Report on the Effect of Purchase of Medical Evidence of Record
[Section 309, P.L. 96-265 (Social Security Disability Amendments of 1980)]

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December, 1984

Executive Summary

Section 309(a) of P.L. 96-265, the "Social Security Disability Amendments of 1980" provided that "any non-federal hospital, clinic, laboratory, or other provider of medical services, or physicians not in the employ of the Federal Government, which supplies medical evidence required and requested by the Secretary under this paragraph shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence." Moreover, section 312 of the 1980 amendments further requires the Secretary of Health and Human Services to send to Congress no later than January 1, 1985, a full and complete report as to the effects produced by the provisions of that act. This report has been prepared to fulfill that requirement.

Section 309 became effective on December 1, 1980. Expenditures on medical evidence of record (MER) rose considerably between fiscal years 1980 and 1981, from $9.5 million to $16.3 million. By 1983, expenditures exceeded $30 million, triple the amount spent in the year prior to the enactment of the 1980 amendments.

The large increase in expenditures on MER is not due solely to the requirement to pay for medical evidence of record in Social Security disability claims. Other factors undoubtedly contributed to the increase in costs, including inflation in medical care costs (which averaged about 10 percent per year during the period in question) and, more importantly, the rise in continuing disability reviews (CDR) provided for by section 311 of the 1980 amendments. Continuing disability reviews rose by 83 percent between FY 1980 and FY 1981 and 122 percent between FY 1981 and FY 1982. On the other hand, the number of new applications for benefits declined after the 1980 amendments, thus dampening the increase in MER costs.

States developed their own payment plans for the purchase of medical evidence of record with provisions that vary considerably. There are apparently three basic types of plans: Fixed payments, variable payments, and reimbursement for "usual and customary" charges. Payment amounts also vary considerably across States. States do not necessarily make the same type of payment to doctors and hospitals, nor are the amounts of the payments the same. In addition, two States indicated that they paid a bonus for "timely" medical evidence, i.e., evidence received in less than 10 days from the request. Three States reported that they paid a bonus for "quality" medical evidence. Quality was defined differently among these States but generally meant evidence which was comparable to a consultative exam or allowed adjudication without a consultative exam. A number of States paid doctors an additional fee if they wrote a narrative report. Disability Determination Services (DDS) in about half the States refuse to pay for MER if it is of poor quality or untimely.

In order to evaluate the impact of section 309 on the quality, timeliness and other aspects of MER, questionnaires were sent to administrators, medical consultants and disability examiners asking their opinions about the effect of the MER payment provision. The survey was limited to current DDS staff members who had experience prior to the application of the section 309 changes. These individuals were asked about changes in willingness to supply MER; about changes in the quality and timeliness of MER; and about the effects on the number of consultative examinations ordered, on case documentation, and on decisional accuracy.

The survey showed that payment generally affected MER positively. A majority of individuals surveyed (62 percent) felt that more sources than before the 1980 amendments were willing to supply medical evidence of record, while a smaller majority (54 percent) felt that overall case documentation had improved. The percentages of respondents reporting improvement in timeliness, quality and accuracy of decision were smaller. Forty percent reported improvement in the timeliness of receipt of MER, 25 percent reported improvement in quality and nearly a third (32 percent) reported improved accuracy in decisions. The majority (57 percent) saw little effect on the number of CEs purchased, though 17 percent said fewer were purchased and 23 percent said more were purchased.

The type of payment plan used by the DDSs made very little differences in these results. No particular payment scheme or other characteristic produced a clear consensus of improvement in medical evidence of record.

DDS administrators also offered their own comments and suggestions about ways to improve collection of MER. A large number suggested increased public relations and education for the medical community which would make their efforts more responsive to SSA needs.

Introduction

The decade of the 1970's witnessed dramatic growth in the Social Security disability insurance (SSDI) program. From 1970 to 1979 the number of disabled worker beneficiaries grew from 1,493,000 to 2,870,000 and expenditures grew from $3.1 billion to $13.7 billion. In addition, the number of applicants grew over the period from 869,800 in 1970 to 1,187,800 in 1979.

The rapid growth in the SSDI program resulted in the passage of the Social Security Disability Amendments of 1980 (P.L. 96-265). The changes made in 1980 increased work incentives to encourage beneficiaries to reenter the labor force, and included provisions to improve accountability and uniformity in the administration of the SSDI program. By 1983, the number of SSDI beneficiaries had fallen to 2,569,000 and new applications had declined to 1,045,447.

One way in which Congress attempted to improve the administration of the SSDI program was by providing for the payment for existing medical evidence (section 309 of P.L. 96-265). That provision states:

> Section 309(a) Section 223(d)(5) of the Social Security Act is amended by adding at the end thereof the following sentence. "Any nonfederal hospital, clinic, laboratory or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Secretary under this paragraph shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence."
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> (b) The amendment made by subsection (a) shall apply with respect to evidence requested on or after the first day of the sixth month which begins after the date of the enactment of this act.

This analysis was prepared in response to section 312 of P.L. 96-265 which required a full report on the effects of the provisions of the 1980 amendments. This report is divided into four sections. The first section provides background to the provision under study. The second section describes the various payment schemes and provisions of State plans for obtaining medical evidence of record (MER). The third section describes the findings of a survey on the effect of paying for medical evidence of record. Finally, section four presents a summary of DDS administrators' opinions about the shortcomings of the present methods of obtaining medical evidence of record along with their suggestions for improving the system.

Background

Claimants are required to submit medical evidence in support of their applications for benefits as well as during a continuing disability review (CDR). Prior to the 1980 amendments, it was the responsibility of the SSDI claimant to assume the cost, if any, of such medical evidence. Applicants for supplemental security income (SSI) disability payments who had not yet received medical attention and had established no medical evidence were not responsible for the costs incurred in securing such evidence. In addition to the medical evidence submitted by the claimant, a consultative examination could be required for any of the following reasons:

a) To clarify the clinical findings and diagnosis; or

b) To obtain highly technical or specialized medical data not otherwise available, when a State agency medical consultant considers it necessary for sound adjudication; or

c) To resolve a material conflict or inconsistency in the evidence in file; or

d) To resolve the issue of medical improvement in continuing disability cases.

Such exams may be obtained from the individual's attending physician, other sources of record, or an independent source. The cost of consultative examinations is borne by the Government.

Inclusion, in the 1980 amendments, of the provision to require payment for medical evidence was based on two beliefs. First, the belief was that, in the case of poor medical evidence of record, disability claims examiners were giving the claimant the benefit of the doubt and allowing or continuing benefits. The feeling was that with better medical documentation there would be more denials. 1/ Second, the States were running out of money allocated for consultative exams. Here again, the feeling was that better medical evidence of record would reduce the need for consultative exams. Congress felt that medical evidence that was paid for might be of better quality and "could be obtained more expeditiously and possbily avoid the need for further consultative examinations." Thus, Congress authorized the payment "for the reasonable cost of providing such evidence." It was left up to the States to determine the reasonable cost of such evidence and to develop a method to pay for medical evidence of record.

1/ Testimony before the Subcommittee on Social Security U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Social Security. Disability Insurance Legislation 96-1. Hearings, page 24.

State Payment Plans

Since each State DDS sets up its own guidelines for paying for medical evidence of record, there is considerable variation in the characteristics of State payment plans. Appendix A summarizes each State's practices in obtaining medical evidence of record (MER), based on DDS reponses to telephone inquiries in March of 1984. 2/

There are basically 3 types of payments made to doctors and hospitals in the 50 States and the District of Columbia. They are fixed amounts, variable amounts based on a fee schedule, or amounts based on "usual and customary" charges. Eight States use a different type of payment for doctors and hospitals. Of these, two States (Maine and Rhode Island), do not pay hospitals at all for medical evidence. 3/ In the other 43 States, the type of payment was the same for both doctors and hospitals although the amount paid to each may have differed.

Twenty-one of the States reimbursed hospitals via a fixed payment; 22 used a variable payment; 6 honored "usual and customary" charges, although most had a maximum permissible payment; and 2 did not reimburse hospitals at all. Doctors were paid a fixed sum payment in 28 States, a variable payment in 19 States, and their "usual and customary" charges in 4 States.

The amount of the payment varied considerably among the States, and often varied within individual States with different amounts authorized for doctors compared with hospitals. In general, physicians were paid more for medical evidence and often were given an additional or higher fee if a narrative report was prepared.

States with fixed payment amounts generally paid lesser amounts for medical evidence than States with variable fee schedules or those paying usual and customary charges. The notable exception occurred in States with variable fee schedules which based the fee paid on the number of pages of photocopied material, sometimes paying as little as 15 cents a page (Arizona). The fixed payment amounts to both doctors and hospitals were most frequently in the $10 to $15 range.

2/ Several States did not respond to the telephone inquiries. Entries for these States in the appendix are from administrative records current to February 1984 where available. Nonresponse States include Illinois, Indiana, Michigan, Minnesota, New Jersey, New York and Wisconsin. Their entries are footnoted in the appendix.

3/ The 1980 amendments require States to offer payment. These two States had no option to choose nonpayment to hospitals. SSA is working to correct this situation.

Fourteen States reported paying physicians an additional fee for writing a narrative report to submit with the medical evidence of record. The basic additional fee varied between $7.50 and $35.00 dollars and was generally a fixed payment, although some States have a fee schedule depending on the length of the narratives. One State, Oregon, paid a $35.00 fee for the first page of narrative and $10.00 for each additional page.

Few States made an additional payment for quality MER or for timeliness in receipt of requested MER. Arizona pays a quality premium of $5.00 for comprehensive narrative reports and California may pay up to $20.00 extra if the physician requests additional payment and the MER is "so comprehensive it is comparable to a consultative exam." Nebraska indicated that it paid more for good quality MER if the report allowed the DDS to adjudicate the case without a consultative exam. The amount of the additional payment was not specified. Several other States, as mentioned previously, paid an additional fee for a physician's narrative but this was not considered an additional payment for good quality MER.

Only two States, Colorado and Massachusetts, pay a bonus for timely receipt of MER. Colorado pays a $5.00 bonus if the MER is received in less than 10 days, while Massachusetts pays $10.00 for receipt in less than 10 days. One State, Utah, has a variable fee schedule but pays the higher fees for MER only if it is received in 10 days, constituting an incentive of sorts. Eighteen States reported that they may refuse to pay for MER if it is "untimely," which was usually defined as 60 days after the request or after the claim has been adjudicated and has cleared the DDS.

Of the 43 States responding to the telephone survey, 15 States indicated that they never refuse to pay for MER and 7 rarely do. The remaining 21 States can and do refuse to pay for MER sometimes. Fourteen States, as mentioned previously, refuse to pay for untimely MER, 15 States refuse to pay for inadequate or poor quality MER and several States do not pay if payment was not requested or the bill was not sent with the MER.

A number of the reporting States indicated that they had special arrangements with some MER sources. Usually the special arrangement involved a DDS employee or a courier service doing the extracting and photocopying of MER at certain hospitals. Another frequent arrangement was for tele-dictating of MER. One State indicated that DDS staff made public relations visits to MER sources to maintain cooperation and obtain feedback on procedures. Another State routinely sends out thank you notes for MER reports received.

Costs of Medical Evidence of Record

Annual State-by-State expenditures for medical evidence of record are presented in appendix B of this paper for fiscal years 1978 through 1983. A summary of national expenditures are presented in table 1 below along with figures on percentage growth in expenditures and on inflation in medical costs, and percentage changes in the number of applications for initial benefits and in

CDRs over the period. It is evident that the large increases in the costs of medical evidence of record occurred in fiscal years 1981 and 1982 with increases of over 70 percent and 50 percent, respectively. Although payment for MER began on December 1, 1980, (2 months into fiscal year 1981) one can certainly not attribute the entire cost increase in these years to the 1980 amendments. Medical cost inflation exceeded 10 percent each year and, although applications dropped 11 percent each year, the number of continuing disability reviews rose 83 percent in 1981 and 122 percent in 1982. It is, therefore, difficult to assess the specific cost impact of section 309 of the 1980 Disability amendments given the changes occurring in numerous other related factors during the same period.

Table 1.—Changes in MER expenditures and associated cost factors

Fiscal year	MER expenditures	Percent change in expenditures over previous year	Percent change in medical care costs - calendar year (CPI change for medical care)	Percent change in applications over previous year	Percent change in CDRs over previous years
1978	7,988,118	—	—	—	—
1979	8,055,055	.8	9.3	.3	16.4
1980	9,532,697	18.3	10.9	6.3	-2.1
1981	16,289,407	70.9	10.8	-11.1	82.9
1982	24,540,912	50.7	11.6	-11.1	122.2
1983	30,293,142	23.4	9.4 1/	2.4	1.2

1/ Change May 1982 to May 1983.

Survey of DDS Personnel

In order to satisfy the requirements of P.L. 96-265, a survey was conducted of DDS staff who were on duty prior to January 1, 1980. The purpose of the survey was to obtain their opinions about the effects of purchasing MER on the adjudicative process. It was believed that the survey was the best way to obtain the information needed from the people who are in the best position to judge the effects of purchasing MER on the adjudicative process. Although a case review study to assess, directly, the effects of purchasing MER was considered, that approach was rejected. Because of the passage of time and

other adjudicative and policy changes that had occurred since the passage of the amendments, it was felt that there was no way to set up an adequate "control" which would be necessary for a case review study.

The survey consisted of two short questionnaires containing a number of questions relating to changes in the willingness to supply MER, quality and timeliness of MER, overall case documentation and decision accuracy, and on purchases of consultative exams. One questionnaire was completed by DDS administrators, the other by disability examiners and medical consultants in each State's DDS. Again, in order to limit the respondents to persons who knew about practices prior to the 1980 amendments, the survey was limited to those DDS personnel on duty prior to January 1, 1980. In addition to the multiple choice questions asked of all DDS personnel, DDS administrators were asked open-ended questions about the problems of current MER procurement practices and asked to offer their ideas for improvements. Sample copies of the questionnaires can be found in appendix C.

The goal of the survey was to obtain responses from the entire universe of disability examiners, medical consultants and administrators with experience both prior to and after the 1980 amendments. Although there is no actual count of the number of persons in the universe, we feel the population of respondents closely approximates the universe. Only six States had not responded to the survey at the time this report was written. 4/ Overall, there were 1,853 respondents: 1,526 disability examiners, 263 medical consultants and 64 administrators.

The Survey Findings

The survey asked experienced disability examiners, medical consultants, and administrators to compare various characteristics of medical evidence of record before and after the 1980 amendments. The survey contained two groups of three questions each. The first group of questions related to the acquisition of medical evidence, asking about willingness of treating sources to supply MER, the quality of the MER and the timeliness of its receipt. The second group of questions related to the impact of MER on the number of CEs purchased, on overall case documentation and on the accuracy of disability decisions.

The Effect on Willingness to Supply, on Timeliness, and on Quality--The survey showed (table 2) that the 1980 provision requiring payment for MER has increased the willingness of treating sources to supply such evidence. A majority of all respondents (62 percent) felt that more sources were willing to supply MER, while 37 percent felt there was no change in the number of sources willing to supply MER. Less than 1 percent felt fewer sources were willing to supply MER. Administrators had a more favorable opinion of the impact of the

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4/ The six States which had not responded included California, Maryland, Montana, Nevada, Washington and Wisconsin.

1980 amendments on the number of sources supplying MER than did examiners and medical consultants. More than 2 out of 3 administrators (69 percent) felt more sources were willing to supply MER compared to 65 percent of medical consultants and 61 percent of disability examiners.

Forty percent of the respondents indicated the 1980 payment provision had also improved the timeliness of receipt of MER (table 3). Fifty eight percent felt little change in timeliness and less than 1 percent felt MER was now received in a less timely fashion. Administrators were again the most optimistic with nearly half (48 percent) indicating timeliness had definitely improved. A smaller percentage of medical consultants and disability examiners saw improvement in timeliness, at 43 percent and 39 percent respectively.

Table 4 shows that one quarter of the respondents felt that the quality of MER had improved as a result of the changes in the 1980 amendments. Approximately, three out of four respondents noted little change in the quality of the MER associated with the changes in the 1980 amendments. Very few respondents (1.4 percent) felt that quality had declined. Again, there was wide divergence between administrators and medical consultants on the one hand and disability examiners on the other. Administrators and medical consultants saw improvement in the quality of MER at a rate (38 and 36 percent respectively) nearly twice that of the disability examiners (22 percent).

The Effect on CEs Purchased, Case Documentation and Decision Accuracy--The survey showed (table 5) that 17 percent of the respondents felt that the purchasing of MER had reduced the number of CEs purchased. On the other hand, 57 percent cited little change in the number of CEs purchased while 23 percent reported an increase.

It is interesting to note that DDS administrators were more optimistic than examiners and medical consultants about the favorable impact of the purchase of MER on willingness to supply, timeliness, and quality, but were less optimistic about the effect on the purchase of CEs. More than 40 percent of the administrators felt more CEs were required after the 1980 amendments compared to 23 percent of examiners and 16 percent of medical consultants. Administrators also had the smallest percentage reporting fewer CEs being required (just over 12 percent) compared to more than 15 percent among examiners and 27 percent among medical consultants.

A variety of other program developments affect these findings. After 1980 continuing disability reviews accelerated and undoubtedly added to the number of CEs required. Secondly, having more medical evidence of record may have produced some conflicting reports which required a consultative exam to resolve. Finally, many DDS administrators indicated in their written comments that increases in CE purchases were due mainly to SSA's documentation requirements rather than to any direct effect of payment for MER.

Table 2.--Effect of payment on the willingness of treating sources to supply MER

Respondent type	Total	Response			
		More sources supply	Fewer sources supply	Little change	Not answered
Total............	100.0	61.8	.4	36.8	1.0
Disability examiner...	100.0	60.9	.3	38.4	.4
Medical consultant....	100.0	65.0	1.5	28.9	4.6
DDS administrator.....	100.0	68.8	0.0	31.2	0.0

Table 3.--Effect of payment on timeliness of MER

Respondent type	Total	Response			
		More timely	Less timely	Little change	Not answered
Total...........	100.0	40.2	.9	57.8	1.1
Disability examiner...	100.0	39.3	1.0	59.2	.5
Medical consultant....	100.0	43.3	.4	51.3	4.9
DDS administrator.....	100.0	48.4	1.6	50.0	0

Table 4.--Effect of payment on quality of MER

Respondent type	Total	Response			
		Substantially improved	Worsened substantially	Little change	Not answered
Total............	100.0	24.6	1.4	73.3	.7
Disability examiner...	100.0	22.0	1.4	76.3	.3
Medical consultant....	100.0	36.1	1.5	59.3	3.0
DDS administrator.....	100.0	38.1	1.6	60.3	0

Table 5.--Effect of payment on the number of CEs purchased

Respondent type	Total	Response			
		More CEs purchased	Fewer CEs purchased	Little change	Not answered
Total............	100.0	22.8	16.9	57.2	3.1
Disability examiner...	100.0	23.2	15.3	58.7	2.8
Medical consultant....	100.0	16.0	27.0	52.1	4.9
DDS administrator.....	100.0	40.6	12.5	43.8	3.1

As shown in table 6, a majority of respondents (54 percent) reported an improvement in overall case documentation with the 1980 amendments. DDS administrators were once again the most enthusiastic about improvements brought about by the purchase of MER. Nearly 3 out of 4 administrators (73.4 percent) found better case documentation compared to just over one half of the examiners and medical consultants (53 and 54 percent respectively).

Table 7 shows the impact of the purchase of MER on the accuracy of disability decisions. About a third of the respondents indicated that the accuracy of disability decisions had improved measurably since the 1980 amendments. Sixty three percent of the respondents noted little change in accuracy and less than 1 percent cited less accuracy in disability decisions. Although three quarters of the administrators felt that case documentation had improved, a smaller percentage (25 percent) felt that decisions were more accurate. In contrast, close to one third of the examiners indicated that decisions were more accurate and almost 4 in 10 medical consultants felt accuracy in decisionmaking had increased.

Regional Differences--Table 8 shows the percent of respondents indicating improvement in the characteristics of medical evidence of record by their Social Security region. All but two of the regions tended to closely approximate the national experience. The Denver region's experience was considerably better than other regions, while the New York region's was far worse. 5/ Nearly 9 of 10 respondents in the Denver region indicated an increased willingness of sources to supply MER compared to the national rate of 62 percent. In the New York region only 32 percent of the respondents cited an increased willingness to supply MER, a rate barely half the national figure. Three out of four Denver respondents reported improved timeliness nearly twice the national norm of 40 percent, while at 22 percent New York's response rate was half the improvement rate nationally. Nationally, one quarter of the respondents indicated that they felt the quality of medical evidence had improved where a full half of respondents in Denver felt quality had improved. In contrast only 16 percent of the New York region reported quality improvement.

As discussed previously, it is difficult to interpret the data reported relating to purchase of CEs. Nationally, 17 percent of respondents noted fewer CEs purchased and 23 percent noted more CEs purchased. In the Denver region, 21 percent indicated fewer CEs purchased and fewer than 10 percent indicated more CEs purchased. New York's reports were roughly the same as the national percentages. Boston and Philadelphia were the extremes with 46 percent of Boston's respondents indicating more CEs were purchased and 27 percent of Philadelphia's respondents reporting fewer CEs purchased.

5/ There were two States reporting in the New York region, New York and New Jersey. Both reported less improvement than the national average, but New York State's report was by far the less optimistic of the two.

Table 6.--Effect of payment on overall case documentation

Respondent type	Total	Response			
		Documentation is better	Documentation is worse	Little change	Not answered
Total............	100.0	53.9	.9	42.5	2.8
Disability examiner...	100.0	52.9	1.0	43.3	2.7
Medical consultant....	100.0	54.4	.4	41.4	3.8
DDS administrator.....	100.0	73.4	0	26.6	0

Table 7.--Effect of payment on accuracy of disability decisions

Respondent type	Total	Response			
		More accurate	Less accurate	Little change	Not answered
Total............	100.0	32.2	.9	63.2	3.7
Disability examiner...	100.0	31.4	.9	64.5	3.3
Medical consultant....	100.0	38.8	.8	54.8	5.7
DDS administrator.....	100.0	25.0	1.6	68.8	4.7

Table 8.—Percent indicating improvement in MER characteristics by region 1/

	Number of respondents	Increased willingness to supply	Increased timeliness	Improved quality	Number of CEs purchased (Fewer)	Number of CEs purchased (More)	Improved case documentation	Improved accuracy of decision
Total	1,853	61.8	40.2	24.6	16.9	22.8	53.9	32.2
Atlanta	445	62.2	26.7	22.9	14.8	21.3	51.7	31.7
Boston	114	64.9	44.7	28.9	14.0	45.6	59.6	34.2
Chicago	303	60.7	31.0	21.5	15.5	32.0	53.5	31.7
Dallas	230	68.7	38.3	18.7	16.1	21.7	57.0	28.7
Denver	62	88.7	74.2	50.0	21.0	9.7	69.4	30.6
Kansas City	99	64.6	43.4	23.2	17.2	14.1	58.6	40.4
New York	270	31.5	21.9	15.9	13.0	18.1	39.6	29.3
Philadelphia	263	76.0	50.6	34.6	27.0	17.5	61.6	36.5
San Francisco	28	75.0	53.6	25.0	14.3	10.7	53.6	32.1
Seattle	38	71.1	44.7	44.7	18.4	26.3	57.9	31.6

1/ Excludes one case of unknown DDS code.

With respect to improved case documentation, Denver and New York again became the extreme cases. Whereas 54 percent of respondents nationally reported improved case documentation, almost 70 percent of Denver respondents indicated improvement. In contrast, only 40 percent of the respondents in the New York region cited improved in case documentation.

Denver's report on the accuracy of decisions was slightly below the national percentage of 32 percent, as was New York's. The largest proportion of respondents indicating improvement in decision accuracy came from the Kansas City region, but at 40 percent citing improvement it was not that far ahead of any of the other regions.

The reason for the relative success of the purchase of MER in the Denver region and the relative failure in the New York region is not clear. Looking at the data on expenditures for MER for fiscal years 1978-1983, the Denver region is among those with the largest proportionate increase in spending between 1980 and 1981 (the period of enactment of section 309) and New York is among the regions with the smallest proportionate increase. The large rise in spending (nearly 300 percent) may alone explain Denver's success.

State Differences--Table 9 shows the percentage of respondents in each State who reported an improvement in MER since the 1980 amendments. The most interesting factor about the table seems to be the lack of consensus within States and the appearance of a consensus across States. Very few of the States show a very high or very low percentage of improvement responses. This means respondents do not appear to agree within each State about the success of the provision to pay for MER. Instead, most of the States have improvement response percentages approximately the same as the national percentage indicating the feelings of improvement are roughly the same across States.

Differences by Characteristics of State Payment Plans--The differences in responses to the survey questions are shown in table 10 broken down by the characteristics of the State's plan for paying for MER. The characteristics of the State's payment plan were associated with some subtle differences in the proportion of respondents indicating improvement in the acquisition of MER but certainly not enough to point to any one payment plan as being far superior to any of the other arrangements.

Fee schedules with variable payments to physicians were associated with a slightly more positive response in willingness to supply, with about 73 percent reporting an increase in willingness to supply compared to 67 percent among States with fixed payment or "usual and customary" payments. The "usual and customary" method of payment to physicians produced more positive responses in timeliness and quality of MER, but also had the highest proportion of respondents indicating the number of CEs purchased had increased. There were no major differences in case documentation or accuracy among the three types of payment to physicians.

Table 9.--Percent indicating improvement in MER characteristics by State 1/

	Number of respondents	Increased willingness to supply	Increased timeliness	Increased quality	Number of CE's purchased (Fewer)	Number of CE's purchased (More)	Improved case documentation	Improved accuracy of decision
Total	1,853	61.8	40.2	24.6	16.9	22.8	53.9	32.2
Alabama	65	50.8	56.9	29.2	16.9	24.6	58.5	41.5
Alaska	5	80.0	40.0	80.0	0.0	60.0	100.0	60.0
Arizona	14	64.3	35.7	14.3	14.3	14.3	57.1	28.6
Arkansas	36	72.2	50.0	22.2	5.6	30.6	63.9	41.7
Colorado	26	84.6	61.5	50.0	15.4	11.5	69.2	26.9
Connecticut	34	64.7	23.5	23.5	2.9	61.8	47.1	23.5
Delaware	7	57.1	14.3	42.8	14.3	42.8	28.6	14.3
District of Columbia	3	33.3	33.3	0.0	0.0	33.3	0.0	0.0
Florida	40	75.0	47.5	27.5	45.0	10.0	55.0	32.5
Georgia	65	63.1	46.2	23.1	13.8	27.7	61.5	49.2
Hawaii	14	85.7	71.4	35.7	14.3	7.1	50.0	35.7
Idaho	9	66.7	33.3	66.7	22.2	22.2	55.5	33.3
Illinois	93	55.9	26.9	25.8	18.3	22.6	51.6	33.3
Indiana	30	76.7	40.0	10.0	13.3	26.7	56.7	20.0
Iowa	16	43.8	12.5	6.3	6.3	25.0	50.0	18.8
Kansas	23	60.9	56.5	30.4	21.7	8.7	56.5	34.8
Kentucky	41	70.7	39.0	24.4	9.8	17.1	46.3	17.1
Louisiana	60	68.3	25.0	11.7	3.3	20.0	56.7	20.0
Maine	11	63.6	0.0	9.1	0	63.6	36.4	18.2
Massachusetts	27	66.7	77.8	25.9	40.7	14.8	70.4	40.7
Michigan	90	64.4	31.1	17.8	17.8	32.2	50.0	44.6
Minnesota	20	60.0	40.0	30.0	10.0	30.0	60.0	30.0
Mississippi	42	78.6	64.3	35.7	7.1	31.0	66.7	59.5
Missouri	46	69.6	41.3	30.4	21.7	6.5	58.7	52.2
Nebraska	14	78.6	64.3	7.1	7.1	35.7	71.4	35.7
New Hampshire	7	85.7	57.1	42.9	14.3	42.9	71.4	57.1
New Jersey	69	47.8	30.4	20.3	17.4	29.0	44.9	30.4
New Mexico	20	95.0	40.0	15.0	30.0	30.0	50.0	25.0
New York	201	25.9	18.9	14.4	11.4	14.4	37.8	28.9
North Carolina	70	51.4	25.7	4.5	10.0	22.9	35.7	12.9
North Dakota	5	100.0	80.0	80.0	100.0	0.0	80.0	40.0
Ohio	70	55.7	30.0	22.9	11.4	47.1	57.1	34.3
Oklahoma	37	51.4	75.7	5.4	5.4	18.9	24.3	12.9
Oregon	24	70.8	50.0	29.2	20.8	20.8	50.0	25.0
Pennsylvania	192	77.6	53.1	33.3	26.6	14.6	61.5	37.5
Rhode Island	21	66.7	47.6	33.3	4.8	57.1	76.2	42.9
South Carolina	48	60.4	39.6	16.7	10.4	31.3	50.0	29.2
South Dakota	11	72.7	54.5	36.4	9.1	18.2	54.5	27.3
Tennessee	74	62.2	44.6	20.3	12.2	8.1	45.9	18.9
Texas	77	68.8	49.4	29.9	32.5	18.2	61.0	32.5
Utah	12	100.0	100.0	58.3	8.3	8.3	83.3	41.7
Vermont	14	50.0	57.1	50.0	14.3	35.7	57.1	35.7
Virginia	34	79.4	50.0	41.2	32.4	26.5	64.7	41.2
West Virginia	27	70.4	44.4	37.0	29.6	18.5	74.1	33.3
Wyoming	8	100.0	100.0	37.5	25.0	0.0	62.5	25.0

1/ Excludes one case of unknown DDS code.

Table 10.—Percent of respondents indicating improvement in MER characteristics by characteristics of State reimbursement plan

	Increased willingness to supply	Increased timeliness	Increased quality	Number of CE's purchased		Improved case documentation	Improved accuracy of determination
				(Fewer)	(More)		
Total	68.4	46.3	27.1	18.0	21.6	57.0	33.0
Type of payment to MD							
Fixed	67.0	47.2	26.4	16.9	20.8	56.1	33.0
Variable	73.3	42.1	26.7	22.2	19.1	59.6	33.2
Usual and customary	66.6	51.9	40.7	14.8	27.8	57.4	31.5
Type of payment to hospital							
Fixed	67.4	48.7	26.7	17.9	19.3	56.2	33.3
Variable	71.0	40.7	25.2	22.4	18.6	58.4	32.8
Usual and customary	70.0	48.0	37.0	10.0	37.0	57.0	30.0
None	65.6	15.0	25.0	3.2	59.4	62.5	34.4
Difference in payment MD vs. Hosp.							
Yes	74.3	53.4	30.5	21.3	23.3	61.5	35.6
No	66.3	43.6	26.3	16.9	20.9	55.3	32.0
Additional payment for MD Narrative							
Yes	68.5	44.0	30.4	17.2	18.3	56.0	31.9
No	68.4	46.9	25.3	18.3	22.4	57.2	33.3
Additional payment for quality							
Yes	71.4	50.0	10.7	10.7	25.0	64.3	32.1
No	68.3	46.2	27.4	18.2	21.5	56.8	33.0
Additional payment for timeliness							
Yes	75.5	69.8	37.7	28.3	13.2	69.8	34.0
No	68.1	45.2	26.7	17.6	21.9	56.4	32.1
Can State refuse to pay							
Yes	65.8	45.9	23.9	15.1	23.7	54.5	31.1
No	72.8	49.3	31.0	22.7	17.7	60.0	34.1
Rarely	63.2	33.0	27.3	13.2	27.4	56.6	38.7

Table 11 shows the amount of the maximum permissible payment to doctors for routine MER, i.e. excluding payments for a written narrative, by the type of payment arrangement actually used. The table shows a general tendency for improvement in MER characteristics with higher payment amounts, but the relationship is neither strong nor consistent.

The type of payment to the hospital produced only minor differences with the exception of States which did not pay hospitals. Those States not paying hospitals for MER had the smallest proportions of improvement cited in willingness to supply MER, timeliness and quality. The largest difference was found in timeliness where only 15 percent cited improvement compared to 40 to 50 percent citing improvement under other types of payment. Not paying hospitals for MER also seems to increase purchases of CEs. Nearly 60 percent of respondents indicated such an increase, a rate almost 3 times the national average. Purchasing those CEs may have improved case documentation and accuracy of decision since States not paying hospitals had slightly (very slightly) more positive responses in case documentation and accuracy of decision.

Table 11 shows that there is, once again, a slight link between the amount of payment to institutions providing MER and improvement in the characteristics of the MER provided. States not paying institutions for MER did have consistently lower reports of improvement and an administrator for a DDS in one of these States stressed, in written comments, the need to pay institutions which supply MER.

States which had a differential in the payment between doctors and hospital had a larger proportion indicating improvement in all aspects of MER; willingness to supply, quality, timeliness, case documentation and accuracy of decision. Since differential payment plans tend to favor doctors, one might assume that the larger payment to MDs was the reason for that finding. However, States offering an additional payment for a physician's narrative were found to have a higher proportion of respondents indicating improvement only in the quality question, and that differential was small with 30 percent indicating improvement in States offering the additional payment compared to 25 percent in those not offering the payment.

The amount of the payment for the physician's narrative (table 12) was found to have a positive effect on improvement of MER. Higher payments did, in general, result in a slightly higher reporting rate of improvement. The notable exception was the one State (Oregon) which offered a payment in the \$25-\$50 category. That State had a slightly smaller proportion of reports of improvement than the States offering a narrative payment in the \$15-\$25 range.

Table 11.—Percent indicating improvement in MER characteristics by type and amount of payment 1/

Type of payment and amount	Number	Increased willingness to supply	Increased timeliness	Improved quality	Number of CEs purchased (Fewer)	Number of CEs purchased (More)	Improved case documentation	Improved accuracy of decision
				Payment to Physician				
Total	1,280	68.4	46.3	27.1	18.0	21.6	57.0	33.0
<$10	524	63.2	45.2	25.2	12.2	22.9	53.2	31.7
10-15	559	71.2	46.7	27.5	20.9	22.2	60.6	33.8
15-25	95	78.9	50.5	25.3	32.6	16.8	51.6	27.4
25-50	40	70.0	47.5	37.5	20.0	20.0	60.0	27.5
>50	11	72.7	54.5	36.4	9.1	18.2	54.5	27.3
No stated maximum	51	70.6	41.2	35.3	19.6	11.8	62.7	52.9
Fixed payment	934	67.0	47.2	26.4	16.9	21.9	56.1	33.0
<$10	523	63.3	45.3	25.2	12.2	22.9	53.3	31.7
10-15	403	71.2	48.6	27.8	22.8	21.1	59.6	34.7
15-25	8	100.0	100.0	37.5	25.0	0	62.5	25.0
Variable payment	292	73.3	42.1	26.7	22.2	19.1	59.6	33.2
<$10	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10-15	142	73.2	40.1	24.6	16.2	23.9	64.1	31.0
15-25	63	79.4	44.4	22.2	38.1	17.5	50.8	28.6
25-50	40	70.0	47.5	37.5	20.0	20.0	60.0	27.5
No stated maximum	46	69.6	41.3	30.4	21.7	6.5	58.7	52.2
Usual and Customary	54	66.7	51.9	40.7	14.8	27.8	57.4	31.5
<$10	—	—	—	—	—	—	—	—
10-15	14	50.0	57.1	50.0	14.3	35.7	57.1	35.7
15-25	24	70.8	50.0	29.2	20.8	20.8	50.0	25.0
25-50	—	—	—	—	—	—	—	—
>50	11	72.7	54.5	36.4	9.1	18.2	54.5	27.3
No stated maximum	5	80.0	40.0	80.0	0.0	60.0	100.0	60.0

Table 11.—Percent indicating improvement in MER characteristics by type and amount of payment 1/ (Continued)

Type of payment and amount	Number	Increased willingness to supply	Increased timeliness	Improved quality	Number of CEs purchased (Fewer)	Number of CEs purchased (More)	Improved case documentation	Improved accuracy of decision
Payment to Institution								
Total	1,280	68.4	46.3	27.1	18.0	21.6	57.0	33.0
No payment	32	65.6	31.2	25.0	3.1	59.4	62.5	34.4
$10	705	67.5	50.1	27.8	17.7	18.6	55.7	33.5
10-15	306	68.3	42.5	24.5	17.6	23.2	60.8	32.0
15-25	87	77.0	46.0	24.1	33.3	18.4	50.6	27.6
25-50	28	57.1	25.0	28.6	25.0	25.0	50.0	21.4
50	11	72.7	54.5	36.4	9.1	18.2	54.5	27.3
No stated maximum	111	71.2	41.4	31.5	12.6	27.0	59.5	39.6
Fixed payment	831	67.4	48.7	26.7	17.9	19.4	56.2	33.3
$10	681	67.8	49.9	27.8	17.6	18.9	55.8	33.5
10-15	150	65.3	43.3	22.0	19.3	21.3	58.0	32.7
Variable payment	317	71.0	40.7	25.2	22.4	18.6	58.4	32.8
$10	24	58.3	54.2	29.2	20.8	8.3	54.2	33.3
10-15	142	73.2	40.1	24.6	16.2	23.9	64.1	31.0
15-25	63	79.4	44.4	22.2	38.1	17.5	50.8	28.6
25-50	28	57.1	25.0	28.6	25.0	25.0	50.0	21.4
No stated maximum	60	68.3	40.0	26.7	20.0	8.3	58.3	46.7
Usual and Customary	100	70.0	48.0	37.0	10.0	37.0	57.0	30.0
$10	—	—	—	—	—	—	—	—
10-15	14	50.0	57.1	50.0	14.3	35.7	57.1	35.7
15-25	24	70.8	50.0	29.2	20.8	20.8	50.0	25.0
25-50	—	—	—	—	—	—	—	—
50	11	72.7	54.5	36.4	9.1	18.2	54.5	27.3
No stated maximum	51	74.5	43.1	37.3	3.9	49.0	60.8	31.4
No payment	32	65.6	31.2	25.0	3.1	59.4	62.5	34.4

1/ For fixed payment schemes the amount cited is the actual fixed payment. For variable and "Usual and Customary" payment schemes the amount shown is the maximum allowable payment if any. Physician payments do not include additional payment for a written narrative report, if any.

Table 12.—Percent indicating improvement in MER characteristics by amount of additional payment for physicians narrative

	Number	Increased willingness to supply	Increased timeliness	Improved quality	Number of CEs purchased (Fewer)	Number of CEs purchased (More)	Improved case documentation	Decision accuracy
No payment...........	1,007	68.4	46.9	25.3	18.3	22.4	57.2	33.3
With payment.........	273	68.5	44.0	30.4	17.2	18.3	56.0	31.9
10................	135	64.4	41.2	24.4	13.3	20.7	51.1	26.7
10-15..............	74	68.9	41.9	32.4	24.3	10.8	63.5	44.6
15-25..............	40	80.0	52.5	47.5	15.0	22.5	62.5	30.0
25-50..............	24	70.8	50.0	29.2	20.8	20.8	50.0	25.0

States which paid a premium for quality MER reports produced one of the most surprising results. Although these States had slightly better than average reports of improvement in willingness to supply, timeliness and case documentation, ironically a smaller percentage of respondents in these States reported improvement in quality than in those States not paying a bonus of quality. In States offering the bonus, only 11 percent indicated they felt improvement in the quality of MER while 27 percent did in the other States. The reason for this result is by no means clear. It is interesting to note, however, that in two of the three States paying a premium for quality MER (i.e. California and Arizona) there were substantial reductions in expenditures on MER between fiscal years 1980 and 1981. Those reductions (18 percent in California and 25 percent in Arizona) may have reflected changes in procurement procedures for MER that resulted in lower quality MER.

An additional payment for timeliness resulted not only in a larger proportion of respondents reporting an improvement in timeliness, but also in all other questions regarding MER acquisition and case development. Among States which paid a premium for timely reports, 70 percent of the respondents cited improved timeliness compared to only 45 percent in States not paying such a premium. These States had somewhat larger proportions reporting increased willingness to supply MER, increased quality, fewer CEs being purchased and improved case documentation. There was only a slight difference in responses associated with decision accuracy.

Several States reserve the right to refuse to pay for MER that they consider unsatisfactory, presumably in order to maintain a high level of timeliness and quality. Judging from the responses to the survey questions this works in reverse. States that never refused to pay for MER reported more improvement in not only quality and timeliness, but also willingness to supply and case documentation. Those States also had a larger proportion of respondents who felt that the number of CEs purchased declined and a smaller proportion who felt CE purchases had increased. Apparently never refusing to pay for MER breeds more cooperation between DDSs and MER sources.

Administrator Comments and Suggestions

At the end of their questionnaires, DDS administrators were asked if there were any problems still evident with regard to the purchasing of medical evidence of record and how those problems could be solved. Responses varied greatly depending on the methods the States employed to obtain MER.

A common problem cited by the administrators was the need for more public relations and education for doctors and medical records personnel. More than a dozen of the 64 administrators felt that increased knowledge in the medical community would lead to more usable MER and fewer CEs. Many of these indicated that doctors didn't know what was needed in terms of MER; and, despite a written narrative, the right questions were not answered and CEs were required. A few felt that special DDS staff should be assembled to assist medical personnel in gathering evidence and writing reports.

The type of payment and fee schedule raised many comments from administrators. Some problems were identified for all the payment plans used by the DDSs. A half dozen administrators indicated that the fee schedule in their State was too low to obtain good MER, while several others indicated that doctors felt that they were not paid enough for supplying MER. On the other hand, a few administrators felt the charges doctors billed were too high for the quality of the MER received. A number of administrators felt that switching to a variable fee schedule from a fixed payment plan would obtain better results. One administrator stated flatly "You get what you pay for." An administrator from a State which pays "usual and customary" charges felt that under such an arrangement it was hard to contain costs and that his DDS should consider switching to a fee schedule. A couple of administrators stressed the need for uniformity in payments or fee schedules between States. Apparently they found it difficult to obtain MER from out-of-State sources due to their State's lower payments. An administrator from one of the two States that do not pay institutions for medical evidence indicated that his State should make these payments.

The State's right to refuse to pay for MER brought comments on both sides of the issue. An administrator from a State which can refuse to pay for MER indicated, as suggested earlier in this report, that the refusal to pay creates problems with MDs and the medical community. On the other hand, three administrators from States which could not refuse to pay for MER were incensed at the required payment for poor quality MER and MER which is so late that it becomes useless. All felt their State should be allowed to refuse payment in those situations.

About a quarter of the administrators had a comment about the number of CEs being purchased. Most felt too many CEs were being purchased to meet more stringent documentation requirements of SSA. In many cases, they felt MER was adequate to make a decision but did not meet documentation requirements set by SSA and thus a CE was ordered. More than a dozen administrators reported that they were ordering more CEs since the 1980 amendments but not due to the 1980 amendments per se. Instead, the increased number of CEs was the result of new documentation requirements promulgated since 1980.

Some responses were more philosophical than administrative in nature. Several administrators commented that the government should never have assumed the responsibility for paying for MER. One administrator further expanded this argument by noting that having the DDS pay for MER takes the applicant out of the picture, and makes case documentation more difficult because examiners often take the easier route and order a consultative exam rather than try to track down MER. That administrator felt it should be left up to the applicant to prove his or her disability. Several administrators also commented that once the government had begun to pay for MER it can not or should not stop.

Finally, there were some miscellaneous comments by the administrators. Several noted that paying for MER had caused accounting and payment headaches for the DDS, particularly when bills did not accompany the report. Additional staff requirements to handle accounting were also stressed. One administrator claimed that doctors were billing patients for MER even when they were being paid by the DDS. That administrator felt the need for new regulations concerning the claimant's financial obligation for this further payment. Finally, several administrators touted the virtues of tele-dictating reports. Both timeliness and availability were significantly improved with the tele-dictating equipment.

Conclusion

The survey showed that payment generally affected MER positively. A majority of individuals surveyed (62 percent) felt that more sources were willing to supply medical evidence of record and a smaller majority (54 percent) felt that overall case documentation had improved. The percentages of respondents reporting improvement in timeliness, quality and accuracy of decision were smaller. Forty percent reported improvement in the timeliness of receipt of MER, 25 percent reported improvement in quality and nearly a third (32 percent) reported improved accuracy in decisions. The majority (57 percent) saw little effect on the number of CEs purchased, though 17 percent said fewer were purchased and 23 percent said more were purchased.

The survey responses were analyzed by the type of payment plan the DDSs employed and there were only small differences in responses. No particular payment scheme or other characteristic produced a clear consensus of improvement in medical evidence of record.

Administrator's comments varied considerably. One of the largest problems cited was the SSA documentation requirements which increased the number of CEs required. A large number suggested increased public relations and education for the medical community which would make their efforts more responsive to SSA needs.

APPENDIX A

Summary of State Methods

of Payment for

Medical Evidence of Record

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Alabama	Fixed payment $7.50	Fixed payment $7.50	No	No	Yes, if not submitted in 60 days and no longer needed	Allows sources to tele-dictate reports
Alaska	No schedule pays "Reasonable and Customary" charge	No schedule pays "Reasonable and Customary" charge	No	No	No, but may pay less than charged	Operates a drop-off and pick-up arrangement for 2 clinics in Anchorage
Arizona	15 cents per page copy	$15.00 per narrative reports. $5.00 for copies of records	Yes, up to $5.00 more can be paid for comprehensive narrative reports	No	Yes, only if bill not submitted with	Once a week DDS sends employee to photocopy records at State Compensation Board
Arkansas	Fixed payment $15.00	Fixed payment $15.00	No	No	No, unless MER was not requested	DDS sends employee to VA hospitals to photocopy MER reports
California	$5.00 minimum $5.00 to $10.00 photo-copy only $10.00 to $15.00 detailed narrative or SSA-826 $15.00 to $20.00 comprehensive narrative report or extensive photocopy.	Same as to left except more than $20.00 may be paid if physician requests additional payment and report is so comprehensive it is comparable to consultative exam report.	Yes, see left	No	May pay less than requested if poor quality. No payment if not requested.	$5.00 maximum for report over remote telephone dictating system. DDS personnel go to frequently used hospitals and microfilm MERs. Microfilm is processed by commercial firms under contract.
Colorado	$10.00 for copy of records	$10.00 for copy of records, $17.00 for short narrative, $29.00 for full report	No, although have pay for narrative	Yes, $5.00 bonus if received in less than 10 days	Yes, if report is poor quality or over 8 weeks after request	50% of MERs are received in 10 days to qualify for timeliness bonus. DDS staff visit Denver area hospitals to collect MER.

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Connecticut	Usual and customary charge	Fixed payment $15.00	No	No	Yes, when inappropriate	Uses hospital liaison person who who may pickup, photocopy MER. Offers free use of tele-recorder and at option of examiner may enlist claimants assistance.
Delaware	Payment of $5.00 for 1st 10 pages of material plus .50 for each additional page, up to $30.00 maximum.	Same as to left. Up to $20.00 paid for narrative.	No	No	No	DDS employee goes to VA hospitals once a week to copy or pickup MER.
District of Columbia	Maximum of $25.00	Maximum of $25.00	No	No	Yes, rarely does	Reports are requested to be furnished within 14 working days. Requests delivered by hand (weekly) to some D.C. hospitals. Employee travels to NIH to photocopy MER.
Florida	Maximum of $16.00, as set by provider.	Maximum of $16.00, as set by provider.	No	No	Yes, if late and case has been cleared.	In Orlando, one source has DDS employee photocopy MER.
Georgia	Fixed payment of $10.00	Fixed payment of $10.00	No	No	Yes, if poor quality	Occasionally a DDS employee visits an Atlanta hospital to copy reports. That hospital is paid a $5.00 fee.
Hawaii	Fixed payment of $10.00	Fixed payment of $10.00	No	No	No	An employee photocopies MER from four major medical sources. On occasion, doctor's MER is photocopied in-house after pickup by courier. Tele-dictating equipment is sometimes used.

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Idaho	Fixed payment of $10.00	Fixed payment of $10.00 $10.00 additional for narrative report.	No, although pay for narrative	No	Yes, very rare instances where illegible	DDU operates a courier service for photocopying at records at at Boise VA Hospital.
Illinois 1/	50 cents page photocopy maximum $15.00 State institution photocopy $15.00	Chart copy $15.00	N/A	N/A	N/A	
Indiana 1/	50 cents page photocopy maximum $15.00	Photocopy $15.00	N/A	N/A	N/A	
Iowa	Basically $7.50, $30.00 maximum	Basically $7.50, $30.00 maximum	No	No	Yes, rare instances	Staff visit volume and review records.
Kansas	Maximum of 50 cents per page or $5.00	$10.00 for photocopy of office records $20.00 for good narrative	No, although pay for narrative	No	No	DDS photocopies records at VA hospitals. DDS delivers requests and picks up one week later.
Kentucky	$7.50 if the DDS photocopies, $10.00 if submitted photocopy	Same as left except $15.00 if narrative report is written	No, although pay for narrative	No	No	In Louisville, DDS visits sources but does not do photocopying. In Lexington, DDS visits local hospitals to do photocopying. Tele-dictating equipment is available.
Louisiana	Variable, maximum of $15.00	Variable, maximum of $15.00	No	No	Yes, if not adequate	Medical liason personnel to charity hospitals to abstract MER.
Maine	No payment	Fixed payment of $5.00	No	No	Almost never	

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Maryland	$6.00 for photocopies of MER. Up to $20.00 for detailed MER. $12.00 if MER is dictated or narrated.	$6.00 for photocopies of MER. Up to $20.00 for detailed MER. $12.00 if MER is dictated or narrated.	No	No	Yes, if not received in	At some hospitals DDS staff visits weekly to photocopy MERs.
Massachusetts	Fixed payment of $10.00, additional $10.00 if received in 10 days	Fixed payment of $15.00, additional $10.00 if received in 10 days	No	Yes, $10.00 if received in 10 days	Yes, if not appropriate	Payment for translation of foreign language MER. Use private firm to obtain and photocopy hospital records.
Michigan 1/	$15.00 maximum if submitted in 30 days	$15.00 maximum if submitted in 30 days	N/A	N/A	N/A	
Minnesota 1/	$35.00 maximum	$35.00 maximum	N/A	N/A	N/A	
Mississippi	Fixed payment of $10.00	Fixed payment of $10.00	No	No	Yes, if received after case cleared	
Missouri	Photocopies 75 cents to $1.00 per page depending on source	Photocopies 75 cents to $1.00 per page depending on source, $14.00 for written report	No	No	Yes, if received after 20 days, but rarely do	DDS staff visit many of the sources.
Montana	Maximum of $10.00	Maximum of $21.24	No	No	Yes, if late	Reports from VR and welfare are obtained at no cost. Make PR visits to MER sources to obtain feedback on MER procedures.

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Nebraska	95 cents per page with maximum of $15.00	Same as left, and $15.00 for dictated report or if DDS form is filled out	Yes, if allows adjudication without CE	No	Yes, if received more than 30 days after request	DDS does photocopying at VA hospitals in same city as DDS.
Nevada	60 cents per photocopy to maximum of $10.00. $2.00 minimum for 3 or less pages	Same as left, with $25.00 for narrative report	No	No	Yes, only if duplicate is sent	In Las Vegas, a courier service has contract to photocopy MERs from hospitals. Exchange agreement with Rehabilitation Department in Nevada.
New Hampshire	$1.00 per photocopied page to maximum of $15.00	Same as left, plus $16.00 for prepared report (maximum $31.00)	No, although pay for prepared report	No	Yes, if inadequate or later than 6 months	DDS staff identifies material to be copied at VA hospitals, and serves as courier to three other hospitals.
New Jersey 1/	Fixed payment of $10.00	Fixed payment of $10.00	N/A	N/A	N/A	
New Mexico	Varies, up to $18.75	Varies, up to $18.75	No	No	Yes, if inadequate	Secretary and clerk travel to various facilities to abstract MER.
New York 1/	Fixed payment of $10.00	Fixed payment of $10.00	N/A	N/A	N/A	
North Carolina	Fixed payment of $10.00	Fixed payment of $10.00	No	No	Yes, if case has cleared	DDS sends employee to photocopy records at two hospitals in Durham.
North Dakota	Fee paid varies between $5 and $30. Pay more for full summary than photocopies	Fee paid varies between $5 and $30. Pay more for full summary than photocopies	No, although pay more for full summary	No	No	Report may be taken over phone by examiner and will pay if billed.

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Ohio 1/	Fixed payment of $10.00	Fixed payment of $15.00	N/A	N/A	N/A	
Oklahoma	Fixed payment of $15.00	Fixed payment of $15.00	No	No	No	Examiner sent to VA hospital to extract MER.
Oregon	Usual and customary subject to following: $20.00 for up to 10 photocopy pages with 50 cents each additional page	Same as left, with $35.00 for first page of written narrative. $10.00 each additional page. 50 cents a page for photocopies sent with narratives	No, although pay more for narrative	No	Yes, if illegible or if received after case has cleared	Tele-recording for MER and CE reports. Uses courier service for copying in Portland-Eugene-Salem area. Have small portable photocopy machine.
Pennsylvania	Fixed payment of $10.00	Fixed payment of $12.00	No	No	Generally no	DDS will accept telephone MERs and type information and return to physician for signature.
Rhode Island	Generally none, but exceptions are made to pay $10.00 to mental centers and one HMO	Fixed payment of $10.00	No	No	Yes, if inadequate or untimely, seldom used	Courier service is used for copying at several mental health centers and one HMO. Effort is made to resolve inadequate MER from physicians on CE panel.
South Carolina	Telephone reports $5.00 Photocopied reports $10.00	Telephone reports $5.00 Photocopied reports $10.00 Narrative reports $15.00	No, although pay for narrative	No	Yes, if not timely or poor quality	Tele-dictation services are available.
South Dakota	Usual and customary charges, Varies between $5.00 and $150.00. Pay more for written report than photocopy of records	Usual and customary charges. Varies between $5.00 and $150.00. Pay more for written report than photocopy of records	No	No	Yes, occasionally if not timely or of poor quality	

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
Tennessee	Fixed payment of $10.00	Fixed payment of $10.00	No	No	Yes, if useless or received after 30 days	DDS uses a photocopy service in Memphis and Knoxville for which they pay up to $10.00.
Texas	Fixed payment of $15.00	Fixed payment of $15.00	No	No	No	Medical record technicians go to various facilities to copy MER.
Utah	Pay what is billed by hospital	Varies between $10.00 and $28.00. Lower amount for short note or copies. Larger amount for summary report typed by source and received in 10 days. Phones in report is paid $20.00	No	No, except note pay higher amount only if received in 10 days	No, unless not requested	
Vermont	Usual and customary subject to $15.00 maximum	Usual and customary subject to $15.00 maximum	No	No	Yes, if over 30 days after request or no bill submitted	Routinely contacts six hospitals, a number of clinics to do pickups, photocopies. Send regular Thank you cards.
Virginia	As charged to maximum of $14.00	As charged to maximum of $14.00	No	No	No	Richmond DDS sends a representative to certain hospitals on weekly basis to photocopy MER. Virginia Beach DDS does the same for some private hospitals.
Washington	$15.00 for photocopies of notes	$15.00 for photocopies of notes. $7.50 additional if physician writes a narrative report	No	No	Yes, done on rare occasions	DDS operates courier services to certain federal and State hospitals and agencies.

State	Type of payment and amount paid for medical evidence of record		Does State pay more for quality MER	Does State pay more for timely MER	Can State refuse payment for MER	Additional miscellaneous comments/ special arrangements
	Hospital	Doctor				
West Virginia	$9.25 for up to 10 pages plus 25 cents for each additional page	Up to $13.75 for photocopy. Up to $25.00 for comprehensive report	No	No	No	Bridgeport DDS send a staff member to photocopy MER at a University hospital.
Wisconsin 1/	Fixed payment of $12.50	Fixed payment of $12.50	N/A	N/A	N/A	
Wyoming	Fixed payment of $10.00	Fixed payment of $20.00	No	No	Yes, if late or poor quality	

1/ This data comes from a different source than direct inquiries. N/A indicates information was not ascertained.

APPENDIX B

Expenditures on Medical Evidence of Record by State and Region

Expenditures on Medical Evidence of Record by State and Region Fiscal Years 1978-1983
(In thousands of dollars)

	FY-1978	FY-1979	FY-1980	FY-1981	FY-1982	FY-1983
United States........	7,988.1	8,055.1	9,532.7	16,289.4	24,540.9	30,293.1
Boston....................	304.6	106.5	109.0	597.1	1,717.5	1,785.3
Connecticut.............	34.1	51.2	17.4	76.8	131.7	188.0
Maine..................	38.6	23.7	10.4	20.0	36.8	36.1
Massachusetts...........	196.4	0	0	388.8	1,362.8	1,338.6
New Hampshire...........	24.1	13.5	50.2	32.7	58.5	81.2
Rhode Island............	5.3	8.1	16.5	28.4	52.9	34.7
Vermont.................	5.9	10.0	14.6	50.3	74.8	106.7
New York..................	540.6	725.9	911.8	1,308.1	2,249.3	2,878.4
New Jersey..............	119.2	136.6	148.3	190.3	289.8	582.3
New York................	338.8	514.3	603.1	1,068.5	1,635.9	1,988.8
Puerto Rico.............	82.6	74.9	160.4	49.3	323.6	307.3
Philadelphia..............	1,500.7	1,549.5	1,814.8	2,150.6	2,670.9	3,847.1
Delaware................	17.1	14.5	15.7	36.8	77.7	145.1
District of Columbia....	15.7	6.2	13.7	11.7	68.9	59.3
Maryland................	98.4	71.7	77.7	195.2	314.7	373.8
Pennsylvania............	613.6	619.6	672.6	753.5	954.4	1,740.7
Virginia................	568.7	666.5	805.7	910.9	921.1	981.7
West Virginia...........	187.2	170.9	229.3	242.6	334.0	546.5
Atlanta...................	1,747.8	1,855.6	2,247.9	3,736.0	5,615.7	7,104.4
Alabama.................	210.9	228.3	266.2	509.7	631.0	632.9
Florida.................	232.1	238.0	300.2	557.2	1,095.4	1,852.0
Georgia.................	327.4	367.8	464.4	655.0	807.5	983.1
Kentucky................	201.9	220.0	264.3	394.0	535.8	685.8
Mississippi.............	144.5	161.3	187.6	417.1	563.6	674.0
North Carolina..........	306.7	293.0	286.7	697.6	901.0	964.2
South Carolina-VR.......	101.3	106.4	154.9	176.3	273.5	349.0
-Blind....	.5	.4	.6	.7	.8	1.0
Tennessee...............	222.5	240.3	323.0	328.3	807.2	962.4

	FY-1978	FY-1979	FY-1980	FY-1981	FY-1982	FY-1983
Chicago	1,474.1	1,194.2	1,414.6	3,109.7	4,982.9	5,473.6
Illinois	569.8	189.9	240.9	314.2	494.3	556.8
Indiana	122.2	137.9	165.4	314.2	686.7	703.1
Michigan	244.5	269.5	276.9	846.2	1,435.0	1,412.9
Minnesota	98.6	129.4	153.0	167.5	367.4	437.1
Ohio	366.1	385.2	491.0	1,213.6	1,606.9	1,878.1
Wisconsin	73.0	82.4	87.3	254.0	392.6	485.7
Dallas	884.2	920.0	1,092.8	2,431.8	3,531.1	4,516.6
Arkansas	151.4	164.2	237.0	398.4	521.8	618.3
Louisiana	198.3	220.9	158.1	519.8	759.3	952.7
New Mexico	37.5	34.1	57.0	75.7	126.3	213.9
Oklahoma	59.3	45.4	73.0	132.4	189.0	294.1
Texas	437.8	455.4	567.7	1,305.5	1,934.7	2,437.6
Kansas City	251.8	179.0	219.0	581.6	718.8	1,129.8
Iowa	84.1	37.9	40.1	115.8	161.6	210.2
Kansas	40.6	20.6	25.8	53.2	57.6	173.2
Missouri	108.3	97.3	115.7	319.9	342.5	554.5
Nebraska	18.8	23.3	37.4	92.7	157.1	191.9
Denver	51.0	93.6	116.4	426.0	704.1	740.8
Colorado	0	31.4	35.2	192.7	278.2	326.9
Montana	22.4	44.1	36.5	120.7	229.9	184.3
North Dakota	13.4	7.6	9.6	35.5	54.8	59.2
South Dakota	4.7	3.7	14.2	27.6	43.0	54.8
Utah	10.5	5.8	20.2	20.1	45.5	48.3
Wyoming	0	.9	.7	29.5	52.6	67.2
San Francisco	847.4	1,081.7	1,166.2	996.4	1,197.1	1,720.8
Arizona	56.3	91.2	101.5	76.6	160.0	189.8
California	767.2	964.9	1,039.1	853.2	964.0	1,443.8
Guam	0	0	0	0	.5	.6
Hawaii	0	8.5	8.0	36.9	45.7	51.9
Nevada	23.9	17.1	17.6	29.6	27.0	34.7
Seattle	385.9	349.1	440.2	952.0	1,153.6	1,096.3
Alaska	0	.8	0	12.3	18.7	25.5
Idaho	61.1	70.8	32.3	182.2	210.7	256.6
Oregon	72.5	80.5	84.6	188.1	253.0	291.1
Washington	252.2	197.0	323.3	569.4	671.1	523.1

Appendix C

Survey Questionnaires

Attachment A

SSA/OD/DDS
June 1984

STUDY OF THE EFFECTS OF PURCHASING MEDICAL EVIDENCE OF RECORD

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE FOR DDS ADMINISTRATORS

The Disability Amendments of 1980 (PL 96-265), require the Secretary of Health and Human Services to report to the Congress on the effects of the various provisions in the law. One of the provisions in the amendments mandated that SSA pay for medical evidence of record (MER) obtained from treating sources during the routine development of a disability claim. The purpose of this study is to obtain information about the effects of that provision on the timeliness and quality of evidence received from treating sources and on the adjudication process.

Each DDS Administrator who was on duty prior to January 1, 1980, should complete the attached questionnaire. We would like each of you to think back to the time before December 1, 1980 (the effective date of the purchased MER provision) and give us your judgment or impression as to the effect of the MER provision. Please answer every question fully and to the best of your ability. Please detach these instructions before completing the questionnaire.

Your cooperation with the survey is greatly appreciated. Please note that the information you supply will be anonymous. You will not be asked to identify yourself or sign your name on the questionnaire.

SSA/OD/DDS
June 1984

PURCHASE OF MEDICAL EVIDENCE OF RECORD

DDS ADMINISTRATOR QUESTIONNAIRE

A. DDS CODE [1 | 2 | 3]

B. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on the willingness of treating sources to supply MER? (Check one of the following statements that best applies.)

[6] More treating sources supply MER than before payment was possible.

[7] Less treating sources supply MER than before payment was possible.

[8] There has been little change in the number of treating sources that supply MER.

Please explain:

C. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on timeliness of the receipt of MER? (Check one of the following statements that best applies.)

[9] In general, MER is now received in a more timely manner.

[10] In general, MER is now received in a less timely manner.

[11] In general, there has been little change in the timeliness of receipt of MER.

Please explain:

D. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on qualitv (completeness, amount of detail) of MER? (Check one of the following statements that best applies.)

12 The quality of MER received has now substantially improved.

13 The quality of MER now received has worsened substantially.

14 There has been little change in the quality of the MER.

Please explain:

E. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on the number of Consultative Examinations purchased? (Check one of the following statements that best applies.)

15 More consultative examinations are required.

16 Less consultative examinations are required.

17 The number of consultative examinations purchased is about the same.

Please explain:

F. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on overall case documentation. (Check one of the following statements that best applies.)

[18] Case folder documentation is now better than before.

[19] Case folder documentation is now worse than before.

[20] There has been little change on case folder documentation.

Please explain

G. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on accuracy of disability decisions. (Check one of the following statements that best applies.)

[21] The accuracy of disability decisions has substantially improved.

[22] The accuracy of disability decisions has substantially declined.

[23] There has been little change in the accuracy of disability decisions.

Please explain:

H. What problems are still evident in the purchasing of medical evidence of record? How can these problems be solved? (Please explain.)

Attachment B

SSA/OD/DD
June 1984

STUDY OF THE EFFECTS OF PURCHASING MEDICAL EVIDENCE OF RECORD

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE FOR DISABILITY EXAMINERS AND MEDICAL CONSULTANTS

The Disability Amendments of 1980 (PL 96-265), require the Secretary of Health and Human Services to report to the Congress on the effects of the various provisions in the law. One of the provisions in the amendments mandated that SSA pay for medical evidence of record (MER) obtained from treating sources during the routine development of a disability claim. The purpose of this study is to obtain information about the effects of that provision on the timeliness and quality of evidence received from treating sources and on the adjudication process.

Each Disability Examiner and Medical Consultant who was on duty prior to January 1, 1980, should complete the attached short questionnaire. We would like each of you to think back to the time before December 1, 1980 (the effective date of the purchased MER provision) and give us your judgment or impression as to the effect of the MER provision. Please answer every question fully and to the best of your ability. Detach these instructions before completing the questionnaire.

Your cooperation with the survey is greatly appreciated. Please note that the information you supply will be anonymous. You will not be asked to identify yourself or sign your name on the questionnaire.

SSA/OD/DDS
June 1984

PURCHASE OF MEDICAL EVIDENCE OF RECORD

DISABILITY EXAMINER AND MEDICAL CONSULTANT QUESTIONNAIRE

A. DDS CODE [1 | 2 | 3]

B. Respondent
(Check applicable box)

[4] Disability Examiner [5] Medical Consultant

C. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on the willingness of treating sources to supply MER? (Check one of the following statements that best applies.)

[6] More treating sources supply MER than before payment was possible.

[7] Less treating sources supply MER than before payment was possible. (Please explain in the comment section below.)

[8] There has been little change in the number of treating sources that supply MER.

D. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on timeliness of the receipt of MER? (Check one of the following statements that best applies.)

[9] MER is now received in a more timely manner.

[10] MER is now received in a less timely manner. (Please explain in the comment section below.)

[11] There has been little change in the timeliness of receipt of MER.

E. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on quality (completeness, amount of detail) of MER? (Check one of the following statements that best applies.)

[12] The quality of MER received has now substantially improved.

[13] The quality of MER now received has worsened substantially. (Please explain in the comment section below.)

[14] There has been little change in the quality of the MER being received.

F. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on the number of Consultative Examinations purchased? (Check one of the following statements that best applies.)

[15] More consultative examinations are required. (Please explain in the comment section below.)

[16] Less consultative examinations are required.

[17] The number of consultative examinations purchased is about the same.

G. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on overall case documentation. (Check one of the following statements that best applies.)

[18] Case folder documentation is now better than before.

[19] Case folder documentation is now worse than before. (Please explain in the comment section below.)

[20] There has been little change on case folder documentation.

H. Since you began to pay for MER (December 1, 1980) what do you think has been the effect on accuracy of disability decisions. (Check one of the following statements that best applies.)

[21] The accuracy of disability decisions has substantially improved.

[22] The accuracy of disability decisions has substantially declined. (Please explain in the comment section below.

[23] There has been little change in the accuracy of disability decisions.

Comment Section

Item

Comment