United States General Accounting Office

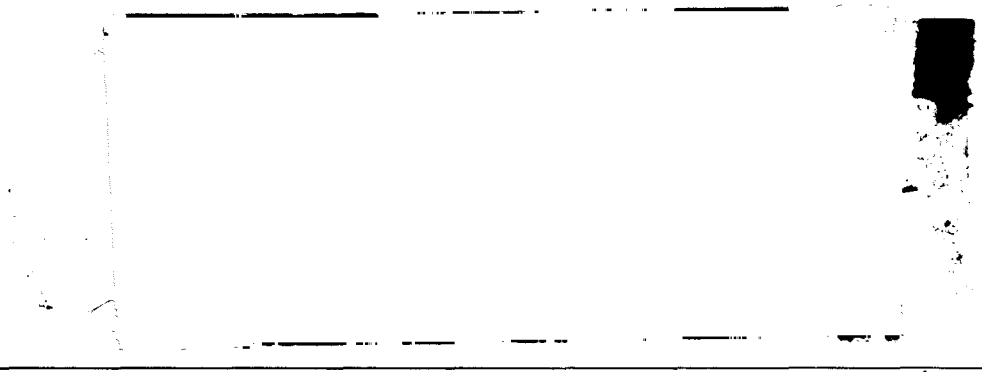
GAO

Briefing Report to the Chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives

September 1988

SOCIAL SECURITY DISABILITY

Implementing the Medical Improvement Review Standard



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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-224648

September 30, 1988

The Honorable Andrew Jacobs, Jr.
Chairman, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

In response to your request and later discussions with your office, we have continued to monitor the implementation, by the Social Security Administration (SSA) and the disability determination services (DDSs), of the medical improvement review standard—established by the Social Security Disability Benefits Reform Act of 1984 (P. L. 98-460). Specifically, you asked us to determine whether (1) SSA has implemented the standard as the Congress intended and (2) DDSs are encountering problems with it.

To obtain information on the implementation of the standard, we sent copies of a questionnaire to 53 of 54 DDS administrators, requesting responses concerning the clarity of SSA's regulations and operating guidelines, as well as any problems encountered. We visited the California DDS and SSA's Region IX office in San Francisco to discuss the standard and review cases in which it had been applied. To obtain a variety of viewpoints, we also discussed the regulations and operating guidelines with officials from SSA headquarters and five regional offices, five DDSs, and a number of beneficiary interest groups and legal aid groups.

Our principal observations are as follows:

- SSA's regulations implementing the standard are consistent with the law.
- DDS administrators said that they understand the standard and have had little difficulty applying it, and the results of SSA's Quality Assurance Program appear to support this.
- The standard has reduced the rate of benefit terminations and the appeal rate for terminations.
- The standard as currently applied appears to have reduced the chances of benefit terminations as a result of improper decisions (based on insufficient information) and arbitrary decisions.

On July 26, 1988, SSA provided us with written comments on a draft of this report. We incorporated these comments where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services and will make copies available to others on request.

Should you need additional information on the contents of this report, please call me on 275-6193.

Sincerely yours,

Franklin Frazier

Franklin Frazier
Associate Director

Contents

Abbreviations

ALJ	administrative law judge
DDS	disability determination service
HHS	Department of Health and Human Services
SSA	Social Security Administration

Social Security Disability: Implementing the Medical Improvement Review Standard

Introduction

The Social Security Administration (SSA) administers two programs, under the Social Security Act, that provide benefits to disabled people who are unable to work: (1) Social Security Disability Insurance, under title II, and (2) Supplemental Security Income, under title XVI.

Although both programs provide benefits to the disabled, each serves different populations. Social Security Disability Insurance serves those disabled, as well as their eligible dependents, who have worked and paid into the Social Security Trust Fund. Supplemental Security Income serves the disabled on the basis of need; the disabled are not required to have paid into the Social Security Trust Fund.

To be eligible for disability benefits under either program, a person must be unable to engage in any substantial, gainful activity because of a medically determinable condition that can be expected to last at least 12 months or result in death. Under the act, a person must be unable to do his or her former previous work, as well as—considering age, education, and work experience—any work existing in the national economy.

Disability determination services (DDSs) make disability decisions for both programs. There are 54 DDSs—one in each state (except South Carolina, which has two, including a separate agency for the blind), the District of Columbia, Guam, and Puerto Rico. SSA provides funding and establishes adjudicative policy that must be adhered to by each DDS. DDSs, in addition to making the initial determinations on disability, determine continuing eligibility by continuing reviews of those on the disability rolls. During these reviews, an adjudicator and a physician decide whether (1) a person's medical condition has improved and (2) he or she can return to work. If a DDS determines that a person is no longer disabled, SSA terminates benefits. Such a person has the right to appeal the decision at one of four appeal levels: (1) reconsideration, (2) administrative law judge (ALJ), (3) SSA Appeals Council, and (4) civil action in federal court.

In 1980, the Congress passed a law requiring SSA or the appropriate state agency to do continuing disability reviews at least once every 3 years beginning in January 1982.[1] SSA began these disability reviews 9 months before the time required by the law because studies indicated that many beneficiaries on the disability rolls were no longer disabled.

[1]The law stated that the permanently disabled were to be reviewed when the Secretary of Health and Human Services deemed it appropriate. The Secretary decided to review these cases every 7 years.

These continuing disability reviews, however, were halted by the Secretary of Health and Human Services (HHS) in October 1984 because of concern about the high number of benefit determinations.[2]

To address the erosion of public faith and confidence in the Social Security disability programs and in SSA as well, the Congress passed the Social Security Disability Benefits Reform Act of 1984 (P. L. 98-460) requiring, with certain exceptions, that medical improvement be shown before terminating benefits. In January 1986, DDSs resumed their continuing reviews under the medical improvement standard, which stipulates the following: No beneficiary should be removed from the disability rolls without (1) "substantial evidence" that medical improvement in his or her medical condition has occurred and that he or she is now able to engage in substantial, gainful activity or (2) the presence of one of the exceptions defined in the law (the exceptions, discussed on p. 11, allow benefits to be terminated under certain circumstances even when a beneficiary's medical condition has not improved).

Objectives, Scope, and Methodology

The Chairman, Subcommittee on Social Security, House Committee on Ways and Means, asked us to monitor the implementation of the medical improvement review standard. In later discussions with the Chairman's office, we were asked to determine whether SSA and DDSs have implemented the standard as the Congress intended.

Our fieldwork was done between September 1987 and April 1988 at SSA headquarters, its Region IX office in San Francisco, and in the California DDS. By telephone, we also discussed the implementation of the standard with officials in five SSA regional offices—Atlanta, Dallas, Kansas City, Philadelphia, and Seattle—and in five DDSs—Florida, Louisiana, Missouri, Virginia, and Washington.

In addition, we sent copies of a questionnaire (see app. I) to 53 DDSs.[3] We designed the questionnaire to obtain DDS administrators' views on these concerns: (1) the clarity of the regulations and guidelines issued by SSA, (2) the identification of any problems in doing continuing disability reviews, and (3) experience with the medical improvement review

[2]In April 1984, the Secretary of HHS placed a national moratorium on continuing disability reviews; but, according to SSA, a limited number of cases were not placed under the moratorium until October 1984.

[3]We sent questionnaires to 53 of the 54 DDSs (excluding the South Carolina state agency for the blind). We received responses from 52 DDSs (the Guam DDS said that it had not processed enough cases to respond to our questions).

standard. We pretested the questionnaire at two DDSs before mailing it tc all; we followed up with telephone calls to some DDSs to obtain additiona information.

To determine how well the standard works from the beneficiaries' point of view, we met with representatives from five beneficiary groups:

- National Senior Citizens' Law Center,
- Save Our Social Security,
- Epilepsy Foundation of America,
- Mental Health Law Project, and
- American Association of Retired Persons.

With these groups, we discussed (1) their overall assessment of the fairness of the standard and (2) any specific problems or observations they might have concerning its implementation by SSA and DDSs. We also asked these groups whether they were aware of complaints from those whose benefits were terminated and, if so, the nature of the complaints.

We spoke with representatives from four legal aid groups that have handled cases for people whose benefits were terminated:

- Legal Aid Foundation of Los Angeles, California;
- Legal Aid Society of Cleveland, Ohio;
- Legal Services of Southern Piedmont Incorporated, Charlotte, North Carolina; and
- Legal Aid Services of Chicago, Illinois.

We asked representatives of these groups about (1) their experience with the standard and (2) any specific problems with it.

With SSA's headquarters and Region IX officials and with DDS officials, we discussed SSA's Quality Assurance Program (as it related to the medical improvement standard). We also reviewed a limited number of quality assurance cases in Region IX. We obtained statistics from the program, including the accuracy rates for disability determinations for all DDSs. We did not, however, do an independent assessment of the validity or accuracy of the program.

To identify any problems in the interpretation, application, and implementation of the medical improvement review standard, we examined (1) case files of continuing disability reviews that were currently being processed in SSA's Region IX and in the California DDS's district office in

Los Angeles (but we did not select a representative sample to make projections) and (2) the case-processing procedures. With SSA and DDS officials, we discussed the results of implementing the standard. We did not, however, verify statistical information reported by SSA about the continuing disability reviews.

Our work was done in accordance with generally accepted government auditing standards. On July 26, 1988, the Commissioner of Social Security provided written comments, which we incorporated where appropriate, on a draft of this report (see app. II). In her response, the Commissioner (1) expressed concern that several questions in the questionnaire were not discussed in the report, (2) believed it would be better not to include these questions in appendix I (which shows the questionnaire and its results), and (3) said that certain of these several questions could have been misinterpreted, leading to inaccurate responses.

We believe that full disclosure of the questionnaire used is appropriate. In the two states in which the questionnaire was pretested, the DDS administrators did not express any difficulty in understanding these questions.

SSA Regulations Are Consistent With the Act

After reviewing SSA's regulations for the standard, we believe that they are consistent with the act.

The Congress Required a Standard

When the mandated continuing disability reviews (see pp. 6-7) began in 1981, much controversy centered on the termination of benefits for those whose medical conditions had not improved. Initially, a review was done on the basis of the eligibility criteria in place at the time of the review. Often, this resulted in evaluating a person for continuing benefits using new criteria that were more specific and sometimes more strict than the criteria under which the person was initially granted benefits. Many beneficiaries did not meet these new criteria. In addition, the judgment of a recent adjudicator on what constituted disability might differ from that of an earlier adjudicator who had initially granted benefits. Accordingly, the use of new criteria or another's judgement often resulted in the termination of benefits.

SSA's Regulations and Guidelines

SSA issued final regulations for the medical improvement review standard on December 6, 1985. Consistent with the standard, these regulations direct benefits to be terminated only when there is "substantial evidence" that a beneficiary (1) has medically improved and can engage in substantial, gainful activity or (2) meets an exception to medical improvement (as mentioned earlier) and (except for certain limited situations) can engage in substantial, gainful activity. These regulations require that decisions be based on all available evidence concerning a beneficiary's previous and current medical conditions.

SSA regulations define "medical improvement" as any decrease in the medical severity of a beneficiary's condition (impairment or impairments)—on the basis of changes in the symptoms as well as signs or laboratory findings (or both) associated with the impairment(s)—since the most recent favorable medical determination. In determining medical improvement, the regulations require adjudicators to use the eligibility criteria for disability in effect at the time of the last favorable decision, thus not penalizing the beneficiaries for changes in the criteria. If medical improvement has occurred, the regulations require the adjudicator to decide whether the improvement affects the beneficiary's ability to work. By comparing functional capacity (ability to do basic work activities) at the time of the current review with that at the most recent favorable decision, the adjudicator can determine if ability to work has increased.

The exceptions called for by the standard allow benefits to be terminated under certain circumstances, even when a beneficiary's medical condition has not improved. Such exceptions include these circumstances:

- the beneficiary is engaged in substantial, gainful activity;
- advances in medical or vocational therapy or technology that allow the beneficiary to work despite an unchanged medical condition (vocational therapy refers to additional education, training, or work experience);
- the beneficiary has undergone vocational therapy and is now able to engage in substantial, gainful activity;
- the earlier review (or adjudicator's judgment) was in error; or
- new or improved diagnostic techniques or evaluations reveal that the medical condition is less disabling than originally thought and, therefore, the individual is able to engage in substantial, gainful activity.

SSA's regulations explaining how to apply the exceptions are consistent with the standard. For example, the regulations concerning exceptions

prohibit an adjudicator from substituting his or her judgments for the judgments used in previous decisions that were favorable. According to the regulations, determining that the previous decision was in error can be concluded only if

- evidence existing at the time of the previous decision was clearly misread;
- required evidence was missing at the time of the previous decision, and, had such evidence been available, disability would not have been found; or
- substantial new evidence, relating to the previous decision, refutes the decision based on the evidence presented then.

To implement the regulations, SSA's operating guidelines for DDSs are included in its operations manual; these guidelines, describing the medical improvement review standard and the exceptions, are similar to, but more detailed than, SSA's regulations.

At HHS's Office of General Counsel, we asked an official responsible for legal matters about any court cases or other legal challenges relating to any aspect of the medical improvement review standard. He stated that he was not aware of any. We also talked with representatives of the four legal aid groups (p. 8); they also told us that they were not aware of any such challenges.

DDSs Understood the Regulations and Guidelines

In responding to our questionnaire, DDS administrators indicated that (1) the regulations and operating guidelines for the standard are "generally clear" and (2) few problems have emerged in implementing the standard. The results of SSA's Quality Assurance Program support these responses.

Administrators Say "Generally Clear"

Of the 52 DDS administrators who responded to our questionnaire, 49 stated that the guidelines overall were clear (8 said "very clear" and 41 said "generally clear"). In addition, we asked the administrators to rate the clarity of specific guidelines in SSA's operations manual and the difficulty in applying them. Most administrators indicated that (1) the guidelines were clear and (2) they had encountered only a few problems in implementing the standard.

According to 36 DDS administrators, however, the guidelines lacked specificity concerning how beneficiaries' age and time on the disability rolls affect their ability to work. According to the administrators, this lack of specificity led to the adjudicators' experiencing problems in understanding and applying the guidelines.

Essentially, the guidelines say that if a person is 50 years of age or over and has been on the rolls for a considerable period of time, the DDS adjudicator should consider the effect that these factors have on the beneficiary's ability to work. The guidelines do not provide details, however, on how to weigh these factors in applying the guidelines. Two administrators commented that this lack of specificity can lead to arbitrary decisions.

An SSA official said that including age and time on the rolls in the guidelines is "inherently judgmental"; therefore, it is difficult to make the guidelines more specific so that they can be routinely applied. In commenting on a draft of this report, the Commissioner said that SSA is in the process of revising its guidelines (for example, SSA's revision will use 7 years as a criterion for the guideline "considerable time on the rolls").

SSA's Quality Assurance Program Shows DDSs Following Regulations

There are two parts to the continuing disability reviews in SSA's Quality Assurance Program. To measure the quality of DDS decisions (showing understanding of regulations) during the continuing reviews, SSA's 10 regional offices do the first part on cases processed by DDSs. SSA headquarters does the second part, in which the quality and consistency of the reviews done by the 10 offices are assessed; a sufficient number of cases are sampled to provide statistically reliable measurements (to within plus or minus 5 percent at the 95-percent confidence level).

Program results indicate that DDSs are generally implementing the medical improvement review standard in accordance with SSA regulations and guidelines. The national accuracy rates for continuing reviews since the implementation of the medical improvement review standard are summarized in table 1.

Table 1: Accuracy Rates for Continuing Reviews of Cases (June 1986 Through Mar. 1988)

Numbers in percent

Period	Accuracy rates		All
	Terminated	Continued	
June-Sept. '86[a]	91.2	97.5	94.5
Oct.-Dec. '86	92.0	95.3	94.8
Jan.-Mar. '87	93.4	95.5	95.2
Apr.-June '87	94.0	95.9	95.7
July-Sept. '87	95.7	94.9	95.0
Oct.-Dec. '87	94.3	95.6	95.5
Jan.-Mar. '88	95.0	96.9	96.7

Note: SSA did not have accuracy rates for continuing disability reviews before June 1986.

[a]The accuracy rate during this period is somewhat higher than actual because of "grace-period cases." (When new instructions are implemented, SSA allows a grace period, usually lasting a couple of months, during which cases with errors are returned to DDSs to be corrected; these cases are included as reviewed cases but are not counted as error cases.)

DDS accuracy rates have been consistently high under the standard. SSA's Office of Program and Integrity Reviews defines as accurate those cases that have been processed in accordance with regulations. The national accuracy rates for continuing reviews was 94.5 percent for fiscal year 1986 and 95.5 percent for fiscal year 1987.

Benefit Terminations and Resulting Appeals Declined Under the Standard

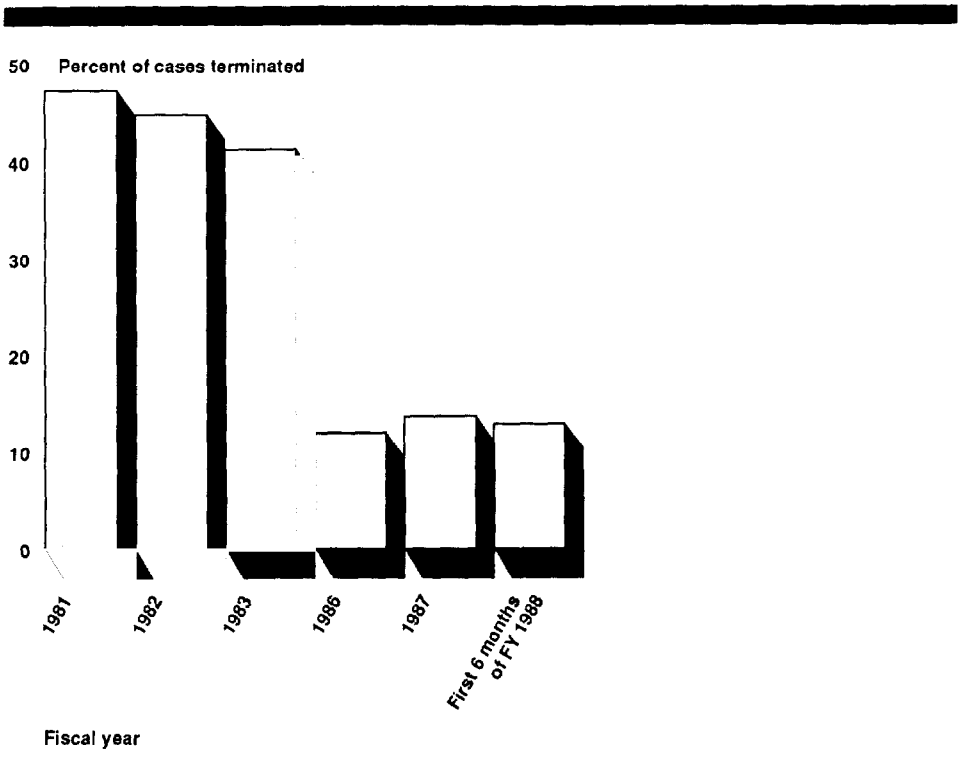
Both the benefit termination rates (as a result of the continuing disability reviews) and the appeal rates for benefit terminations have declined significantly since SSA implemented the medical improvement review standard—about two-thirds decline for the termination rates and almost one-half for the appeal rates. Although recognizing there are several possible reasons for the declining rates, we believe, as do SSA and DDS officials, that the major reason is the standard.

Termination Rates Drop Significantly

In the years before the standard, DDSs found about 41 to 47 percent of the cases they reviewed to be ineligible for continuing benefits. Since the standard, DDSs have terminated benefits in 12.0 percent of the cases they reviewed in fiscal year 1986 and in 13.7 percent in 1987. In the first 6 months of fiscal year 1988, the termination rate was 12.9 percent. (The termination rates for fiscal years 1981-88—only October 1987 to March 1988—are shown in fig. 1.)

In our analysis, we did not include data for the fiscal year 1986 termination rate because the conditions of the cases SSA selected for review in 1986 had a low probability for medical improvement; thus, the 1986

Figure 1: Termination Rates for Decisions in Continuing Disability Reviews (1981 Through Mar. 1988)



Note: Termination rates for fiscal years 1984 and 1985 are not shown because a national moratorium on continuing disability review was in effect for those years.

cases were not comparable with cases SSA selected for review in other years. According to SSA officials, the types of cases reviewed in fiscal year 1987 were more representative of the types of cases reviewed before the standard and the types of cases expected to be reviewed in the future. In fiscal year 1987, SSA selected a mix of cases that had a high and low probability for medical improvement, thus providing a better indication of the benefit termination rate under the medical improvement review standard.

As a means of prioritizing the workloads for continuing reviews, SSA has classified the conditions of the cases into four distinct categories, reflecting the relative potential for medical improvement. These categories are defined as follows:

Decision review—cases in which termination decisions were made before the medical improvement standard and, therefore, required by a

court action to be reviewed under the new standard (according to an SSA official, cases in this category should be completed by January 1989).

Medical improvement expected—cases in which improvement in medical condition is expected and was predicted at the time of the initial decision (usually scheduled for review within 6 to 18 months after the initial decision).

Medical improvement possible—cases in which improvement in medical condition is possible, but a specific time period for improvement is not predicted (usually scheduled for review every 3 years).

Medical improvement not expected—cases classified as permanently disabled in which improvement in medical condition is not expected (reviewed at 5- to 7-year intervals).

The number of cases in each of these four case categories and the benefit termination rates for fiscal years 1987-88 (only Oct.-Mar. for 1988) are included in table 2.

Table 2: Benefit Termination Rates for Continuing Reviews by Case Category

	Fiscal year 1987		October 1987 through March 1988	
Case category	**Cases processed**	**Termination rates**	**Cases processed**	**Termination rates**
Decision review	12,348	29.0%	4,978	34.7%
Medical improvement expected	84,366	12.4	73,180	12.6
Medical improvement possible	46,608	8.1	43,203	7.4
Medical improvement not expected	4,427	6.4	1,893	4.6
Other[a]	12,102	31.2	8,853	32.0
Total	**159,851**	**13.7%**	**132,407**	**12.9%**

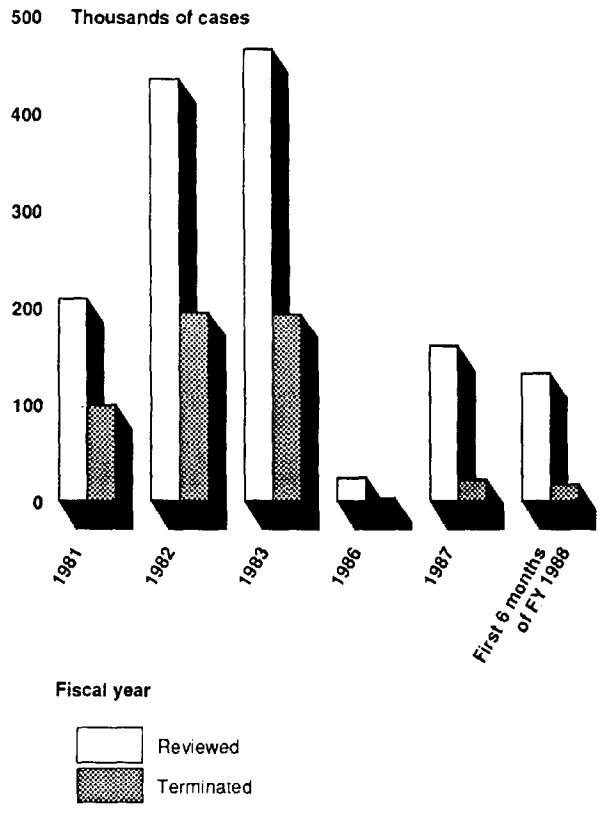
[a]This group of cases includes (1) cases reviewed by DDSs because the beneficiaries were believed to be working, bringing up the question as to whether the impairment continued and (2) cases with court-ordered reopenings not specifically required by Public Law 98-460.

The number of continuing reviews done by DDSs under the medical improvement standard is significantly fewer than the number of reviews done before the standard. In January 1986, DDSs gradually began doing reviews under the new standard. DDSs increased the number of these reviews in fiscal years 1987 and 1988, but the number remained far

below that of the early 1980's. In an October 1987 report,[1] we stated that SSA limited the number of continuing reviews because of budget constraints; we noted that this would probably continue into fiscal year 1988.

The number of continuing reviews and the number of benefit terminations for fiscal years 1981, 1982, 1983, 1986, 1987, and October 1987 to March of 1988 are shown in figure 2. We excluded fiscal years 1984 and 1985 because of the moratorium on continuing reviews during that period (fiscal year 1986 was only partially affected by the moratorium).

Figure 2: Disability Cases That Were Reviewed and Terminated (1981 Through Mar. 1988)



Note: Termination rates for fiscal years 1984 and 1985 are not shown because a national moratorium on continuing disability review was in effect for those years.

[1]Social Security: Effects of Budget Constraints on Disability Program (GAO/HRD-88-3, Oct. 28, 1987).

Appeal Rates Declined

Since SSA implemented the standard in January 1986, a much lower percentage of beneficiaries have appealed the decisions in continuing disability reviews. The reason for this lower rate appears to be the standard.

As mentioned earlier, a person whose benefits are terminated has the right to four levels of appeal. In the first, reconsideration by a DDS (a face-to-face hearing with a disability hearing unit at a DDS) is available to the beneficiary as part of the reconsideration. If the termination of benefits is affirmed, the beneficiary may appeal to an SSA ALJ and then to SSA's Appeal Council. The final level of appeal is to the federal court system.

Information provided by SSA on the reconsideration level shows that in fiscal years 1982 and 1983, beneficiaries appealed about two-thirds of the cases terminated by DDSs; in fiscal year 1987, they appealed 41 percent. The chief of SSA's Performance Management Branch, Office of Disability, said that the 1987 appeal rate is probably representative of future appeal rates.

The number of beneficiaries who appeal to an ALJ has declined even more significantly. In 1983, for example, 86 percent of those denied at reconsideration continued their appeals to an ALJ, but, in 1987, only 16 percent continued their appeals (this figure could be slightly understated because of the 60-day period allowed to appeal).

SSA officials and representatives from legal aid groups, as well as most of the DDS administrators who responded to our questionnaire, attributed the decline in the termination and appeal rates to the medical improvement review standard. We too believe that the standard has been the overriding cause for the drop in these rates. Because the standard terminates benefits only for those who clearly can work, there are likely to be fewer appeals.

Reducing Chance of Improper Benefit Terminations

Concerned with the improper termination of benefits to some people, the Congress passed the Social Security Disability Benefits Reform Act of 1984 to reduce the chance of benefit terminations as a result of improper decisions (based on insufficient information) and arbitrary decisions. Most people we spoke with agreed that the medical improvement standard, as currently being applied, has reduced the chance.

According to representatives from the beneficiary groups and legal aid groups, their experience to date has shown that the medical improvement standard has reduced the number of improper and arbitrary benefit terminations. In addition, DDS administrators responding to our questionnaire indicated that the standard has achieved what the Congress intended it to.

Conclusion

SSA and DDSs have generally implemented the medical improvement standard as the Congress intended. SSA's regulations covering the standard are consistent with the act. We are not aware of any legal challenges to implementation of the standard by SSA or DDSs. State administrators said that they understand the standard, and SSA's quality assurance results indicate that DDSs are following the regulations and guidelines.

We found that the medical improvement standard has reduced

- the benefit termination rates,
- the appeal rates, and
- the chance of terminations because of improper and arbitrary decisions.

Survey of DDS Administrators About the Medical Improvement Review Standard

|__|__|

The United States General Accounting Office (GAO), an agency of the U.S. Congress, is conducting a study of the Medical Improvement Review Standard (MIRS). The Congress would like to learn about the states' experience implementing the MIRS so that it can evaluate how well the standard is working.

GAO is sending this questionnaire to all Disability Determination Service (DDS) administrators. The items ask about how easy or difficult the MIRS is to implement and what effect you feel the standard might be having. You may consult with members of your staff about answers to any of the questions. A best estimate is sufficient to answer the questions. No special studies should be conducted.

Please complete this questionnaire and return it within 2 weeks from receipt. A postage-paid, preaddressed business reply envelope is enclosed for your convenience. Should you have any questions about the items on this form, please call Tim Fairbanks collect at (213) 894-3813 or FTS 798-3813. He will be happy to help you.

We urgently need your assistance with this task. Without information from every DDS we cannot accurately convey to the Congress how well the MIRS is working.

I. General Information about Cases Completed using the MIRS

1. When did your DDS begin performing continuing disability reviews (CDRs) using the MIRS? (ENTER MONTH & YEAR)

|__|__|--|__|__|
mo. yr.

2. About how many continuing disability reviews (CDRs) did your state complete in fiscal years 1986 and 1987? (ENTER NUMBER.)

_____CDRs

NOTE: Questionnaires were sent to 53 DDSs, and 52 DDSs responded. For each question, the total number of responses does not always total 52 because some DDSs did not respond to all questions.

II. **Your State's Experience Implementing the MIRS**

3. The POMS contain guidelines for implementing the MIRS. Some MIRS guidelines apply in all cases. Others are not always relevant. Listed below are some of the guidelines contained in the POMS. Consider all the cases your state completed CDRs on in fiscal years 1986 and 1987. For each guideline **estimate** the percentage of CDRs where that MIRS guideline was relevant. (CHECK ONE BOX FOR EACH GUIDELINE.)

	Estimated percentage of .. CDRs?						
	None 0%	A Few 1-10%	Some 11-40%	About Half 41-60%	Many 61-90%	Almost All 91-99%	All 100%
MEDICAL IMPROVEMENT/RELATED MEDICAL ISSUES	** NOTE ** The numbers listed below and in subsequent questions represents the number of DDSs giving that response.						
1.Definition of medical improvement		1		1	17	24	9
2.Determining the comparison point decision (CPD)					10	26	16
3.Determining which impairments should be considered at the CPD				2	12	32	6
4.Dealing with impairments which began after the CPD		6	38	5	2	1	
5.Dealing with impairments subject to temporary remission and/or temporary worsening		35	17				
6.Dealing with undocumented impairments at the CPD		22	28	1	1		
RELATING MEDICAL IMPROVEMENT TO THE ABILITY TO WORK							
1.Determining residual functional capacity (RFC) considering only impairments present at the CPD		5	23	12	12		
2.Determining RFC considering all impairments		9	27	9	6	1	

3.(continued) Estimated percentage of... CDRs?

	None 0%	A Few 1-10%	Some 11-40%	About Half 41-60%	Many 61-90%	Almost All 91-99%	All 100%
	1	2	3	4	5	6	7
3.Considering age and time on the rolls in the RFC	2	25	20	2	3		
4.Determining when medical improvement is related to the ability to work— that is comparing CPD RFC to current RFC considering only impairments at the CPD		11	24	12	4	1	
5.Relating medical improvement to the ability to work in cases involving widow(er)s, surviving divorced spouses and children receiving benefits under Title XVI	4	39	7	1		1	
EXCEPTIONS TO MEDICAL IMPROVEMENT							
1.Determining when the SGA exception applies	13	35	3				
2.Determining when the advances in medical or vocational therapy or technology exception applies	21	30					
3.Determining when the vocational therapy exception applies	24	27					
4.Determining when the new or improved diagnostic or evaluative exception applies	22	29					
5.Determining when the error exception applies	8	38	5				

4. Listed below are MIRS guidelines from the POMS.

In Part A, based on your examiners' experience implementing each guideline, indicate whether each, as written, seems very clear, generally clear or vague. (CHECK ONE BOX.)

In Part B, for each guideline consider all CDRs where that guideline was relevant. **Estimate** what proportion of the CDRs where the guideline was relevant that your DDS had difficulty applying that guideline. (CHECK ONE BOX FOR EACH GUIDELINE.) **If you want to comment on any of the MIRS guidelines, please do so on the last page.**

	PART A Clear or Vague?			PART B Difficulty applying in ... CDRs?						
	Very clear	Generally clear	Vague	None 0%	A Few 1-10%	Some 11-40%	About Half 41-60%	Many 61-90%	Almost All 91-99%	All 100%
	1	2	3	1	2	3	4	5	6	7
MEDICAL IMPROVEMENT/ RELATED MEDICAL ISSUES										
1. Definition of medical improvement	14	35	3	2	26	21	2	1		
2. Determining the CPD	36	16		6	40	5		1		
3. Determining which impairments should be considered at the CPD	10	38	4	2	39	9	1	1		
4. Dealing with impairments which began after the CPD	14	35	3	3	38	10		1		
5. Dealing with impairments subject to temporary remission and/or temporary worsening	4	30	18	1	36	11	1	2	1	
6. Dealing with undocumented impairments at the CPD	3	36	13	4	31	12	2	3		

4. (continued)

	PART A Clear or Vague?			PART B Difficulty applying in ... CDRs?					
	Very Clear	Gene-rally clear	Vague	None 0%	A Few 1-10%	Some 11-40%	About Half 41-60%	Many 61-90%	Almost All 91-99%	All 100%
	1	2	3	1	2	3	4	5	6	7
RELATING MEDICAL IMPROVEMENT TO THE ABILITY TO WORK										
1.Determining residual functional capacity (RFC) considering only impairments present at the time of the CPD	11	35	6	5	23	20	4			
2.Determining RFC considering all impairments	19	33		6	33	12	1			
3.Considering age and time on the rolls in the RFC	1	15	36	4	19	11	3	6	7	2
4.Determining when medical improvement is related to the ability to work—that is comparing CPD RFC to current RFC considering only impairments at the CPD	9	36	7	3	22	21	3	2		
5.Relating medical improvement to the ability to work in cases involving widow(er)s, surviving divorced spouses and children receiving benefits under Title XVI	10	31	10	8	36	5		1	1	

4. (continued)

	PART A Clear or Vague?			PART B Difficulty applying in ... CDRs?						
	Very Clear	Gene-rally clear	Vague	None 0%	A Few 1-10%	Some 11-40%	About Half 41-60%	Many 61-90%	Almost All 91-99%	All 100%
	1	2	3	1	2	3	4	5	6	7
EXCEPTIONS TO MEDICAL IMPROVEMENT										
1.Determining when the SGA exception applies	10	36	6	13	30	5	2	1		
2.Determining when the advances in medical or vocational therapy or technology exception applies	4	35	13	20	20	2	1	1	4	1
3.Determining when the vocational therapy exception applies	4	34	14	10	22	1	2		4	1
4.Determining when the new or improved diagnostic or evaluative techniques exception applies	4	37	10	18	26	1	2	3		
5.Determining when the error exception applies	4	37	11	9	33	5	2		2	

5.Overall, do you think the MIRS standard is very clear, generally clear, or vague? (CHECK ONE.)

1.[ ]Very clear 8

2.[ ]Generally clear 41

3.[ ]Vague 3

6.To what extent has SSA's Quality Assurance feedback related to the MIRS helped your DDS avoid making CDR decisional errors? (CHECK ONE)

1.[ ] To a very great extent 0

2.[ ] To a great extent 1

3.[ ] To a moderate extent 7

4.[ ] To some extent 20

5.[ ] To little or no extent 24

III. **The Effect of the MIRS**

7.According to House Report #98-618, the overall purpose of the bill establishing the MIRS was "...to insure that no beneficiary loses eligibility for benefits as a result of careless or arbitrary decision-making." To what extent, if any, do you feel the MIRS, as implemented, is achieving this objective? (CHECK ONE)

1.[ ]To a very great extent 13

2.[ ]To a great extent 28

3.[ ]To a moderate extent 5

4.[ ]To some extent 1

5.[ ]To little or no extent 5

8.Under what circumstances,if any, does the MIRS fall short of achieving this objective?

_____

_____

_____

_____

9.As of September 30, 1987, how many CDR's has your DDS continued since resuming CDR processing using the MIRS? (ENTER NUMBER)

_____CDR cases

10.Consider all the CDRs your state continued as stated in question 9. In any of these cases did your reviewer feel that the beneficiary was clearly able to work at the CDR, based on the eligibility criteria in effect at the time of the CPD? (CHECK ONE)

1.[ ]Yes 50

2.[ ]No--> (SKIP TO 14.) 1

11.Through September 30 1987, about what percentage of the CDRs that your state continued would you estimate that this was the case? (CHECK ONE)

[ ] 0-5% 3

[ ] 6-10% 10

[ ] 11-20% 19

[ ] 21-30% 10

[ ] 31% and over 8

12. Consider all the CDRs your DDS estimated in question 11. Estimate what percentage of these continuances had each of the following characteristics. (CHECK ONE BOX FOR EACH CHARACTERISTIC.)

	None 0%	A Few 1-10%	Some 11-40%	About Half 41-60%	Many 61-90%	Almost All 91-99%	All 100%
	1	2	3	4	5	6	7
1. The documentation in file was not sufficient to determine what impairments were relevant to the CPD, and/or their medical severity at that time	1	29	18	2			
2. The CPD was made at the DDS level and that decision continued benefits to a beneficiary that was clearly able to work, given the eligibility criteria in effect at the time	1	44	5				
3. The CPD was made at the ALJ level and that decision continued benefits to a beneficiary that was clearly able to work, given the eligibility criteria in effect at that time			5	14	25	6	
4. Other characteristics (PLEASE SPECIFY) _____							
_____							
_____							
_____							
_____							

13. In your opinion, what effect will each of the following have on the rate at which your DDS continues to encounter cases as described in question 10? (CHECK ONE BOX FOR EACH ITEM.)

Because...	...the rate will ...?				
	Greatly increase	Somewhat increase	Remain About the same	Somewhat decrease	Greatly decrease
	1	2	3	4	5
1.States have been more fully documenting claimants' impairments and their medical severity at the time of the initial claim and at the CDR		1	12	28	9
2.The initial eligibility criteria is now more specific and less open to judgement than it was in the past			24	23	3
3.Other factor that might affect this rate (PLEASE SPECIFY.) _____ _____ _____					
4.Other factor that might affect this rate (PLEASE SPECIFY.) _____ _____ _____					
5.Other factor that might affect this rate (PLEASE SPECIFY.) _____ _____ _____					

14. To what extent have you used the exceptions to the medical improvement standard to cease benefits to beneficiaries that appeared clearly able to work at time of the CDR, using the eligibility criteria in effect at the time of the CPD? (CHECK ONE.)

1.[ ] To a very great extent	0
2.[ ] To a great extent	0
3.[ ] To a moderate extent	0
4.[ ] To some extent	13
5.[ ] To little or no extent	39

15. Statistics show that the CDR termination rate has declined in all states since the MIRS was implemented. To what extent do you attribute this decline to the MIRS? (CHECK ONE.)

1.[ ]To a very great extent	47
2.[ ]To a great extent	5
3.[ ]To a moderate extent	0
4.[ ]To some extent	0
5.[ ]To little or no extent	0

16. Please explain why you feel the MIRS is responsible, at least in part, for this decline.

_____

_____

_____

_____

_____

17. Preliminary statistics indicate that the appeal rate for CDR cessations is declining. To what extent do you attribute this decline to the MIRS? (CHECK ONE)

1.[ ]To a very great extent	23
2.[ ]To a great extent	19
3.[ ]To a moderate extent	5
4.[ ]To some extent	0
5.[ ]To little or no extent-->	5 (SKIP TO 19.)

18. Please explain why you feel the MIRS is responsible, at least in part, for this decline.

_____

_____

_____

_____

_____

19. Please write any other comments you have about your state's experience with the MIRS or the effects of the MIRS, in the space below.

Comments From the Social Security Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Social Security Administration

Refer to

Memorandum

Date: JUL 26 1988

From: Dorcas R. Hardy
Commissioner of Social Security

Subject: General Accounting Office Draft Briefing Report, "Social Security Disability: Status of the Medical Improvement Review Standard (Audit No. 187044)--INFORMATION

To:
Mr. Lawrence H. Thompson
Assistant Comptroller General
General Accounting Office
Human Resources Division

Thank you for the opportunity to comment on the draft briefing report, "Social Security Disability: Status of the Medical Improvement Review Standard." While the report is favorable to our efforts to implement the new standard, we believe the inclusion of the questionnaire results with, in some instances, no analysis or explanation tends to create questions and possible problems. The important responses are covered in the body of the report. Those responses which were not covered in the report are better not shown since they could lead the uninformed to draw erroneous conclusions. We further believe that the manner in which certain questions were phrased was probably misleading to the administrators and lead to responses which were not what was meant. For these reasons we think exclusion of appendix I, with the questions and tabulated results would improve the report.

We are attaching a list of editorial changes which we believe will also strengthen the report.

Attachment

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