SOCIAL SECURITY

Office of the Inspector General

MEMORANDUM

Date: September 20, 2001

Refer To: ICN 31263-23-222

To: Larry G. Massanari
Acting Commissioner
of Social Security

From: Inspector General

Subject: Fees Paid by State Disability Determination Services to Purchase Consultative Examinations (A-07-99-21004)

The attached final report presents the results of our audit. Our objectives were to review the fees paid by State Disability Determination Services to purchase consultative examinations and to compare those fees to Medicare fees for the same or similar type of service.

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

James G. Huse, Jr.

Attachment

OFFICE OF
THE INSPECTOR GENERAL

SOCIAL SECURITY ADMINISTRATION

FEES PAID BY STATE DISABILITY DETERMINATION SERVICES TO PURCHASE CONSULTATIVE EXAMINATIONS

September 2001 **A-07-99-21004**

AUDIT REPORT

Mission

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

Authority

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

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

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

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

Vision

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

Executive Summary

OBJECTIVE

Our objectives were to review the fees paid by State Disability Determination Services (DDS) to purchase consultative examinations (CE) and to compare those fees to Medicare fees for the same or similar type of service.

BACKGROUND

Each State's DDS performs disability determinations under the Social Security Administration's (SSA) Disability Insurance (DI) and Supplemental Security Income (SSI) programs in accordance with Federal regulations. DDSs are responsible for obtaining adequate medical evidence to support disability determinations. In doing so, DDSs may purchase CEs to supplement the medical evidence of record obtained from claimants' treating sources. CEs may include medical and psychological examinations, x-rays, and laboratory tests.

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), administers the Medicare program. Medicare provides health insurance to approximately 39 million Americans including people who are age 65 and over, those who have permanent kidney failure, and certain people with disabilities. Medicare is the largest single purchaser of medical services in the world.

Medicare reimburses health care providers for medical services based on fees adjusted for geographical differences in costs. This adjustment allows for the establishment of individual State Medicare fee schedules for medical examinations, laboratory tests, and radiological services within each State. CMS updates the Medicare fee schedules annually to account for changes in medical practice.

RESULTS OF REVIEW

Our audit disclosed that SSA had limited involvement in establishing the fees paid by State DDSs to purchase CEs. Federal regulations allow each DDS to establish its rate of payment for purchasing CEs. The rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar type of service.

Our audit focused on controlling the costs of individual CEs by limiting payment amounts for CEs to Medicare fees. For five DDSs (Illinois, Kansas, Iowa, Wisconsin, and Delaware), we identified the CEs that accounted for 75 percent of the total dollars expended by the DDSs during Calendar Year (CY) 1998 for non-psychological CEs. For these 91,122 CEs, we compared the DDS' CE payment amounts to Medicare's fees for the same or similar service. For 66,220 of the 91,122 CEs, our audit disclosed that the DDS' fees exceeded Medicare fees by approximately $2.4 million. The Illinois DDS accounted for $2 million of these potential savings. For 24,902 of the 91,122 CEs analyzed, the DDS' fees were $317,389 less than Medicare fees. We commend the

DDSs for purchasing these CEs at fees less than those allowed by Medicare. The DDSs should continue their efforts to negotiate with medical providers to obtain the lowest prices available for CEs.

Our audit also disclosed that the DDS' ability to provide SSA with management data related to CEs varies. The variance exists because DDSs use different computer systems to collect CE data and SSA has not provided DDSs with uniform requirements for CE data collection. Furthermore, the use of non-uniform CE coding systems by DDSs affects their ability to provide SSA with essential management information.

Unless SSA adopts a standardized coding system, such as the American Medical Association's (AMA) coding system adopted by Medicare, its ability to obtain CEs electronically may be hindered. This will significantly affect SSA's plan for implementing the electronic disability folder. The intent of the electronic folder is to move to a totally paperless process where all disability claims information, including CEs, is electronically received and stored.

CONCLUSIONS AND RECOMMENDATIONS

SSA is projecting that disabled beneficiaries will increase to as many as 9.5 million in the next 10 years. As the volume of disability claims increases, controlling the fees paid for CEs will become increasingly important. In FY 2000, SSA recognized the need to control CE costs, initiated changes to decrease these costs, and reported that the CE purchase rate dropped by 2.2 percent. Because of the drop in the CE purchase rate, total medical costs dropped by approximately $2 per case. This represented overall savings in medical costs of $6 million. While SSA has made progress in controlling overall medical costs, there is still an opportunity for additional medical cost savings, and consequently, a need still exists to control the costs of individual CEs.

Our audit shows that SSA could reduce the costs of individual CEs by requiring DDSs to limit CE payment amounts to Medicare fees. Because the medical services provided for Medicare and DDSs are the same or very similar, we found no reason for DDSs to reimburse medical providers at fees higher than those allowed by Medicare.

To help control CE costs, we recommend that SSA:

- Conduct a CE fee study at DDSs with annual CE expenditures of approximately $10 million or more. The study should identify whether the potential cost savings at the Illinois DDS are representative of other DDSs with comparable CE expenditures and how the use of Medicare fees would affect the DDS' ability to obtain CEs. If the study identifies similar cost savings and proves that the use of Medicare fees will not adversely affect the disability programs, SSA should seek legislation requiring DDSs to use Medicare fees as the limiting CE payment amount.

- Improve its oversight of the DDS CE process by: (a) developing uniform CE data collection requirements for DDSs; (b) performing periodic evaluations of CE data collection processes at DDSs to develop best practices; and (c) encouraging DDSs to adopt the AMA's coding system for CEs.

AGENCY COMMENTS

In response to our draft report, SSA agreed with both of our recommendations. However, SSA disagreed with our assertion that medical services provided for Medicare and DDSs are the same or very similar and that there is no reason for DDSs to reimburse medical providers at fees higher than those allowed by Medicare. (See Appendix D for the full text of SSA's comments to our report.)

OIG RESPONSE

In its comments, SSA noted four reasons to support DDSs reimbursing medical providers at fees higher than those allowed by Medicare. As part of the CE fee study that SSA has agreed to conduct, the Agency should be able to determine how the use of Medicare fees would affect DDSs' ability to obtain CEs and whether valid reasons do exist for reimbursing medical providers at fees higher than those allowed by Medicare.

Table of Contents

Acronyms

AMA	American Medical Association
CE	Consultative Examination
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
DDS	Disability Determination Services
DI	Disability Insurance
EDI	Electronic Data Interchange
FY	Fiscal Year
HHS	Department of Health and Human Services
MER	Medical Evidence of Record
OD	Office of Disability
SSA	Social Security Administration
SSI	Supplemental Security Income

Introduction

OBJECTIVE

Our objectives were to review the fees paid by State Disability Determination Services (DDS) to purchase consultative examinations (CE) and to compare those fees to Medicare fees for the same or similar type of service.

BACKGROUND

State DDSs

Each State's DDS performs disability determinations under the Social Security Administration's (SSA) Disability Insurance (DI) and Supplemental Security Income (SSI) programs in accordance with the Social Security Act, Federal regulations, and other written guidelines. DDSs are responsible for obtaining adequate medical evidence to support the disability determinations. In doing so, DDSs may purchase CEs[1] to supplement the medical evidence of record (MER)[2] obtained from claimants' treating sources. SSA reimburses DDSs for 100 percent of allowable expenditures.

Medicare

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS)[3] administers the Medicare program. Medicare provides health insurance to approximately 39 million Americans including people who are age 65 and over, those who have permanent kidney failure, and certain people with disabilities. Medicare is the largest single purchaser of medical services in the world.[4]

In January 1992, Medicare began a new payment system for physicians' services. This new payment system was in response to a rapid escalation of medical costs, and was implemented to provide equity and consistency in payments to all physicians.[5] Medicare's payment system reimburses health care providers for medical services based on fees adjusted for geographical differences in costs. This adjustment allows

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

[2] MER includes copies of laboratory reports, prescriptions, x-rays, ancillary tests, operative and pathology reports, consultative reports, and other technical information.

[3] CMS was formerly named the Health Care Financing Administration.

[4] The Department of Health and Human Services' Inspector General's February 17, 2000 testimony before the House Committee on the Budget.

[5] Committee on Ways and Means, United States House of Representatives, The 1996 Green Book, 15th Edition, Appendix E, Medicare Reimbursement to Physicians.

for the establishment of individual State Medicare fee schedules for medical examinations, laboratory tests, and radiological services within each State. CMS updates the Medicare fee schedules annually to account for changes in medical practice.[6]

SCOPE AND METHODOLOGY

To accomplish our objectives we:

- Reviewed pertinent sections of the Social Security Act, the Code of Federal Regulations, and SSA's Program Operations Manual System;
- Reviewed the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT) 1998 Handbook, SSA's Disability Evaluation Under Social Security, and SSA's CE Guide for Health Professionals;
- Gained an understanding of Medicare's payment system for reimbursing health care providers for medical services;
- Randomly selected 10 DDSs for on-site field work and obtained electronic data files of CE payments made during Calendar Year (CY) 1998 (see Appendix A);
- Analyzed CE cost information for the 54 DDSs for Fiscal Years (FY) 1994 through 1998 obtained from SSA's Office of Disability (OD) (see Appendix B);
- Obtained the individual State Medicare fee schedules for CY 1998 for the 10 randomly selected State DDSs;
- Compared CE payment amounts in the electronic data files obtained from the 10 DDSs to the CE payment amounts reported to SSA on the Report of Obligations (Form SSA-4513) to validate the completeness of the data;
- Compared CE payments made by 5 of the 10 randomly selected DDSs to Medicare fee schedules (see Appendix C); and
- Administered a questionnaire to the 48 continental United States DDSs to obtain information on CE fees.[7]

[6] Committee on Ways and Means, United States House of Representatives, The 1996 Green Book, 15th Edition, Appendix E, Medicare Reimbursement to Physicians.

[7] We excluded the Hawaii, Alaska, District of Columbia, Puerto Rico, Guam, and Virgin Islands DDSs.

We conducted our audit field work between March 1999 and March 2001 in Kansas City, Missouri. The entities reviewed were the State DDSs and OD under the Deputy Commissioner for Disability and Income Security Programs. We conducted our audit in accordance with generally accepted government auditing standards.

Results of Review

Our audit disclosed that SSA had limited involvement in establishing the fees paid by State DDSs to purchase CEs. Federal regulations allow each DDS to establish its rate of payment for CEs. We found that SSA could reduce the costs of individual CEs by requiring DDSs to limit CE payment amounts to Medicare fees. In fact, during CY 1998, SSA could have saved approximately $2.4 million if they had used Medicare's fees as the limiting CE payment amount.

Our audit also disclosed that the DDS' ability to provide SSA with management data related to CEs varies. The variance exists because DDSs use different computer systems to collect CE data and SSA has not provided DDSs with uniform requirements for CE data collection. Furthermore, the use of non-uniform CE coding systems by DDSs affects their ability to provide SSA with essential management information.

RATES OF PAYMENT FOR CEs

A DDS's rate of payment for a CE may not exceed the highest rate paid by the Federal or other agencies in the State for the same or similar types of service.[8] We administered a questionnaire to the 48 continental United States DDSs to find out how they derive their CE fees. We found that DDSs use various and multiple sources when establishing CE fees.[9]

- Twenty-five percent of DDSs use some CE fees established by Medicaid.
- Thirty-nine percent of DDSs use some CE fees established by Medicare.
- Fifty-two percent of DDSs use some CE fees established by their parent State agency.
- Thirty-three percent of DDSs pay usual and customary charges for some CEs.

[8] 20 C.F.R. §§ 404.1624 and 416.1024

[9] The DDSs use multiple sources to establish their CE fee schedules; therefore, a DDS can fall into multiple categories resulting in the percentages adding to more than 100 percent.

INCREASED CE COSTS

SSA has experienced increased CE costs over the past several years. From FY 1994 to FY 1998, the average CE cost per claim[10] increased by approximately 14 percent.

FY	CE Cost Per Claim
1994	$159
1995	$162
1996	$171
1997	$173
1998	$181

We found that 45 of the 54 DDSs experienced increased CE costs from FY 1994 to FY 1998. We requested 15 of the 45 DDSs[11] to explain why CE costs increased. We selected these DDSs because their average CE costs rose by twice the amount of the national average. The DDSs attributed increased CE costs to various reasons including:

- Increased CE fees;
- Increased continuing disability reviews which resulted in additional CEs;
- Increased SSI claims which require additional CEs;
- Additional multiple impairments alleged on claims which require more CE purchases;
- High DDS examiner attrition rates resulting in less-experienced examiners who request more CEs.

COMPARISON OF DDS AND MEDICARE FEES

For five DDSs, we examined 91,122 CEs accounting for 75 percent of the total CE dollars expended for non-psychological examinations by the DDSs during CY 1998. For these 91,122 CEs, we compared the DDS' payment for the CEs to Medicare fees for the same or similar service. For 66,220 of the 91,122 CEs, the DDS' fees exceeded Medicare fees by $2.4 million. Therefore, SSA could have saved approximately $2.4 million by using Medicare fees as the limiting payment amount (see Appendix C).

[10] The average CE cost per claim represents the total CE costs divided by the total number of CEs purchased for all claims processed.

[11] The 15 DDSs were: Connecticut, Maine, Delaware, Georgia, North Carolina, Illinois, Louisiana, Utah, New Mexico, Wisconsin, Kentucky, Indiana, Hawaii, Massachusetts, and Oregon.

For 24,902 of the 91,122 CEs, the DDS' fees were $317,389 less than Medicare fees (see Appendix C). We commend the DDSs for purchasing these CEs at fees less than those allowed by Medicare. The DDSs should continue their efforts at negotiating with medical providers to obtain the lowest price for CEs.

The Illinois DDS

Our analysis of CE expenditures at the five DDSs showed that SSA could have saved $2.4 million during CY 1998 by using Medicare fees as the limiting payment amount. The Illinois DDS accounted for $2 million of these potential savings. The potential cost savings at the Illinois DDS may be greater because the DDS pays an additional fee to obtain the written report of the CEs. During CY 1998, the DDS paid approximately $1.6 million for CE reports.[12]

The Illinois DDS was the only DDS in our analysis with CE expenditures that exceeded $10 million during CY 1998.[13] Given the significance of the potential cost savings we identified at the Illinois DDS, the SSA should determine whether similar cost savings could be realized at DDSs with comparable CE expenditures. SSA should also determine how the use of Medicare fees would affect its disability programs. This audit did not determine the impact that the use of Medicare fees as the limiting CE payment amount would have on the DDS' ability to obtain CEs.

Difference In DDS and Medicare Fees

Because the medical services provided for Medicare and DDSs are the same or very similar, we found no reason for DDSs to reimburse medical providers at fees higher than those allowed by Medicare. The one notable difference we found related to DDSs requesting information from CE providers in addition to the results of the CE. For example, DDSs will ordinarily request from CE providers a statement on the claimant's ability to perform work-related activities as well as other written reports on specific questions. DDSs use this statement to assist in making a residual functional capacity determination. Medicare does not require this statement; therefore, it is not part of Medicare fees. As such, DDSs should provide reasonable compensation to the CE provider for completing the statement. If Medicare fees are adopted by DDSs as the limiting CE payment amount, SSA should consider compensating medical providers for information requested in addition to the results of the CE separately from the cost of the CE. This would allow SSA to monitor the cost and benefit of the additional documentation requirements, while allowing comparability to Medicare for the specific CE requested. Since the DDSs' do not identify the cost of the additional documentation separately, we could not determine what impact, if any, such costs might have on the results of our testing.

[12] Of the five DDSs in our review, the Illinois DDS was the only one that paid a separate fee for the CE report.

[13] The DDSs with FY 1998 CE expenditures exceeding $10 million included California, New York, Texas, Ohio, Florida, Michigan, and Georgia.

THE ABILITY OF DDSs TO PROVIDE CE MANAGEMENT DATA

Our audit disclosed that the DDS' ability to provide SSA with management data related to CEs varies. This variance exists because DDSs use different computer systems to collect CE data and SSA has not provided DDSs with uniform requirements for CE data collection. Furthermore, the use of non-uniform CE coding systems by DDSs affects their ability to provide SSA with essential management information.

DDS Computer Systems

The DDSs use multiple, disparate and incompatible computer systems and software to process disability claims. The 54 DDSs support a variety of software programs.[14] We found that the ability of DDSs to provide information and the type of information DDSs can provide varies and this presented us with several problems in collecting and analyzing CE data for this audit. SSA staff will have these same problems in reviewing CE data.

SSA's Oversight of CE Collection

SSA has not provided DDSs with uniform CE data collection requirements. As such, DDSs choose what information is collected resulting in inconsistent information being collected at DDSs. For example, during our review of 10 randomly selected DDSs, we found 3 DDSs were unable to provide information for individual CE costs (See Appendix A). This occurred because the DDSs batch multiple CEs for a claimant into one record, with a single CE cost recorded. Therefore, we question how, or if, the DDSs and SSA determine whether individual CEs are routinely purchased for more than the established CE fee.

Uniform Coding System

The DDSs use different coding systems to identify CEs. Adoption of a standardized CE coding system, like the AMA coding system used by Medicare, would improve SSA's and the DDSs' ability to monitor CE costs and provide a mechanism for comparison against fees paid by other government agencies. Presently, approximately 65 percent of the continental United States DDSs use the AMA coding system to some extent.

The Health Insurance Portability and Accountability Act of 1996,[15] required HHS to adopt national standards for Electronic Data Interchange (EDI) formats for health care information transactions, as well as code sets for use in those transactions. Code set means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes.

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

[15] Public Law No. 104-191

Unless SSA adopts a standardized coding system, such as the AMA coding system adopted by Medicare, SSA's ability to obtain CEs electronically may be hindered. This will significantly affect SSA's plan for the electronic disability folder. The intent of the electronic folder is to move to a totally paperless process where all disability claims information, including CEs, is electronically received and stored. Furthermore, SSA's adoption of the health care industry's standards for electronic transactions, including the AMA coding system, would improve its ability to obtain management data on the CE process.

Conclusions and Recommendations

SSA projects that disability beneficiaries will increase to as many as 9.5 million in the next 10 years. As the volume of disability claims increases, controlling the fees paid for CEs will become increasingly important. In FY 2000, SSA recognized the need to control CE costs, initiated changes to decrease these costs, and reported that the CE purchase rate dropped by 2.2 percent. Because of the drop in the CE purchase rate, total medical costs dropped by approximately $2 per case. This represented overall savings in medical costs of $6 million. While SSA made progress in reducing overall medical costs, a need still exists to control the costs of individual CEs.

Our review shows that SSA could reduce the costs of individual CEs by requiring DDSs to limit CE payment amounts to Medicare fees. Because the medical services provided for Medicare and DDSs are the same or very similar, we found no reason for DDSs to reimburse medical providers at fees higher than those allowed by Medicare.

Furthermore, SSA may not be able to obtain CEs electronically from medical providers unless it adopts a uniform CE coding system such as the AMA coding system adopted by Medicare. A uniform CE coding system used by all DDSs will become increasingly important for SSA oversight of the disability determination process. DDS utilization of electronic transmission standards would provide many benefits, such as:

- Allowing DDSs to obtain medical information faster and more cost efficiently;
- Assisting in SSA's migration to a paperless environment; and
- Allowing easier comparison of DDS CE rates to the Medicare rates paid for similar services.

To help control CE costs, we recommend that SSA:

1. Conduct a CE fee study at DDSs with annual CE expenditures of approximately $10 million or more. The study should identify whether the potential cost savings at the Illinois DDS are representative of other DDSs with comparable CE expenditures and how the use of Medicare fees would affect DDS' ability to obtain CEs. If the study identifies similar cost savings and proves that the use of Medicare fees will not adversely affect the disability programs, SSA should seek legislation requiring DDSs to use Medicare fees as the limiting CE payment amount.

2. Improve its oversight of the DDS CE process by: (a) developing uniform CE data collection requirements for DDSs; (b) performing periodic evaluations of CE data collection processes at DDSs to develop best practices; and (c) encouraging DDSs to adopt the AMA's coding system for CEs.

AGENCY COMMENTS

In response to our draft report, SSA agreed with both of our recommendations. However, SSA disagreed with our assertion that medical services provided for Medicare and DDSs are the same or very similar and that there is no reason for DDSs to reimburse medical providers at fees higher than those allowed by Medicare. (See Appendix D for the full text of SSA's comments to our report.)

OIG RESPONSE

In its comments, SSA noted four reasons to support DDSs reimbursing medical providers at fees higher than those allowed by Medicare. As part of the CE fee study that SSA has agreed to conduct, the Agency should be able to determine how the use of Medicare fees would affect DDSs' ability to obtain CEs and whether valid reasons do exist for reimbursing medical providers at fees higher than those allowed by Medicare.

Appendices

Appendix A

Sampling Methodology and Data Analysis

Sampling Methodology

To complete our objectives, we randomly selected 10 Disability Determination Services (DDS) to provide electronic data of consultative examination (CE) payments issued during the period of January 1, 1998, through December 31, 1998. The 10 DDSs were Arizona, Delaware, Illinois, Massachusetts, New York, North Carolina, South Dakota, Tennessee, Virginia, and Wisconsin.

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

Accordingly, we obtained electronic data on CE payments from the Delaware, Illinois, Iowa, Kansas, Massachusetts, North Carolina, Oklahoma, Utah, Virginia, and Wisconsin DDSs. However, additional difficulties with the electronic data resulted in our inability to use files received from the Massachusetts, North Carolina, Oklahoma, Utah, and Virginia DDSs. The files received from the Massachusetts and Virginia DDSs were not complete files of all CE payments. The North Carolina, Oklahoma and Utah DDSs batch CE payments and we were unable to identify individual CE payments.

Data Analysis

We concentrated our review on CE payments for non-psychological examinations. We identified the DDS's Current Procedural Terminology (CPT) codes that represented non-psychological examinations. We then selected the CPT codes with the most expenditures until we reached 75 percent of the individual DDS's total expenditures for non-psychological CEs.

Although Medicare uses the American Medical Association's (AMA) CPT coding system, DDSs are not required to code CEs using this standard. As a result, to compare DDS and Medicare fees, the CPT codes used by DDSs had to be cross-walked[1] to the applicable AMA CPT. We contacted each DDS for assistance in cross-walking the codes we selected for our review.[2]

[1] Cross-walk refers to the process of converting the DDS code for an examination to the Medicare code for the same or similar examination.

[2] The Delaware DDS was not willing to provide assistance in cross-walking the CPT codes therefore; we performed the cross-walk without the DDS's assistance.

Using the AMA CPT codes provided by the DDS, we determined the maximum Medicare fee amounts. We also calculated the average amount the DDSs paid for CEs for each of the CPT codes included. We then compared this average to the maximum Medicare fee amount, and calculated any differences. Next, we multiplied the difference by the number of CEs the DDS purchased. This resulted in the amount the DDS would have saved if they had purchased CEs using the Medicare fee schedule amount (see Appendix C).

Appendix B

Disability Determination Services (DDS) Average Consultative Examination (CE) Cost Per Disability Claim for Fiscal Years (FY) 1994 through 1998

CE COST PER DISABILITY CLAIM AVERAGES						
Region/State DDS	**FY 1994**	**FY 1995**	**FY 1996**	**FY 1997**	**FY 1998**	**Average Increase or (Decrease)**
National	**$159.02**	**$161.62**	**$171.36**	**$172.58**	**$180.88**	**13.75%**
Region I	**155.41**	**162.99**	**177.27**	**164.24**	**177.13**	**13.98%**
Connecticut	144.47	182.30	201.47	160.14	204.20	41.34%
Maine	190.21	162.57	192.68	167.09	269.41	41.64%
Massachusetts	157.81	148.25	159.09	156.28	140.21	-11.15%
New Hampshire	162.80	180.89	207.46	203.24	182.79	12.28%
Rhode Island	156.17	189.38	156.02	196.69	191.27	22.48%
Vermont	105.41	110.17	108.67	109.87	107.77	2.24%
Region II	**180.91**	**178.28**	**172.30**	**181.29**	**189.79**	**4.91%**
New Jersey	195.51	212.32	213.17	240.31	242.60	24.09%
New York	179.04	175.80	172.37	175.25	188.61	5.35%
Puerto Rico	162.09	141.21	123.78	145.42	132.87	-18.03%
Virgin Islands	Unavailable					
Region III	**157.94**	**169.61**	**174.14**	**183.34**	**173.39**	**9.78%**
Delaware	204.00	199.60	188.75	197.46	193.15	-5.32%
District of Columbia	198.03	183.29	207.76	211.96	251.20	26.85%
Maryland	123.63	152.34	144.02	136.48	149.77	21.14%
Pennsylvania	147.90	166.59	165.48	186.56	150.85	1.99%
Virginia	151.78	156.92	162.51	172.58	183.83	21.12%
West Virginia	213.52	204.40	237.19	231.74	255.33	19.58%
Region IV	**138.52**	**144.59**	**150.11**	**150.17**	**163.81**	**18.26%**
Alabama	129.70	132.25	131.48	136.02	137.30	5.86%
Florida	128.41	136.84	125.65	131.17	138.05	7.51%
Georgia	166.22	178.49	184.96	192.11	214.45	29.02%
Kentucky	127.13	158.91	175.73	160.59	176.84	39.10%
Mississippi	149.43	154.97	148.33	136.55	144.25	-3.47%
North Carolina	150.48	139.11	150.87	160.20	194.41	29.19%
South Carolina – Vocational	131.54	136.32	149.90	142.81	160.98	22.38%
South Carolina – Blind	62.62	61.06	45.73	61.39	37.87	-39.52%
Tennessee	136.38	130.19	161.45	152.36	157.31	15.35%

CE COST PER DISABILITY CLAIM AVERAGES						
Region/State DDS	**FY 1994**	**FY 1995**	**FY 1996**	**FY 1997**	**FY 1998**	**Average Increase or (Decrease)**
Region V	**149.29**	**146.87**	**173.52**	**179.68**	**177.85**	**19.13%**
Illinois	138.65	139.45	178.87	183.50	178.43	28.69%
Indiana	115.02	124.53	133.61	147.13	147.93	28.61%
Michigan	129.09	128.84	150.63	150.95	149.26	15.62%
Minnesota	175.63	151.32	217.25	221.56	204.87	16.65%
Ohio	193.32	181.71	201.84	212.59	206.94	7.05%
Wisconsin	154.38	154.63	185.01	195.57	221.02	43.17%
Region VI	**168.24**	**172.92**	**187.64**	**183.34**	**192.20**	**14.24%**
Arkansas	119.17	127.23	129.17	128.63	132.49	11.18%
Louisiana	123.54	125.47	159.31	150.55	167.85	35.87%
New Mexico	149.53	164.28	175.48	196.11	197.30	31.95%
Oklahoma	116.18	113.32	118.84	128.62	118.32	1.84%
Texas	230.61	236.60	248.78	238.25	244.82	6.16%
Region VII	**155.79**	**143.52**	**156.60**	**155.47**	**181.72**	**16.64%**
Iowa	163.06	172.79	201.39	201.74	254.61	56.14%
Kansas	162.17	150.77	165.20	155.93	184.86	13.99%
Missouri	154.96	134.62	145.12	142.07	166.50	7.45%
Nebraska	138.34	139.34	143.38	160.74	161.28	16.58%
Region VIII	**172.24**	**184.76**	**185.09**	**195.48**	**207.41**	**20.42%**
Colorado	165.77	174.10	168.77	178.71	161.36	-2.66%
Montana	174.48	161.04	156.10	151.44	164.32	-5.82%
North Dakota	144.46	161.09	173.02	165.71	181.52	25.65%
South Dakota	210.51	229.27	241.72	234.28	254.01	20.66%
Utah	158.33	177.70	191.23	233.22	290.22	83.30%
Wyoming	252.75	320.36	321.89	315.43	340.53	34.73%
Region IX	**173.40**	**172.17**	**177.87**	**169.69**	**179.61**	**3.58%**
Arizona	163.42	175.78	194.30	183.44	196.36	20.16%
California	168.83	168.31	173.11	163.88	174.77	3.52%
Guam	315.05	260.57	262.98	337.86	292.31	-7.22%
Hawaii	303.54	296.05	278.21	244.08	271.12	-10.68%
Nevada	237.99	227.07	255.80	295.84	249.66	4.90%
Region X	**186.32**	**203.75**	**226.73**	**230.27**	**265.37**	**42.43%**
Alaska	338.43	417.76	419.63	464.96	615.20	81.78%
Idaho	202.75	190.73	212.16	216.97	230.23	13.55%
Oregon	186.22	242.85	238.87	238.02	307.08	64.90%
Washington	172.04	175.19	204.96	205.80	215.68	25.37%

Appendix C

Disability Determination Services (DDS) Calendar Year 1998 Consultative Examination (CE) Cost Comparison to Medicare

Table C-1: Average CE Fees Paid by Five DDSs that exceeded the Medicare Fee Schedule Amount

State DDS	DDS Code	Medicare Code	DDS Average Fee	Medicare Fee	DDS Average Fee Less Medicare Fee	Number of CEs Purchased by DDS	Number of CEs Times the DDS Average Fee Less Medicare Fee
Illinois	01800	99201	$80.34	$37.71	$42.63	35,846	$1,528,114.98
Illinois	01887	99201	80.69	37.71	42.98	6,163	264,885.74
Illinois	94060	94060	94.70	70.70	24.00	6,349	152,376.00
Kansas	710100000	71010	42.34	27.06	15.28	1,123	117,159.44
Kansas	940100000	94010	91.25	32.50	58.75	1,319	77,491.25
Kansas	721000000	72100	64.83	36.42	28.41	2,198	62,445.18
Illinois	5010	92506	80.94	58.17	22.77	2,197	50,025.69
Iowa	72100	72100	84.18	35.19	48.99	742	36,350.58
Iowa	01255	97001	164.84	57.57	107.27	333	35,720.91
Iowa	94060	94060	110.53	56.71	53.82	479	25,779.78
Iowa	90622	99244	181.00	137.25	43.75	569	24,893.75
Wisconsin	T01	94060	102.10	60.64	41.46	516	21,393.36
Wisconsin	X03	72100	50.41	37.52	12.89	1,569	20,224.41
Wisconsin	16A	92506	110.36	52.43	57.93	270	15,641.10
Wisconsin	X031	72100-26	20.32	12.08	8.24	1,568	12,920.32
Wisconsin	T14	78461	860.63	247.10	613.53	18	11,043.54
Delaware	E1000	99253	118.87	110.76	8.11	1,146	9,294.06
Kansas	735600000	73560	44.56	28.14	16.42	564	9,260.88
Kansas	OPHTHOOO	92081	67.03	24.64	42.39	214	9,071.46
Kansas	735600002	73560	98.79	56.28	42.51	203	8,629.53
Wisconsin	X10	73560	55.04	28.98	26.06	309	8,052.54
Kansas	735600001	73560	46.00	28.14	17.86	425	7,590.50
Delaware	E2000	92506	177.29	55.37	121.92	48	5,852.16
Wisconsin	T05	93015	243.53	120.76	122.77	47	5,770.19
Wisconsin	X11	73560	85.67	57.96	27.71	194	5,375.74
Kansas	940102600	94010-26	22.93	16.91	6.02	657	3,955.14
Wisconsin	X01	71020	44.61	35.67	8.94	367	3,280.98
Kansas	930000000	93000	33.83	28.85	4.98	457	2,275.86
Delaware	E1050	99244	160.50	151.14	9.36	202	1,890.72
Delaware	E1400	99244	161.46	151.14	10.32	128	1,320.96
Totals						**66,220**	**$2,438,086.75**

Table C-2: Average CE Fees Paid by Five DDSs that were Below Medicare's Fees

State DDS	DDS Code	Medicare Code	DDS Average Fee	Medicare Fee	Medicare Fee Less DDS Average Fee	Number of CEs Purchased by DDS	Number of CEs Times the Medicare Fee Less DDS Average Fee
Illinois	72110	72110	47.95	60.52	12.57	8,131	102,206.67
Wisconsin	06A	99244	119.54	143.38	23.84	2,327	55,475.68
Wisconsin	01A	99244	118.42	143.38	24.96	1,627	40,609.92
Iowa	90620	99244	127.74	137.25	9.51	3,234	30,755.34
Kansas	906001104	99244	110.05	140.13	30.08	546	16,423.68
Wisconsin	08A	99244	122.45	143.38	20.93	685	14,337.05
Wisconsin	15A	99245	118.26	193.21	74.95	162	12,141.90
Kansas	906000CMC	99242	75.24	77.08	1.84	3,583	6,592.72
Kansas	906008501	99243	90.44	99.91	9.47	636	6,022.92
Kansas	906008509	99243	84.94	99.91	14.97	398	5,958.06
Kansas	906007000	99242	69.79	77.08	7.29	817	5,955.93
Kansas	906008504	99243	85.36	99.91	14.55	249	3,622.95
Iowa	90621	99244	135.21	137.25	2.04	1,714	3,496.56
Wisconsin	10A	99243 + 92082	126.49	137.2	10.71	296	3,170.16
Wisconsin	01B	99244	118.47	143.38	24.91	120	2,989.20
Wisconsin	07A	99244	124.67	143.38	18.71	157	2,937.47
Wisconsin	08C	99244	123.43	143.38	19.95	124	2,473.80
Wisconsin	01E	99244	120.27	143.38	23.11	96	2,218.56
Totals						**24,902**	**$317,388.57**

Table C-3: List of CPT Codes Reviewed and Associated Descriptions

Medicare Code	Code Description
71010	Radiologic examination, chest, single view, frontal
71020	Radiologic examination, chest, two views, frontal and lateral
72040	Radiologic examination, spine, cervical, anteroposterior and lateral
72100	Radiologic examination, spine, lumbosacral, anteroposterior and lateral
72100-26	Interpretation – LS spine X-ray, two views
72110	X-Ray, spine, lumbosacral, multiple views
73560	Radiologic examination, femur, anteroposterior and lateral views
78461	Multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination
92082	Intermediate examination
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92553	Pure tone audiometry, air and bone
92555	Speech audiometry, threshold
92556	Speech audiometry with speech recognition
93000	Electrocardiogram, routine ECG with a least 12 leads; with interpretation and report
93005	Electrocardiogram, routine ECG with a least 12 leads; tracing only, without interpretation and report
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercises, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94010-26	Spirometry interpretation
94060	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise
97001	Physical therapy evaluation
99201	Initial office visit or other outpatient services
99242	Office or other outpatient consultation
99243	Office or other outpatient consultation
99244	Office or other outpatient consultation
99245	Office or other outpatient consultation
99253	Initial inpatient consultation

Agency Comments

SOCIAL SECURITY

MEMORANDUM

Date: August 29, 2001 Refer To: S1J-3

To: James G. Huse, Jr.
Inspector General

From: Larry G. Massanari
Acting Commissioner of Social Security

Subject: Office of the Inspector General Draft Report, "Review of Fees Paid by State Disability Determination Services to Purchase Consultative Examinations" (A-07-99-21004)—INFORMATION

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

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

Attachment:
SSA Response

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL (OIG) DRAFT REPORT, "FEES PAID BY STATE DISABILITY DETERMINATION SERVICES TO PURCHASE CONSULTATIVE EXAMINATIONS" (A-07-99-21004)

We appreciate OIG's efforts in conducting this review and the opportunity to comment on the draft report. Our comments on the recommendations are provided below.

Recommendation 1

Conduct a consultative examinations (CE) fee study at Disability Determination Services (DDS) with annual CE expenditures of approximately $10 million or more. The study should identify whether the potential cost savings at the Illinois DDS are representative of other DDSs with comparable CE expenditures and how the use of Medicare fees would affect DDS' ability to obtain CEs. If the study identifies similar cost savings and proves that the use of Medicare fees will not adversely affect the disability programs, SSA should seek legislation requiring DDSs to use Medicare fees as the limiting CE payment amount.

SSA Comment

We agree that the recommended study should be conducted. The Office of Disability and Income Security Programs is planning to begin the study in December 2001 and to complete the necessary analysis by the end of July 2002. Any recommendations such as a legislative proposal will depend on the results of the study.

We disagree with the assertion in the Executive Summary that medical services provided for Medicare and DDSs are the same or very similar and that there is no reason for DDSs to reimburse medical providers at fees higher than those allowed by Medicare. There are several reasons for higher reimbursement rates:

- The nature of the "service" differs (reimbursement for medical treatment versus evaluation of disability);
- The price-setting mechanism differs (Medicare reimbursements have been limited by Congressional action in recent years; marketplace considerations may affect CE costs);
- SSA may reasonably pay a higher price for a CE in order to get fast and reliable medical information to process a medical determination;
- States may use other public (Federal or State) fee schedules.

On page 5 of the subject report OIG states that DDSs, in the CE process, request written statements on a claimant's ability to work as well as other written statements not required by Medicare, thus justifying a higher reimbursement rate for CEs. Such information is used by the DDSs for disability determinations.

Recommendation 2

Improve its oversight of the DDS CE process by: (a) Developing uniform CE data collection requirements for DDSs; (b) performing periodic evaluations of CE data collection processes at DDSs to develop best practices; and (c) encouraging DDSs to adopt the AMA's coding system for CEs.

SSA Comment

We agree and provide the following: a) We have and will continue to provide the funding for the DDSs to purchase software that will enable them to develop CE data collection. Additionally, SSA understands that the Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the Department of Health and Human Services (HHS) to adopt national standards for Electronic Data Interchange (EDI) formats for health care information transactions, as well as code sets for use in those transactions. The implementation of HIPAA should address the issue of the DDSs establishing the uniform coding system for the data collection. b) The Office of Disability and Income Security Programs facilitates the sharing of best practices on all issues regarding the collection of DDS medical cost data. c) On March 12, 1999, the Office of Disability and Income Security Programs issued a DDS Administrators' Letter which identified steps that a DDS should follow if it elected to relate its medical procedure fee schedule to the Medicare fee schedule (which uses the AMA's coding system). We will reissue this reminder to the DDSs on an annual basis. However, some DDSs may still be required, by the State, to use a parent agency fee schedule, coding system and payment process.

OIG Contacts and Staff Acknowledgments

OIG Contacts

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

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