not provide similar results.

For example, a woman from Pennsylvania filed for SSI disability payments in April 2008. At the time of the application, she alleged that she and her spouse each had two life insurance policies. SSA did not confirm the value of these policies, and sent her claim to the DDS for a medical determination. The DDS denied her claim, and she filed a request for a hearing before an ALJ in December 2008. In December 2009, the ALJ approved her claim. SSA verified the value of the life insurance policies in March 2010 and found that they were worth over $4,000, which made her ineligible for SSI payments. Had SSA verified this information at the time of application, the Agency would not have sent the claim for a medical determination[10]—and would have saved almost $1,700. As of August 2011, this claimant was still not receiving SSI.

THIRD-PARTY DATA

SSA relies on recipients to report their income and resources accurately. In FY 2010, financial accounts exceeding the resource limit were the leading cause of SSI overpayments—projected at $858 million.[11] The Agency examined alternatives to the traditional SSI asset verification practices of recipient self-reporting. As a result, SSA created the Access to Financial Institutions (AFI) initiative, which allows the Agency to request and receive financial account information electronically. Using AFI, a vendor handles the request for, and receipt of, financial information; automatically checks an applicant's known bank accounts; and systematically checks for unknown accounts with financial institutions in a given area. SSA started the AFI initiative in 2003, with three States testing the program. As of June 2011, all SSA offices were using AFI.

Additional third-party data exist that SSA could use to verify resources—if the Agency could find an efficient way to use these data. For example, SSA staff can access the LexisNexis Risk Management Solutions database as an optional tool to obtain information about the SSI applicants' real property ownership, transfer of real property

[10] SSA, POMS, DI 11055.035 (June 1, 2010).

[11] SSA, Office of Quality Performance, *FY 2010 Title XVI Payment Accuracy (Stewardship) Report*, June 2011.

for less than fair market value, or recent sale of property. Of the 102 cases (89 from the 250 DDS sample cases and 13 from the 50 ALJ sample cases) that SSA properly handled based on the information provided by the claimant, 14 contained information on LexisNexis that, if queried, would have alerted SSA that the claimant was over the resource limit.

We published two reports that recommend SSA use electronic data sources to verify recipients' allegations of resources.[12] These reports stated that some recipients did not report resources that could be detected using data available to the Agency. In response to our recommendations for both of these reports, SSA agreed to assess the costs/benefits of using electronic data sources for SSI applicants.

CONCLUSION AND RECOMMENDATION

Our review found that although SSA properly referred most SSI cases for medical determinations, the Agency obtained some medical determinations unnecessarily. We estimate that SSA unnecessarily obtained medical determinations for 7,391 SSI claims in 2009 at a cost of about $3.8 million. These cases represent a very small percentage of the more than 2 million SSI disability claims processed in 2009. The cost of processing a non-medical denial is $16.70 per claim, while the cost for the DDS to make a medical determination is about $519 per claim and the cost for an ALJ decision is about $1,171 per claim.

Therefore, we recommend SSA remind staff to process non-medical denials for SSI claims that do not meet requirements before referring to the DDS.

AGENCY COMMENTS

SSA disagreed with the recommendation. The Agency stated that in 2009, it correctly referred 99.7 percent of its cases to the DDSs for a medical decision. Because of the Agency's high level of accuracy, it did not believe a reminder was necessary at this time. Additionally, SSA provided some general comments on the statistical methods we used in our audit work. (See Appendix C for the Agency's comments.)

OIG RESPONSE

Our report demonstrates the need for SSA to issue a reminder to staff to process non-medical denials for SSI claims that do not meet requirements before referring to the DDS. Specifically, our review showed that SSA spent about $3.8 million on 7,391 unnecessary medical determinations for SSI-only claims in 2009 (0.7 percent of the 1.1 million SSI-only medical determinations completed during the year). Although the Agency correctly referred 99.3 percent of SSI-only claims to the DDSs for medical

[12] SSA OIG, *Supplemental Security Income Recipients with Unreported Real Property* (A-02-09-29025), June 2011, and *Supplemental Security Income Recipients with Unreported Vehicles* (A-02-08-28038), July 2009.

determinations, cutting costs wherever possible should be a priority for SSA. This is increasingly important given the current budget environment—as noted in the excerpt below from the SSA Commissioner's message to all employees on December 23, 2011.

> Accounting for the across-the-board reduction that each agency had to take, we received a small increase of about $25 million over last year's budget. This budget increase does not pay for much of our more than $300 million increase in fixed costs, so it will be another very tight year. We are in the process of making some difficult decisions so that we can accomplish our most important missions.

Furthermore, as noted in the Background section of our report, it costs SSA $16.70 to process a non-medical denial claim; whereas it costs $519 per claim if the case is sent to a DDS for a medical determination. Reminding staff to deny a claim because the individual does not meet the non-medical eligibility factors so the Agency only incurs a cost of $16.70 instead of sending the case to the DDS for a medical decision at a cost of $519 is fiscally responsible—especially since the time to issue such reminders is minimal.[13]

We initially held a meeting with SSA on June 21, 2011, at the start of our audit, to discuss our audit objective and methodology. At that time, no one from SSA raised any concern about our sample size or methodology. On September 14, 2011, we issued the discussion draft report to SSA and met with Agency staff on September 22, 2011 to discuss it. At that time, no one—including the employees from SSA's Office of Quality Performance—raised any concern about the statistical method used for this review.

Also, although an invitation for the September 22nd meeting was sent to the Office of the Chief Actuary, no one from the Actuary's office attended. On November 1, 2011, SSA contacted us and inquired about the projection upper and lower limits in Appendix B of the report. We answered SSA's question on that same day and informed SSA staff that if they had ". . . any further questions . . . to contact our statistician . . . ." SSA did not contact us further with any concerns with the statistical methods used in our audit until it provided written comments to the draft report on December 23, 2011. These comments are in Appendix C.

We offer the following information to address SSA's specific comments on the statistical methods we used in our audit work.

- Our statistical methods, policies, and procedures were sound and followed standard protocol.

- The Agency expressed concern that the sample sizes used were unnecessarily small. For this review, we randomly sampled 250 individuals from our first

[13] Between 1997 and 2011, the OIG made 82 recommendations in 68 reports that involved reminding staff of current Agency policy. SSA agreed with all 82 recommendations, issued 77 reminders (24 were released before we issued our final reports) and, as of January 2012, planned to issue 5 reminders.

population of 19,395 and 50 individuals from a second population of 519 to determine whether these individuals needed a medical determination of disability. Our finding rate was of critical importance. For our first sample, 93 (37 percent) of the 250 individuals did not need a medical determination of disability. For 17 (34 percent) of the 50 individuals in our second sample, this also held true. With such high finding rates from randomly selected samples, large sample sizes were unnecessary. Our analysis showed that over one-third of the individuals in both our samples received medical determinations but did not meet the non-medical criteria for SSI.

- Our findings were reliable, and a larger sample size would not have provided more reliable results. The Agency requested sample sizes that allow for reporting at the 95-percent confidence level. Our current standards are, and have been for over a decade, to report at the 90-percent confidence level. Furthermore, other Federal agencies use the 90-percent confidence level for reporting purposes. For example, the Department of Health and Human Services' OIG used the 90-percent confidence level and a sample of 100 for a population of 17,640. In another example, the Treasury Inspector General for Tax Administration used the 90-percent confidence level and a sample of 296 for a population of 222,509.

- The Agency was concerned about the information displayed in the tables in the body of the report. We did not report the margin of error in Tables 1 and 2, as these tables illustrated the various reasons for denial for the sampled claims with an unnecessary medical determination (the 93 and 17 cases). We did not provide any projections or estimation of these reasons; rather, we provided the reader a detailed analysis of the denials. Based on SSA's concerns, we added notes to Tables 1 and 2 to more clearly indicate that the information in the tables is the detail of our actual sample cases. Attempting to apply statistical significance to each of these reasons would have been erroneous, as we were only showing the make-up of the 93 and 17 cases, respectively, in the tables. Failure to share these reasons with the reader and Agency would have been a disservice, as they can assist policymakers as they attempt to address this issue.

- We reported the margins of error with our projection lower and upper limits in Tables B-2, B-3, B-5, and B-6 in Appendix B. In the future, we plan to continue reporting this detailed statistical information in the appendices of our reports and will include this information in the body of the report, when appropriate.

- The Agency was concerned with the calculation of the total cost of unnecessary medical determinations. To arrive at our figure of approximately $3.8 million, we multiplied the point estimates of our two attribute projections by the FY 2009 average medical determination cost figures. We explained in detail in Appendix B the steps taken to develop our estimate.

- Under Government Auditing Standards, we are required to have a peer review at least once every 3 years. Since SSA became an independent agency in 1995, we have had a peer review performed by another OIG within every 3-year period and no concerns have been raised with our sampling methodologies.

Patrick P. O'Carroll, Jr.

Appendices

APPENDIX A – Acronyms

APPENDIX B – Scope, Methodology, and Sample Results

APPENDIX C – Agency Comments

APPENDIX D – OIG Contacts and Staff Acknowledgments

Acronyms

AFI	Access to Financial Institutions
ALJ	Administrative Law Judge
CY	Calendar Year
DDS	Disability Determination Services
DDSQ	Disability Determination Services Query
FY	Fiscal Year
OAct	Office of the Chief Actuary
OIG	Office of the Inspector General
ORS	Online Retrieval System
POMS	Program Operations Manual System
SSA	Social Security Administration
SSI	Supplemental Security Income
SSR	Supplemental Security Record
U.S.C.	United States Code

Scope, Methodology, and Sample Results

To achieve our objective, we:

- Reviewed applicable sections of the *Social Security Act* and the Social Security Administration's (SSA) regulations, rules, policies, and procedures.
- Reviewed prior Office of the Inspector General reports.
- Obtained a file of Supplemental Security Income (SSI) only claims with a medical determination made by the disability determination services (DDS) in Calendar Year (CY) 2009 that appeared to have been non-medically denied. From this file, we identified 19,395 claimants whose claims appeared to have been unnecessarily sent to the DDS.
    - ✓ Selected a random sample of 250 cases for detailed review.
    - ✓ For each case, we reviewed SSA's systems, including the Supplemental Security Record (SSR), Disability Determination Services Query (DDSQ), and the Online Retrieval System (ORS) to determine whether the claims should have been non-medically denied instead of being sent to the DDS for a medical determination.
- Obtained a file of SSI-only claims with medical decisions made by an administrative law judge (ALJ) in CY 2009 that appeared to have been non-medically denied. From this file, we identified 519 claimants whose claims appeared to have been unnecessarily sent to an ALJ.
    - ✓ Selected a random sample of 50 cases for detailed review.
    - ✓ For each case, we reviewed SSA's systems, including the SSR, DDSQ, and ORS to determine whether the claims should have been non-medically denied instead of being sent to an ALJ for a medical decision.
- Obtained the average cost per case for DDS determinations and ALJ decisions.
- Obtained the number of SSI disability claims denied without being sent to the DDS in 2009.
- Obtained the SSA field office average cost to process a non-medical denial in 2009.

We conducted our audit between June and August 2011 in Boston, Massachusetts. The entity audited was SSA's field office staff under the Office of the Deputy Commissioner for Operations. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we

plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We tested the data obtained for our audit and determined them to be sufficiently reliable to meet our objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

SAMPLE RESULTS

Table B-1: Population and Sample Size: DDS Cases	
Population size	19,395
Sample size	250

Table B-2: SSI Claims with Unnecessary Determinations Made by the DDS	
Attribute Projections	
Sample cases	93
Point estimate	7,215
Projection lower limit	6,233
Projection upper limit	8,240

Note: All projections were calculated at the 90-percent confidence level.

Table B-3: SSI Claims Unnecessarily Referred to the DDS	
Attribute Projections	
Sample cases	89
Point estimate	6,905
Projection lower limit	5,935
Projection upper limit	7,924

Note: All projections were calculated at the 90-percent confidence level.

Table B-4: Population and Sample Size - ALJ Cases	
Population size	519
Sample size	50

Table B-5: SSI Claims with Unnecessary Decisions Made by an ALJ	
Attribute Projections	
Sample cases	17
Point estimate	176
Projection lower limit	122
Projection upper limit	238

Note: All projections were calculated at the 90-percent confidence level.

Table B-6: SSI Claims Unnecessarily Referred to an ALJ	
Attribute Projections	
Sample cases	14
Point estimate	145
Projection lower limit	95
Projection upper limit	206

Note: All projections were calculated at the 90-percent confidence level.

To calculate the amount spent on unnecessary referrals, we took the point estimate projected from the number of cases unnecessarily referred and multiplied it by the average cost to make a medical determination. The total estimated amount SSA spent on unnecessary referrals in 2009 was $3,753,490. This consisted of $3,583,695 spent on unnecessary referrals to the DDS and $169,795 spent on unnecessary referrals to an ALJ.

- For the unnecessary referrals to the DDS, we multiplied the point estimate of 6,905 (in Table B-3) by $519, the average cost for the DDS to process a medical determination in FY 2009.

- For the unnecessary referrals to an ALJ, we multiplied the point estimate of 145 (in Table B-6) by $1,171, the average cost for an ALJ to make a medical decision in FY 2009.

Agency Comments

SOCIAL SECURITY

MEMORANDUM

Date: December 23, 2011 Refer To: S1J-3

To: Patrick P. O'Carroll, Jr.
Inspector General

From: Dean S. Landis /s/
Deputy Chief of Staff

Subject: Office of the Inspector General Draft Report, "Unnecessary Medical Determinations for Supplemental Security Income Disability Claims" (A-01-10-20120)—INFORMATION

Thank you for the opportunity to review the draft report. Please see our attached comments.

Please let me know if we can be of further assistance. You may direct staff inquiries to Frances Cord, at (410) 966-5787.

Attachment

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL (OIG) DRAFT REPORT, "UNNECESSARY MEDICAL DETERMINATIONS FOR SUPPLEMENTAL SECURITY INCOME DISABILITY CLAIMS" (A-01-10-20120)

GENERAL COMMENTS

We offer several comments on the statistical methods used in this audit that are generally applicable to all OIG audits. Statistical analyses should follow standard protocol, including:

- Selecting sufficient sample sizes to allow for statistically sound findings;
- identifying confidence intervals, margins of error, and the associated statistical significance of reported findings;
- confirming that the study sample is representative of the population studied; and,
- stating whether any extrapolation from the sample to the overall study population is sound and reliable.

In addition to these issues, which relate to statistical sampling and reporting procedures, failure to identify or address data quality and reliability issues can significantly affect the reported results.

Both the Office of Quality Performance (OQP) and the Office of the Chief Actuary (OCACT) reviewed this report and found the presentation to be incomplete and potentially misleading. First, the sample sizes used were unnecessarily small. As you are aware, a small sample size results in a greater margin of error for the findings (a wider confidence interval) for any selected level of confidence (90 or 95 percent). For example, using standard formulae for calculating minimum sample sizes, the 19,395 population of disability determination services (DDS) cases using the sample size of 250 is consistent with a 5.2 percentage-point margin of error, assuming a 90 percent level of confidence. For the 519 population of Administrative Law Judge cases, the sample size of 50 is consistent with an 11.1 percentage-point margin of error, assuming a 90 percent level of confidence. Using a larger sample size for either of these cohorts would result in more reliable findings with less margin of error. For future reports, we urge OIG to use adequate sample sizes that will produce results consistent with a level of confidence not less than 95 percent.

A major shortcoming of the report concerns the information displayed in the tables found in the body of the report. These tables do not identify the margin of error in the results, thereby seemingly implying that the results are valid. In Table 1, found on page 4 of the draft report, the 90 percent confidence interval may be as wide as ***plus or minus 13 cases***. The table fails to cite this critical piece of information, and even includes several results that are below or near the margin of error. Specifically, the number of cases cited for *Fugitive Felon Status*, and *In a Public Institution* in Table 1, 4 cases and 1 case respectively, are not significantly different from 0 for statistical purposes. A similar argument applies to the 14 cases in the *Not a Citizen or Qualified Alien* column. For Table 2, found on page 7 of the draft report, each number would be about plus or minus 5.5 cases for the same confidence interval, resulting in two of the categories (*Not a Citizen or Qualified Alien* and *In a Public Institution*) to be statistically insignificant. The remaining two categories, each of which contains 7 cases, border the margin of error. While you

reflect these margins of error with the projection lower and upper limits in Appendix B in Tables B-2, B-3, B-5, and B-6, it is potentially misleading to exclude this critical information from the body of your report. It is also misleading to represent as findings numbers of cases that fall well within the margins of error in your studies.

You also calculate the total cost of the unnecessary medical determinations for the 7,391 Supplemental Security Income claims. Unfortunately, presenting that information without acknowledging the margin of error in both dollars and the number of cases represents an incomplete and statistically unreliable analysis.

We urge you to apply sound statistical principles so that future reports fully disclose all relevant information, are statistically sound, and offer a reliable and thorough analysis of the issues under consideration. IG could remedy most of the issues we raise by using larger sample sizes in your studies and by fully disclosing in the body of the report the margins of error for the data you present. We will continue to consult with OCACT during our review of future reports containing statistical analyses and will raise similar objections in the future as needed.

RESPONSE TO RECOMMENDATION

Recommendation

The Social Security Administration should remind staff to process non-medical denials for SSI claims that do not meet requirements before referring to the DDS.

Response

We disagree. In 2009, we correctly referred 99.7 percent of our cases to the DDSs for a medical decision. Because of our high level of accuracy, we do not believe a reminder is necessary at this time.

SOCIAL SECURITY

MEMORANDUM

Date: January 23, 2011 Refer To: S1J-3

To: Patrick P. O'Carroll, Jr.
Inspector General

From: Dean S. Landis
Deputy Chief of Staff

Subject: Office of the Inspector General Draft Report, "Unnecessary Medical Determinations for Supplemental Security Income Disability Claims" (A-01-10-20120)—INFORMATION

Thank you for the opportunity to review your rebuttal to our December 23, 2011 comments. We shared your comments with the Chief Actuary and include his response below. However, we would first like to address two issues raised in your rebuttal.

First, you state that your limited sampling was due to a "constrained resource environment." While we understand the need to find the proper balance between competing workloads during periods of limited budgets, we do not believe "constrained resource[s]" are a sufficient justification for the limited sampling done in this audit. Focusing our resources on the most significant issues, and conducting more thorough and statistically sound analyses on those issues, better serves both the Inspector General (IG) and the agency.

Second, you highlight that the Office of the Chief Actuary (OAct) did not attend either the entrance or exit conference for this audit. OAct is not always able to attend the numerous entrance and exit conferences due to the press of other work. We assume that your own statisticians do not attend the entrance and exit conferences to explain the statistical methodology used in your analyses for similar reasons. To alleviate these concerns, we request that you provide written sampling plans that clearly describe the statistical methodology used in the study earlier in the audit process. We will share them with OAct and review them prior to providing written comments.

In response to your most recent comments, the Chief Actuary provided the following remarks:

> The IG concludes that the Social Security Administration (SSA) has a 99.3 percent accuracy rate in referring cases to the Disability Determination Services (DDS) for medical determinations where SSA asserts a 99.7 percent accuracy rate. Your estimate that SSA referred 7,931 cases inappropriately is subject to a considerable margin of uncertainty because you based this estimate on a relatively small sample of cases, and, therefore, it is difficult to conclude that these accuracy rates are materially different. In any case, an accuracy rate greater than 99 percent would be very good considering the often complex and subjective judgments involved in disability determinations. The estimated $3.8 million in additional administrative expense is also subject to a large range of uncertainty. While we agree there will always be inaccuracies in making referrals to the DDS, the accuracy of these referrals indicated here would seem not only reasonable but also commendable.
>
> In the second bullet on the bottom of page 9 of the draft report, the IG acknowledges that " ... a small sample size results in greater margin of error ... " and we agree with this point. However, in the first bullet on page 1 0, you seem to contradict this statement, asserting, "a larger sample size would not have provided more reliable findings." Since these statements are contradictory, we recommend clarification.
>
> In the second bullet on page 10, the IO suggests that indicating the margin of error for tables 1 and 2 would have been erroneous. We disagree. Providing a statistically valid margin of error for the distributions of sample cases by reason of inappropriate referral for a medical review could only serve to assist the reader in interpreting the values in the tables. While the distributions shown are clearly exact for the small samples used, the implication is that these distributions would apply to the broader universe of cases. It would be helpful to indicate the margin of uncertainty for these values as estimated for the distribution for the entire universe of cases.
>
> In the third bullet on page 10, you indicate that the margin of error is shown in Appendix B. However, we suggest that you disclose equivalent information about the margin of error in tables 1 and 2, and also on page 3, where you present the estimated percentage of cases you find referred inappropriately.
>
> In the final bullet on page 10, you indicate that showing margin of error at a 90-percent level of confidence is adequate per Government Accountability Office standards. While we prefer a stricter level of confidence at 95 percent, we would not object to the 90-percent level of confidence if clearly indicated. Fully informing the reader of the limitations of the data is very important.

OIG Contacts and Staff Acknowledgments

OIG Contacts

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Acknowledgments

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