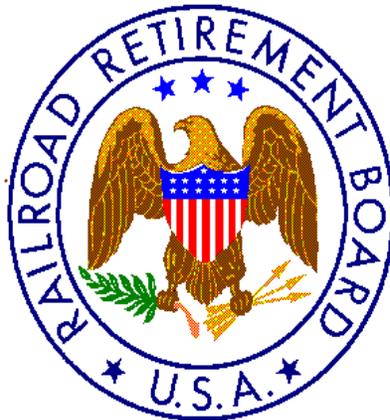


OFFICE OF INSPECTOR GENERAL

Audit Report

**Control Weaknesses Diminish the Value of Medical
Opinions in the Railroad Retirement Board
Disability Determination Process**

**Report No. 16-05
March 9, 2016**



RAILROAD RETIREMENT BOARD

EXECUTIVE SUMMARY

Background

The Office of Inspector General (OIG) for the Railroad Retirement Board (RRB) conducted an audit of the effectiveness of the RRB's contract for medical services. The audit objectives were to determine: (1) if contracted medical opinions added value to the disability determination process, and (2) if the RRB exercised the appropriate contract oversight.

Findings

Our audit found that the reviewed medical opinions provided limited added value to the RRB's disability determination process. The RRB disability claims examiners (RRB claims examiners) accepted opinions with inaccuracies, and assumed the medical doctor considered all evidence in the disability claim file, when the opinion did not support that assumption. In addition, the RRB did not effectively monitor the contract for medical licenses, insurance requirements, and timeliness. Controls were in place to ensure that contract requirements were met, but these controls were not always effective.

Our audit determined:

- Significant weaknesses in controls over the medical opinions decreased their value to the disability determination process. These weaknesses included:
 - medical opinion lacked an overall conclusion;
 - old medical evidence was cited in the medical opinion;
 - conflicting evidence in the medical opinion was not resolved;
 - incomplete medical opinion forms were accepted;
 - medical files were not prepared properly and inefficiencies resulted; and
 - improperly prepared medical opinion forms were identified.
- The RRB failed to monitor aspects of the contract, such as the confirmation of medical licenses and proof of medical liability insurance by the contractor for doctors preparing medical opinions, which exposed the RRB to unnecessary risk. In addition, timeliness aspects of the contract were not effectively monitored.

The RRB did not receive full value for the medical opinions paid for under this contract and weaknesses in the medical opinions diminish their value.

Recommendations

In total, we made 18 recommendations to improve the effectiveness of controls associated with the medical services contract. Key recommendations included:

- modify the medical opinion form to require the doctor to provide a documented conclusion on the medical severity of the claimant's medical ailments;
- revise procedures for RRB claims examiners to ensure that medical evidence cited in the medical opinions is current;
- ensure that RRB claims examiners accept the medical opinions only when all conflicting medical evidence is appropriately resolved;
- improve procedures for RRB claims examiners when reviewing and accepting the medical opinions;
- modify the medical opinion form to elicit required information;
- develop controls to ensure that contract requirements concerning medical licenses and insurance are monitored properly; and
- develop controls to ensure timeliness of the medical opinions and to ensure that the contract is properly monitored.

Management's Response & Our Comments

RRB management has agreed to take corrective action for 12 of the 18 recommendations made in this report. The full texts of management's responses are included in Appendices V and VI, and a detailed description of Management's response to each recommendation and our comments are incorporated throughout this report.

Fourteen recommendations were made to the Office of Programs (OP), which concurred with eight recommendations and did not concur with six recommendations. Regarding the six recommendations with which OP did not concur, these OIG recommendations were intended to improve the value medical opinions provide to the RRB's disability determination process based on the weaknesses identified in the 226 disability cases reviewed as part of the audit. Improving the quality of medical evidence is imperative in the RRB's disability program, especially as it has faced Congressional, Government Accountability Office, and OIG scrutiny. In fact, improving medical evidence is a key part of the RRB's disability program improvement plan as reported by the Three-Member Board to Congress in 2015. Specifically, the RRB explained that it relies on three major medical sources of information, one of which is consultative medical opinions, and stated that these opinions are rendered by contracted independent physicians who review all of the medical evidence in the applicant files and render an opinion. By not implementing these recommendations, the RRB does not receive the full value of a key control intended to incorporate medical professionals as a component of the disability adjudication process. For the eight recommendations with which they concurred, OP proposed corrective action to address the recommendations.

The remaining four recommendations, made to improve contractor administrative oversight, were directed to the Office of Administration (OA). OA concurred with the recommendations and agreed to take corrective action. However, for one recommendation, the corrective action proposed only partially meets the intent of the recommendation.

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INTRODUCTION

This report presents the results of the Office of Inspector General's (OIG) audit of the effectiveness of the Railroad Retirement Board's (RRB) contract for medical services.

Background

The RRB is an independent agency in the executive branch of the Federal government. The RRB administers comprehensive retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act (RRA) and the Railroad Unemployment Insurance Act. These programs provide income protection during old age and in the event of disability, death, temporary unemployment, or sickness. During fiscal year 2015, retirement and survivor benefit payments totaling approximately \$12.2 billion were paid to about 558,000 retirement and survivor beneficiaries.

The RRB reported that during fiscal year 2014 it paid approximately \$160 million to about 5,300 annuitants receiving an occupational disability. The RRB also reported that they paid approximately \$1.2 billion to about 36,400 annuitants who first received a disability benefit under the occupational disability standards but then were subsequently adjudicated by RRB claims examiners to meet the Social Security Administration's standards to receive a total disability. The average monthly payments were \$2,686 for occupational disabilities and \$1,671 for total and permanent disabilities.

Under the RRA, a disability annuity terminates when an individual ceases to be disabled, dies, or attains full retirement age, which is between the ages of 65 and 67 depending upon the individual's year of birth. When an individual reaches full retirement age, their annuity converts to an age and service annuity.

Disability Determination at the RRB

The RRA mandates a disability program, which is administered by the Office of Programs' (OP) Disability Benefits Division (DBD), within the RRB. This office is responsible for evaluating evidence submitted in support of disability applications, obtaining additional evidence when necessary, and awarding or denying disability benefits. The RRB has contracted for medical consulting services because additional medical services were sometimes used when making determinations of disability for railroad employees, their widows, or dependents. The medical services contractor at the time of this audit had been the provider of medical consulting services for the RRB since 1981, with one five-year interruption.¹ Under the terms of the contract, the contractor provided medical services, including medical opinions, training, and onsite visits to the RRB. Our audit focused mainly on the medical opinions provided by the contractor. A medical opinion was a document, prepared by a licensed medical doctor, summarizing

¹ The contract that was the subject of this audit expired on September 30, 2015. A new contract was awarded and the new contractor began providing medical services on December 1, 2015.

their review of documents in a disability claimant's folder. The documents reviewed would include medical records, hospitalization records, RRB forms, and other pertinent documents. Other medical services provided by the contractor include providing medical policy clarification, development and interpretation of standards, training for RRB disability claims examiners (RRB claims examiners), and onsite visits to RRB headquarters to work with RRB claims examiners on disability claims. These services were provided by a medical contractor because RRB claims examiners were not trained medical experts such as doctors, nurses, or clinicians.

When RRB claims examiners determined a medical opinion was necessary for a disability case, they prepared a request form called Medical Opinion Request (hereafter referred to as a request for medical opinion).² An example of a blank request for medical opinion form is shown in Figure 1. At the time of our review, some disability determinations, such as, disability denial decisions, decisions that must be coordinated with the Social Security Administration, and medical reviews to determine if a disabling condition had improved, required a medical opinion.

² Independent medical examinations (IME) may also be ordered by the RRB. The documents that are created for the record of the IME become part of the medical evidence in the disability case. These documents are also part of the medical evidence that will be reviewed for the medical opinion. However, the IME is ordered through a separate contract. Medical examinations were not part of this audit.

Figure 1: Request for Medical Consultant Opinion

NAME: _____	CLAIM NUMBER: _____
EXAMINER: _____	DATE: _____
MEDICAL OPINION REQUEST	
A. <u>Type of Application/Decision</u>	
<input type="checkbox"/> Occupational	<input type="checkbox"/> T & P
<input type="checkbox"/> Dual Freeze	<input type="checkbox"/> Reconsideration
<input type="checkbox"/> Child	<input type="checkbox"/> Widow(er)
<input type="checkbox"/> Continuing Disability Review	<input type="checkbox"/> Single Freeze
B. <u>Type of Request</u>	
<input type="checkbox"/> Re-evaluation for Significant Medical Improvement	<input type="checkbox"/> Onset Date
<input type="checkbox"/> Severity Assessment & RFC	<input type="checkbox"/> Rep Payee Needed
	Alleged Onset Date: _____
C. <u>Examiner Summary/Questions/Comments</u>	
D. <input type="checkbox"/> <u>Treating Source RFC(s) in file (See Below)</u>	
E. <input type="checkbox"/> <u>Examining Source RFC(s) in file (See Below)</u>	

Below is a list of the most common reasons a medical opinion was requested as part of the RRB's disability program determination process. This list includes each choice in the form above under "A. Type of Application/Decision." A Glossary in Appendix I at the end of this report has further definition for these terms and for other terms used in this report.

1. Occupational – Occupational Disability Annuity - A railroad employee may qualify for an occupational disability if the employee is permanently disabled for work in their regular railroad occupation. There are age and service requirements also.
2. T&P – Total and Permanent Disability - A claimant may qualify for a total and permanent (T&P) disability if permanently disabled for all types of work. There are age and service requirements also.
3. Child – Disabled Adult Child - An unmarried disabled child over age 18 is entitled to a survivor annuity if the child became totally and permanently disabled before age 22.

4. Widow(er) - A widow(er) between ages 50-59 may receive an annuity if the widow(er) is totally and permanently disabled and unable to work in any regular employment.
5. Single Freeze - The single freeze determination includes a requirement that the employee meets the definition of disability under the Social Security Act, meaning an inability to work in any substantial gainful activity. A career railroad employee may be granted a single freeze when applying for a disability annuity.
6. Dual Freeze - The dual freeze determination includes a requirement that the employee meets the definition of disability under the Social Security Act, meaning an inability to work in any substantial gainful activity. A career railroad employee may be granted a dual freeze when applying for a disability annuity, if there is a likelihood that Social Security benefits may be paid.
7. Reconsideration - When an initial disability decision is made and the claimant disagrees with the decision, the claimant may ask for a reconsideration of that decision.
8. Continuing Disability Review - Continuing disability reviews (CDR) are conducted after disability benefits are awarded by the RRB. CDRs may be conducted to assess the current medical condition.

After the request for a medical opinion was prepared, clerical staff in the DBD entered the request into the Financial Management Integrated System (FMIS), to be paid after the RRB claims examiner accepted the opinion for payment. Then the form and the disability claim folder were picked up by the contractor so that the contractor could prepare a medical opinion.

When the medical opinion was complete, it was returned to the requesting RRB claims examiner for review, along with the claim file.³ The RRB claims examiner reviewed the medical opinion and determined whether to accept or reject the medical opinion. If the RRB claims examiner accepted the medical opinion, then the RRB claims examiner updated the approval of the medical opinion in FMIS. If the RRB claims examiner rejected the opinion, the reason for the rejection was recorded and the opinion form and the file was sent back to the contractor. See Appendix II for an example of the medical opinion form.

Listing of Impairments Used in Medical Opinions

Certain disability cases involve an examination of a claimant's condition and a determination that the condition is found in the "Listing of Impairments" (hereafter referred to as "the listing").⁴ The listing defines common medical conditions, such as chronic heart failure or chronic liver disease, and how to review medical evidence for these conditions. For some determinations of disability, a medical condition must be

³ In some instances, the medical services provider prepared a medical opinion on a different form, such as a Social Security Administration form used for psychiatric opinions.

⁴ Title 20 Code of Federal Regulations (CFR) Part 404, Subpart P, Appendix 1.

found to either “meet or equal the listing.” A claimant’s condition “meets the listing” when the impairment manifests as described in the medical criteria for that impairment in the listing. The claimant’s condition “equals the listing” when the medical findings for the claimant are at least equivalent to those specified in the listing.

Contract Specifications for Medical Opinions

The Acquisition Management group in the Office of Administration (OA) at the RRB manages the agency’s contracting activities including selection, award, administration, and close out of all agency contracts. The Chief of Acquisition Management is the agency’s Contracting Officer and is the only person authorized to make or approve changes in contract requirements. The Contract Official’s Representative’s (COR) responsibilities include monitoring the contractor’s performance and providing technical direction within the scope of work defined in the contract. The COR for the medical services contract is the Director of DBD.

One of the requirements for medical opinions, as included in the contract at the time of our review, is that the contractor must review the medical evidence received in support of disability based claims and prepare advisory medical opinions. These medical opinions will clearly communicate specific considerations when appropriate. The specifics that must be communicated in the medical opinions include:

1. a severity assessment of the physical and mental impairments cited;
2. whether the physical and mental impairments cited are medically disabling and/or meet or equal the Listing of Impairments and/or provide a medical assessment for RRB claims examiners to use to determine a railroad occupational disability decision;
3. a complete, comprehensive and appropriate residual functional capacity (RFC) assessment based on the medical evidence in file and considering RFC assessments from treating or consulting physicians⁵ ;
4. the resolution, if possible, of conflicting evidence and opinions;
5. a reasonable disability onset date based on the medical evidence of record, including dates of changes in the severity level of the impairment; and
6. the frequency of future medical reviews to be conducted in accordance with the RRB regulations.

If an opinion is being prepared in a continuing disability review case, the opinion must determine whether significant medical improvement has occurred by comparing the annuitant’s present physical and mental impairments to the physical and mental

⁵ A residual functional capacity (RFC) assessment is based on whether the claimant’s impairment(s) causes physical and mental limitations that affect what the claimant can do in a work setting. The RFC is an assessment of what the claimant can do despite his or her limitations. The assessment of the claimant’s RFC for work is not a decision on whether the claimant is disabled, but is used as the basis for determining the particular types of work the claimant may be able to do despite his or her impairment(s).

impairments that existed at the time of the most recent favorable disability decision. In some cases, the opinion may contain a recommendation for medical evidence or for a consultative medical examination when a medical assessment cannot be provided based on the information in file or if needed for resolution of conflicting evidence and/or opinions. In occupational disability cases, this can include but is not limited to functional capacity examinations.

Under the terms of the contract, the contractor is to maintain a roster of doctors on staff to perform professional medical services for the RRB, including the preparation of medical opinions for individual cases. The doctors were required to maintain current licenses and to have had a variety of fields of medicine represented in their experience and education. The doctors that perform these professional medical services were also required to maintain evidence of medical liability insurance.

The RRB paid the contractor approximately \$1.7 million since fiscal year 2011, as shown in Table 1.

Table 1: Amounts Paid to Medical Services Contractor for fiscal years 2011 - 2014

Fiscal Year	Amount Paid
2011	\$460,628
2012	\$448,558
2013	\$396,340
2014	\$402,745
Total	\$1,708,271

The terms of the contract also included timeliness standards. For a medical opinion to be timely, it should be rendered to the RRB within five business days of the request. If the medical opinion is deemed urgent by the RRB, then the medical opinion must be rendered within two business days of the request. These standards must be met for at least 95 percent of the cases for medical opinions.

Contractor's timeliness was monitored through a multi-step process. First, the RRB claims examiner entered the request date on the medical opinion request form. A clerk in the disability section stamped the anticipated return date on the opinion request form. When the opinion was returned to the RRB, the return date was recorded on the opinion request form. The return date was then entered into FMIS and a monthly report regarding timeliness was produced.

Recent Events Concerning the Disability Determination Process at the RRB

In February 2014, the OIG sent a letter to the RRB's Three-Member Board to alert the RRB to serious and flagrant deficiencies in the administration of the RRB's occupational disability program. The OIG issued this letter using the authority granted in Section 5(d) of the Inspector General Act of 1978 (5 U.S.C. App. 3, Sec. 5 (d)). A letter issued using this authority is often referred to as a "Seven-Day Letter." Additionally, 33 people were charged in connection with the Long Island Rail Road occupational disability fraud and all have pled guilty or were convicted at trial. These events raised concerns about the RRB's occupational disability program.

On May 1, 2015, the RRB's Inspector General and the Chairman of the RRB's Three-Member Board testified before the U.S. House of Representatives, Committee on Oversight and Government Reform, Subcommittee on Government Operations. The Inspector General testified on systemic deficiencies within the RRB's occupational disability program. This audit was conducted with a consideration for the OIG's concerns.

During 2015, the RRB proposed several changes to the administration of the disability program. The RRB also developed a Disability Program Improvement Plan (DPIP) that contains these proposed changes. One proposal was to increase the amount of time the medical doctors would visit RRB headquarters to meet with RRB claims examiners. During the audit, RRB officials confirmed to us that these increased visits began in April 2015. The scope of this audit is calendar year 2014; therefore this audit does not assess any impact that these visits may have had on the disability determination process. Another proposal in the DPIP was for the Disability Advisory Committee to assess the increased onsite visits by medical consultants. These assessments are projected to be completed by May 1, 2017. Because these assessments are not yet available, they are outside the scope of this audit.

The DPIP also proposed to increase the number of Independent Medical Examinations (IME) required for disability applicants. This proposal would require all disability applicants claiming orthopedic and mental impairments to undergo an IME. IMEs are provided to the RRB under a separate contract.

Recent events, such as the Seven-Day Letter, Long Island Rail Road fraud prosecution, and the May 2015 congressional hearing, raised concerns for the need for effective oversight, controls, and monitoring of the RRB disability program.

Strategic Objectives and Goals

The medical services provider contract that we reviewed impacted several of the RRB's strategic objectives. These objectives are to:

- pay benefits timely and accurately;

- use outside sources and partnerships, when appropriate, to accomplish the agency's mission; and
- ensure that the RRB consistently pays the lowest price for products and medical services commensurate with quality, service, delivery, and reliability.

This audit addresses the RRB's strategic goals of:

- providing excellent customer service; and
- serving as responsible stewards for our customers' trust funds and agency resources.

Audit Objectives

The audit objectives are to determine if:

- medical opinions added value to the disability determination process; and
- the RRB exercised the appropriate oversight of the medical services contractor.

Scope

The scope of this audit includes all paid medical opinions for the medical services provided in calendar year 2014. As discussed previously, this audit does not assess any program modifications put in place after calendar year 2014.

Methodology

To accomplish our objective, we:

- reviewed agency policies and procedures to obtain an understanding of the RRB's disability determination process;
- tested a statistically valid sample of 226 disability cases where a paid medical opinion was received in calendar year 2014, to assess the effectiveness of the internal controls over the medical opinion process, and to assess the value of the paid medical opinions to the disability determination process. This testing included reviewing the disability case file, medical opinion, and any other pertinent information to answer our audit objectives. One type of sampling was estimation sampling which allows a projection of a minimum number of errors that may be found in the universe of paid medical opinions. See Appendix III for the appendix presenting the sample results and Appendix IV for an analysis of sample case characteristics;

- performed a second type of statistical sampling for control tests to determine if the controls tested were operating as intended. This type of sampling was a one-step acceptance sample. See Appendix III for the sample results;
- reviewed regulations regarding medical opinions and medical services;
- interviewed RRB staff responsible for disability claims determinations;
- obtained and reviewed documentation for the medical services contract;
- obtained an understanding of agency procedures used in evaluating medical opinions for the disability determination process;
- obtained and reviewed copies of reports of timeliness for the contracted medical opinions; and
- assessed the reliability of data used in this audit by reviewing existing documentation regarding certification and approvals, interviewing responsible agency personnel that are knowledgeable about the system, and identifying the relevant controls for preparation and approval of transactions. We concluded that the data are sufficiently reliable for the purpose of the audit.

We conducted field work from March 2015 through August 2015 at RRB headquarters in Chicago, Illinois.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

RESULTS OF AUDIT

We found that the reviewed medical opinions provided limited added value to the RRB's disability determination process. RRB claims examiners accepted opinions with inaccuracies and assumed the medical doctor considered all evidence in the disability claim file when the opinion did not support that assumption. In addition, the RRB did not effectively monitor the contract for medical licenses, insurance requirements, and timeliness. Controls were in place to ensure that contract requirements were met, but these controls were not always effective.

Our audit determined that:

- significant weaknesses in controls over medical opinions decreased their value to the disability determination process; and
- failures to monitor aspects of the contract exposed the RRB to unnecessary risk.

Overall, we tested 21 internal controls, 13 of which were tested for operating effectiveness. We found that 8 of the 13 controls tested for effectiveness were not operating as intended. We also found 3 additional controls where test results indicated control weaknesses. See Appendix III for the list of controls and test results.

The details of our findings and recommendations for corrective action follow. We made 18 recommendations to the RRB. RRB management has agreed to take corrective action for 12 of the 18 recommendations. The full texts of management's responses are included in Appendices V and VI.

Fourteen recommendations were made to OP, which concurred with eight recommendations and did not concur with six recommendations. Regarding the six recommendations with which OP did not concur, these OIG recommendations were intended to improve the value medical opinions provide to the RRB's disability determination process based on the weaknesses identified in the 226 disability cases reviewed as part of the audit. Improving the quality of medical evidence is imperative in the RRB's disability program, especially as it has faced Congressional, Government Accountability Office (GAO), and OIG scrutiny. In fact, improving medical evidence is a key part of the RRB's DPIP as presented by the Three-Member Board to Congress in 2015. Specifically, the RRB explained that it relies on three major medical sources of information, one of which is consultative medical opinions, and stated that these opinions are rendered by contracted independent physicians who review all of the medical evidence in the applicant files and render an opinion. By not implementing these recommendations, the RRB does not receive the full value of a key control intended to incorporate medical professionals as a component of the disability adjudication process. For the eight recommendations with which they concurred, OP proposed corrective action to address the recommendations.

The remaining four recommendations, made to improve contractor administrative oversight, were directed to OA. OA concurred with the recommendations and agreed to take corrective action. However, for one recommendation, the corrective action proposed only partially meets the intent of the recommendation.

Weaknesses in Controls over Medical Opinions Decreased Their Value to the Disability Determination Process

Control weaknesses over medical opinions limited their usefulness as part of the disability determination process. The RRB claims examiners obtained medical opinions and accepted them even though they lacked a conclusion on the medical severity of the claimant's impairment, which significantly negated any added value to the process. The RRB claims examiners did not always prepare the disability file properly when requesting a medical opinion. The RRB claims examiners did not always properly sign and date the medical opinion forms. In addition, we found that the medical doctors preparing the medical opinions:

- sometimes cited medical evidence in the medical opinion that was not current;
- did not always resolve conflicts found with medical evidence in the claim file;
- did not complete all parts of the form and did not always complete them accurately;
- failed to include a reference to all applicable medical evidence in the claim file; and
- did not always sign and date the medical opinion form properly.

Lack of Conclusion on Medical Severity Decreased Value of Medical Opinions

The intent of the contract for medical opinions and services was to incorporate medical expertise in the RRB's disability determination process. However, as it was designed at the time of our review, the medical opinions added limited value to the determination process because the doctor was not required to conclude on an overall severity assessment of the claimed disabling condition. As a result, nonmedical RRB claims examiners had to interpret all of the individual statements made by the doctor in the medical opinion in order to conclude on the overall severity assessment for the claimed disabling condition. For our sample case review of 226 cases, 146 cases had no clearly stated conclusion on the overall severity of the claimed disabling condition.

The contract specified what information was to be conveyed in a medical opinion. Specifically, the contract required the contractor to prepare a medical opinion with a severity assessment of the physical and mental impairments cited, when appropriate. The contract also contained a specification that the contractor clearly communicates their medical opinion.

In one case reviewed, a railroad worker applied for disability benefits based on medical ailments that included bulging cervical disks. The RRB claims examiner requested a medical opinion to provide a severity assessment of the worker's claimed medical conditions. In the medical opinion, the doctor checked boxes assessing such things as the claimant could lift or carry up to 20 pounds occasionally, stand or walk at least 6 hours in an 8 hour work day, and noted postural limitations that included never climbing when ladders, ropes, or scaffolds are present. There is no box provided for, and the doctor did not write in, a conclusion as to the overall severity of the worker's claimed conditions. On the RRB claims examiner's Disability Decision Rationale form, the RRB claims examiner stated, "[t]he medical consultants have given the claimant an RFC for light work" even though auditors found no evidence of that statement or conclusion on the medical opinion form. In this case, the RRB claims examiner granted the total and permanent disability annuity based on a determination that the railroad worker could not perform any substantial gainful work.

In another case that we reviewed, a railroad worker applied for disability benefits based on medical ailments that included lumbar spine herniated disc, spinal stenosis, and radiculopathy. The RRB claims examiner requested a medical opinion. The medical opinion was prepared by the contractor and noted limitations, including lifting or carrying up to 20 pounds occasionally, standing or walking at least 6 hours in an 8 hour work day, and inability to walk on uneven terrain. These limitations and others were indicated in the medical opinion on the railroad worker's ability to perform work in certain conditions. There is no box provided for, and the doctor did not write in, a conclusion as to the overall severity of the worker's claimed conditions. On the RRB claims examiner's Disability Decision Rationale form, the RRB claims examiner stated, "Based on impairments EE [employee] has a light residual functional capacity with restrictions," even though auditors found no evidence of that statement or that conclusion on the medical opinion form.

As stated above, of the 226 cases we reviewed, we found 146 cases where the medical opinions did not come to a conclusion on the severity of the applicant's condition. For the remaining 80 cases, most had a claimant's condition that met or equaled the listing, and the claimant was found to be totally and permanently disabled. Some of the other cases had a medical opinion that requested more medical evidence, or the case had a determination pending, or other circumstances where a conclusion was not necessary.

The GAO's *Standards for Internal Control in the Federal Government* (GAO Standards) provides an overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges and areas of greatest risk of fraud, waste, abuse, and mismanagement.⁶ Internal control is an integral component of an organization's management that provides reasonable assurance concerning the effectiveness and efficiency of operations, reliability of financial reporting, and compliance with applicable laws and regulations. GAO

⁶ Government Accountability Office, *Standards for Internal Controls in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C., November 1999). A newer version, effective beginning in fiscal year 2016 has been published, GAO 14-704G (Washington, D.C., September 2014).

Standards state that an entity must control its operations by having relevant, reliable, and timely information. GAO Standards also require the design of internal control that assures ongoing monitoring, including comparisons and reconciliations to assess the quality of performance. In preparing medical opinions, doctors are recording information to communicate their assessment of the claimant's condition and how it relates to the claimant's ability to work. This opinion is significant to the disability determination process.

While the medical opinion form contains areas for doctor's notes, it has no distinct section for the doctor to explain their methodology or state an overall conclusion. When we discussed this matter with RRB officials, they stated that the doctor provided appropriate information, but did not make the disability determination. RRB claims examiners requested medical opinions because they are not medically trained and need to obtain a medical doctor's severity assessment. However, the RRB accepted the medical opinions without a clearly communicated conclusion on the severity assessment. Without a clear conclusion provided by doctors with medical expertise, the purpose of obtaining the medical opinions is not fulfilled. Without a documented conclusion, the medical opinion does not adequately provide independent medical expertise to the RRB claims examiner in determining a claimant's ability to work or to receive disability benefits. For fiscal year 2014, the RRB paid the contractor approximately \$400,000. These payments are an inefficient use of funds because the RRB did not receive a clearly documented medical conclusion with the medical opinion, and therefore, did not get the independent medical expertise for which they had contracted.

Recommendation

1. We recommend that the Office of Programs modify the medical opinion form to require the doctor to provide a documented conclusion on the medical severity of the claimant's medical ailments.

Management's Response & Our Comments

With regards to Recommendation 1, OP did not concur. OP stated that during a meeting held with the OIG in January 2016, the auditors indicated that the medical opinion should include a Residual Functional Capacity (RFC) conclusion (i.e., a determination of if the applicant's limitations are sedentary, light, or medium). Further, OP states that the overall RFC determination is an administrative determination that is required under the Code of Federal Regulations (CFR) to be made by the examiners, not a medical source, and claims examiners have to consider factors such as age, education, and past work experience, which are vocational factors that are not within the expertise of medical sources as specified in the CFR.

OIG continues to believe this recommendation should be implemented and notes that in our report we do not indicate that the medical opinion should include a RFC conclusion. The audit report and this recommendation specifically call for a conclusion of the

medical severity of the claimant's medical ailments to be in compliance with the contract requirements that the contractor review medical evidence received in support of disability claims and prepare advisory medical opinions clearly communicating, when appropriate, a severity assessment of the physical and mental impairments cited. Without this conclusion, the RRB is not fully leveraging medical expertise in its disability determination process.

Medical Evidence Cited in the Medical Opinion Was Not Current

The OIG found six cases in which the medical opinion included medical evidence that was not current, as defined in RRB policies. Specifically, disability case files in our sample had medical opinions where medical evidence was cited that was older than the most recent 12 month period, with no explanation why the older evidence was cited.

The Disability Claims Manual (DCM) instructs RRB claims examiners to consider medical evidence from the most recent 12 month period. Exceptions apply for determinations of child and widow disability benefits, disability onset dates, and single freeze determinations. In the sample cases where older evidence was cited, it appeared that the doctor mentioned this older evidence to make the opinion more robust.

In one case we reviewed, the medical opinion was requested for a dual freeze determination for a railroad worker. The medical opinion was dated June 5, 2014. The onset date was established as May 2013. The medical evidence cited included x-ray reports dated April 2012. No explanation was given in the medical opinion about why this older evidence from 2012 was cited. Based on the DCM, there were no exceptions in the circumstances of the case that would allow for the older evidence to be used.

In another case, a medical opinion was requested for a dual freeze determination for a railroad worker. The medical opinion was dated August 27, 2014. The onset date was established as May 2014. The medical evidence cited in the medical opinion included evidence dated April 2008, June 2008, November 2011, March 2012, and December 2012. Based on the DCM, there were no exceptions in the circumstances of the case that would allow for the older evidence to be used.

The RRB's procedures for the acceptance of medical opinions were not specific. While initially it would appear that considering a long-term medical history would be useful in making a disability determination, dated medical information may not accurately reflect improvement of the medical condition in more recent years. Thus, disability determinations may have been based on medical evidence that no longer accurately represents the claimant's current medical condition.

Recommendation

2. We recommend that the Office of Programs revise procedures to instruct RRB claims examiners to ensure that all medical evidence cited is current, prior to accepting the medical opinion.

Management's Response & Our Comments

With regards to Recommendation 2, OP concurs. Management stated that the recommendation was based on a review of cases where the medical opinion cited older evidence rather than evidence from the most current 12 months. OP outlined that the DCM is one of many procedure references examiners use to adjudicate claims and the CFR outlines the considerations for determining a period of disability. They also pointed out that the cited medical evidence in the opinion is one of many factors and stated that the older evidence may be the most relevant for supporting the established severity. They agreed to remind claims examiners to confirm that any newer evidence does not conflict with the cited medical opinion evidence. The OIG does not consider this action to fully address the recommendation. In addition to confirming that newer evidence does not conflict with the cited medical opinion, the RRB claims examiners need procedures to ensure that current medical evidence in file is considered in reviewing the claimant's medical condition and that undue reliance is not placed on dated medical evidence when new evidence may show an improvement in the disabling condition.

Contractor Did Not Resolve Conflicting Medical Information

We noted instances when the doctor stated disagreement with the results of a medical examination in the disability claim file, including instances when the examination was performed by RRB contracted medical examiners, also known as an independent medical examinations or IMEs. Specifically, in 87 of the 226 sample cases we reviewed, the doctor disagreed with medical examination findings; however, the doctor did not explain the disagreement, except to say that the examining doctor's residual functional capacity determination did not agree with the medical evidence. The doctor did not resolve the conflict in the opinion.

The contract requires the doctor to clearly communicate the resolution of conflicting evidence and the medical opinion. Therefore, the doctor preparing the opinion must reconcile a conflict found between the opinion prepared and evidence in the file that created a conflict.

When reviewing the 87 sample cases where the doctor stated disagreement in the medical opinion, we found that RRB claims examiners accepted these medical opinions without requiring the conflicts to be resolved. Further, we determined that the RRB claims examiners put more emphasis on the medical opinion and disregarded the residual functional capacity examination assessment, which includes an in person examination of the applicant. In many of these cases, the RRB paid for medical opinions and did not require that the conflict with the medical evidence in file be resolved.

If the medical services contractor is not required to fulfill the contract by detailing the conflicting medical evidence and resolution of the conflict in the medical opinion, then not only are those services of limited value to the determination process, but the payments were an inefficient use of funds. Further, unless given appropriate weight in the determination process with the conflicts reconciled, the medical examinations provide limited value to the determination process and may be wasteful spending. In fiscal year 2014, the RRB paid approximately \$1.8 million for medical examinations for disability claimants.

The RRB has proposed changes to the disability program in the DPIP. One of the proposed changes would require that all disability applicants claiming orthopedic and mental impairments will undergo an independent medical examination. If the RRB increases the number of examinations ordered without assuring that conflicts are appropriately resolved, the amount paid for ineffectual examinations will increase.

Recommendation

3. We recommend that the Office of Programs ensure that medical opinions resolve all conflicting medical evidence.

Management's Response & Our Comments

With regards to Recommendation 3, OP does not concur. They stated that according to the DCM, medical opinions are used to resolve significant differences in medical findings and that disability examiners ensure that opinions that they receive resolve conflicting relevant medical evidence for the primary impairment. The OIG disagrees with the conclusion by OP based on the 87 cases identified in our statistically valid sample in which there were conflicts between the medical opinion prepared and the medical evidence submitted that were not resolved. Based on the statistically valid sample, we project that approximately 1,200 cases in the year under audit, or about 34%, were received in which the doctor did not resolve conflicting evidence and the doctor did not explain the conflict in the opinion. This, combined with our finding that claims examiners placed greater emphasis on the medical opinion and disregarded the residual functional capacity examination assessment, which includes an in person examination of the applicant, highlight the importance in the RRB ensuring that medical opinions resolve all conflicting medical evidence.

Medical Opinion Forms Not Completed Properly or Accurately

Based on the 226 sample cases we reviewed, we found that doctors preparing medical opinions did not always complete the opinion form properly. Doctors left required sections of the medical opinion form blank or did not complete sections properly (126 instances), medical opinions were not always properly referenced to evidence in the folder (15 instances), and all current applicable medical evidence in the case file was not referenced in the medical opinion (53 instances).

We identified 126 cases that did not have all required sections of the medical opinion form completed properly. The medical opinion form has specific sections that must be completed, including sections on the physical ailments of the claimant and limitations and restrictions on the claimant's ability to work. In some instances, additional forms are used for psychiatric and mental ailments. Some instances where the medical opinion form was not completed properly included the following:

- A specific section of the opinion form in which the doctor is asked to indicate by checking a 'yes' or 'no' box whether the treating source statements regarding the claimant's physical capacity is complete and consistent with the medical evidence. In the sample cases we reviewed, this section was not completed in 36 cases.
- A section of the opinion form in which the doctor is asked to note any postural limitations and to describe the specific type of physical activity where the postural limitations would occur. The doctor noted postural limitations by checking boxes on the form but did not include any description of the activity. As a result, the information was incomplete.
- Another section of the opinion form in which the doctor noted environmental limitations by checking a box. The form has space below the box where the doctor must describe the environmental limitation noted. The doctor did not complete the description section for environmental limitations.
- A psychiatric form where boxes may be checked by the doctor including one box that is checked when there is an impairment present that does not satisfy diagnostic criteria. After noting the disorder, there is an area for the doctor to describe symptoms, signs, and laboratory findings that substantiate the impairment. The doctor left the description area blank.

We also identified 15 instances in our sample where the medical opinion was not properly referenced to the evidence in the disability claim folder. As a result, the medical opinion did not always provide a complete and accurate summary of supporting evidence contained in the disability claim folder, as required by the contract. We noted the following instances when this occurred:

- A medical opinion referenced medical evidence from the applicant's treating physician with a specific date. Our review of this sample case did not disclose evidence from the treating physician with this date.

- A medical opinion referenced an examination with a specific date. Our review of this case did not disclose an examination that took place on that date.
- A medical opinion was requested by the RRB claims examiner to consider additional medical evidence and an RFC exam with a specific date. The medical opinion prepared does not reference the additional medical evidence or the RFC.

Finally, we identified 53 cases where the disability case file contained current medical evidence that should have been referenced in the medical opinion, but was not.

RRB claims examiners did not properly identify these deficiencies. We observed deficiencies in the process RRB claims examiners follow when reviewing and accepting medical opinions. RRB claims examiners did not have complete procedures to follow in order to evaluate the completeness and accuracy of the medical opinion. As a result, RRB claims examiners often overlooked incorrect references to specific examinations or evidence in file that was not cited in the medical opinion. We discussed these weaknesses on several occasions with RRB officials and RRB claims examiners who explained that they assumed all medical information had been considered by the contractor. Specifically, we were told that if:

- information was missing or inaccurately referenced they had assumed the information had been considered by the doctor;
- there was an incorrect date for medical evidence and if the RRB claims examiner could still identify the evidence considered, they would not ask the contractor to correct the date or to identify the specific evidence referenced; or
- a medical opinion did not mention medical evidence that was in the file, RRB claims examiners assumed that all evidence was considered even though it was not cited in the medical opinion.

The contract specifications for medical opinions stated that the doctor shall review medical evidence received and prepare a medical opinion that clearly communicates the appropriate severity assessment of the impairments cited and other specific details. In addition, the contract states that the RRB has sole authority to determine whether a medical opinion is acceptable. The RRB may return an opinion to the contractor if it is determined to be unacceptable. The contract requires the contractor to review medical evidence received in support of disability based claims.

Because RRB claims examiners did not have complete procedures to follow when a medical opinion was received from the contractor, they did not always properly evaluate the medical opinion details, resolve missing or incomplete information, or know why medical evidence was omitted from the medical opinions. As a result, RRB claims examiners may have made inaccurate disability determinations based on incomplete and inaccurate medical opinions provided by the contractor. In addition, current medical evidence may be in the file that contradicted the medical evidence considered for the

medical opinion. Further, RRB claims examiners were not properly overseeing the contractor to assure quality work was delivered and paid for by the RRB.

Recommendations

We recommend that the Office of Programs:

4. improve procedures for medical opinion review and acceptance so that RRB claims examiners do not accept opinions that lack the appropriate information;
5. modify the medical opinion form to elicit required information from the medical doctors;
6. update procedures to direct the RRB claims examiners to ensure that the medical doctors provide a clear legible referenced explanation to the supporting evidence; and
7. update procedures for RRB claims examiners to ensure that all current applicable medical evidence, that has been received in support of the disability based claim, is referenced by the doctor in the medical opinion, before they accept the medical opinion for payment.

Management's Response & Our Comments

OP concurred with Recommendations 4 and 6. In response to Recommendation 4, OP stated that the medical opinion form includes sections for doctors to provide information regarding the impairment evaluated, the resulting limitations, and the medical consultant's comments. They stated that the current contractor that was retained on December 1, 2015, has been instructed to ensure that doctors are including documentation throughout the form of where detailed information can be found. OP stated that they will issue a reminder to the current medical contractor and to the RRB claims examiners regarding the proper completion of the form. With regards to Recommendation 6, OP concurred and indicated that they will provide a reminder to staff to obtain legible explanations from the medical opinion providers.

OP did not concur with Recommendations 5 and 7. With regards to Recommendation 5, OP stated that the revision of the form is not necessary because Part II A of the medical opinion form captures this information. They stated that the current contractor was retained on December 1, 2015, and has been instructed to ensure that doctors are including documentation throughout the form of where detailed information can be found. They stated that they will issue another reminder as stated in their response to Recommendation 4. The OIG found that often the medical opinion form did not contain the detailed information for some sections. The reminder to the contractor and the RRB claims examiner is not sufficient to ensure that all detailed information will be properly recorded on the medical opinion form.

With regards to Recommendation 7, OP responded that the recommendation suggests that “all” current applicable evidence be referenced in the doctor’s medical opinion and that the contract specifications for medical opinions state that the specifics needed to resolve conflicting evidence are included “if possible.” In addition, they stated that the examiners are trained to agree, accept, pay, and use opinions that appropriately address relevant medical evidence for the primary impairment. However, the contract states that the medical contractor shall review medical evidence received in support of disability-based claims. The contract states that the medical contractor will prepare advisory medical opinions clearly communicating the medical opinion. In the 53 cases outlined in the sample case review, the doctor preparing the opinion did not specifically cite all evidence and the OIG could not be sure that the doctor or the RRB claims examiners considered the totality of the medical evidence if it was not referenced in the medical opinion.

Lack of File Preparation Resulted in Inefficiencies

During our audit, we identified 12 cases where the doctor asked for additional medical evidence, such as a more recent medical examination or current medical evidence, before they could render an opinion. Additionally, in one case that was reviewed, the RRB claims examiner requested and paid for two opinions, when they could have coordinated to have both opinions done at the same time. The contract stipulates that the RRB claims examiners may request both a physical and a mental opinion at the same time. Because they did not request them at the same time, the RRB paid for two opinions rather than one and delayed the disability determination process. The DCM requires that the RRB claims examiner thoroughly review the file, prior to sending the file for a medical opinion. These observations indicate that the RRB claims examiners did not follow procedures and did not thoroughly prepare the file before they requested an opinion.

The RRB's Strategic Plan includes a goal to ensure the effectiveness, efficiency, and security of operations. Program efficiency would be improved if RRB claims examiners thoroughly reviewed the file to ensure sufficient evidence, prior to requesting an opinion.

Agency officials told us that beginning in April of 2015 the contractor was sending a doctor to the RRB headquarters twice a week. The agency had amended the contract to increase the number of visits that the doctor would make to RRB Headquarters. Agency officials suggested that the RRB claims examiners could avoid the request for more medical evidence or another examination by meeting with the doctor when they were onsite at the RRB. By meeting with the doctor, the RRB claims examiner could resolve questions for cases where they were unsure if more evidence was needed. However, this process modification of increased visits will only improve the determination process if the RRB claims examiners thoroughly prepare the file before meeting with the doctor or requesting an opinion.

Because of the lack of file preparation and review, there were delays in the disability determination process and the RRB paid for incomplete medical opinions. These

process inefficiencies occurred because the doctor could not provide a complete medical opinion based on the evidence in the file, and had to return the file and request more evidence.

Recommendations

We recommend that the Office of Programs:

8. update RRB procedures to instruct the RRB claims examiner to meet with the doctor when onsite if the RRB claims examiner is not certain that enough medical evidence is in file; and
9. retrain the RRB claims examiners to thoroughly review and prepare the file, prior to ordering a medical opinion.

Management's Response & Our Comments

OP did not concur with Recommendation 8 and in response stated that procedure in the current DCM states that examiners can request advice by contacting the onsite medical doctor when they are not certain that the evidence provided is sufficient. They further stated that since December 2015, OP has required examiners to log and track their consultations with the onsite doctor, who visits twice per week. Also, claims examiners receive extensive medical and programmatic training to make a determination of disability eligibility and are aware of the resources at their disposal. Finally, they stated that doctors do not make the decision and examiners are not required to seek the advice of a doctor on every case. They stated that according to the CFR, the examiner is responsible for making the decision about whether a claimant meets the statutory definition of disability. This information is not responsive to the recommendation.

The OIG recommendation was made because during the sample case review, OIG found 12 instances where the medical opinion requested was returned to the RRB with a comment indicating more medical evidence was needed. The RRB staff we met with during the audit told us that increased visits by the contracted medical doctor would alleviate some of these situations. However, the recommendation is intended to improve efficiency of the process to avoid rework and to strengthen the claims examiner use of the resource implemented to help them determine if enough evidence is present in the claim file.

With regards to Recommendation 9, OP concurs. They stated that initial examiner training instructs claims examiners to review and prepare the file prior to ordering a medical opinion. They stated that reminder training will be completed for all current disability claims examiners.

Medical Opinion Forms Were Not Signed and Dated Properly

During our review of 226 sample cases, we found that 11 cases did not have proper signatures and dates on the medical opinion form; 4 in which the doctor had not signed and dated the medical opinion form properly, and 7 in which the RRB claims examiner did not sign and date the medical opinion form.

On the medical opinion form, there is a designated area for the doctor to sign and date. There is another section of the form for the RRB claims examiner to indicate their acceptance or rejection of the opinion. The RRB claims examiner also signs and dates the form.

We found deficiencies in the RRB's procedures outlined in the DCM. These procedures did not specifically instruct the RRB claims examiner to indicate acceptance or rejection of the medical opinion, or to sign and date the form.

Because some opinions were not properly signed and dated by the doctors, RRB claims examiners may have accepted and paid for incomplete opinions. Additionally, without the RRB claims examiner's signature, there was no proof of acceptance of the opinion. The RRB claims examiner is not held accountable for accepting or rejecting a medical opinion if they are not required to sign and date the form. As a result, the medical opinion may or may not have been used in determining the applicant's eligibility based on a disability.

Recommendations

We recommend that Office of Programs:

10. update procedures to instruct RRB claims examiners to ensure that the medical opinion form is signed and dated by the doctor in order to be accepted; and
11. update the RRB procedures to instruct the RRB claims examiners to indicate their acceptance or rejection of the medical opinion, and to require them to sign and date the form.
12. take action to recover amounts improperly paid for medical opinions that did not meet the contract requirements for the term of the medical services contract.

Management's Response & Our Comments

With regards to Recommendation 10, OP concurred. They stated that this issue occurred with the prior contractor. A new contractor began preparing medical opinions in December 2015. OP stated that the current contract has an on-site physician who reviews the medical evidence prior to a disability determination by an examiner. They stated that the issue of signing and dating the form was specifically addressed with the

new contractor. OP emphasized the necessity of properly signed and dated medical opinions. They intend to review a random sample of cases to confirm that the forms are properly signed and dated.

With regards to Recommendation 11, OP concurred. They stated that they have a procedure in place. OP stated that they will remind staff that prior to approving payments in FMIS, they must sign and date the form. The OIG maintains that the procedures do not specifically instruct the RRB claims examiner to sign and date the form.

With regards to Recommendation 12, OP does not concur and stated that no action to recover payments made for these medical opinions should be taken. They stated that OP has seven days to either accept or reject medical opinions and that the claims cited in the OIG audit were processed in calendar year 2014. OP further stated that the medical opinions were accepted because OP agreed with the assessment. They stated that as a result OP paid and used the opinions in the adjudication of claims. They stated that the overall determination for the claims was determined to be adequate. The OIG disagrees. Based on the totality of the findings in this report, the RRB paid for services that were not delivered in compliance with contract terms and, as such, in protecting its trust funds, should take every legal action to recover amounts improperly paid.

The RRB Did Not Properly Monitor Contractor Qualifications and Timeliness

Significant contractor qualifications and timeliness were not properly monitored by the RRB. The contract required that the doctors preparing medical opinions be licensed and carry medical liability insurance. During the course of our audit, the RRB could not provide documentation to prove that medical licensure was current during calendar year 2014 and could not provide proof of insurance when auditors requested it. Further, the RRB could not provide adequate support regarding the contractor's timeliness in providing medical opinions when requested.

Lack of Oversight of Medical Licenses and Medical Insurance

The RRB could not provide documentation that the medical contractors held medical licenses or adequate medical liability insurance for calendar year 2014, as required by the contract. In response to a request by the OIG, the RRB's OP DBD provided seven medical licenses for doctors preparing medical opinions in March 2015. The licenses did not have any dates on them to indicate the timeframe for which they were valid. Further, the RRB did not provide evidence that they had monitored the medical licenses or the proof of medical liability insurance for the doctors during calendar year 2014 or any prior year. Finally, the RRB could not provide proof that the medical insurance certificates were provided when the contract was awarded.

The medical services contract reviewed was initially awarded in 2010 with four, one year options that were exercised. Contract terms remain in effect when an option is exercised. The contract required:

- all physicians performing medical services under the contract to be currently licensed in the state in which contractual medical services are rendered, and to have training and experience necessary to perform these medical services;
- that the contractor not employ any individual or entity that is excluded, suspended, or otherwise barred from participating in Medicare, Medicaid, or any other federal or federally assisted program; and
- the contractor to maintain liability insurance, issued by a responsible insurance carrier, of not less than the following amount(s) for each specialty for each occurrence: \$1,000,000 for each wrongful act or series of continuous, repeated or interrelated wrongful acts or occurrences; and \$3,000,000 aggregate for the year, during the term of this contract. Additionally, the contractor, upon request by the contracting officer prior to the contract award, shall provide evidence of its insurability concerning the medical liability insurance required.

The Federal Acquisition Regulations (FAR) provides contracting officer responsibilities including ensuring compliance with the terms of the contract. In this case that would include confirming current medical licenses and insurance.⁷ In addition, the FAR defines the contract administration office functions, which include reviewing the contractor's insurance plans.⁸ The requirements of the contract, such as the medical licenses and proof of medical liability insurance are to be provided to the contracting officer, if requested, prior to the award of the contract.

During the course of our audit, on July 21, 2015, the RRB's Director of Disability Benefits and the RRB's Chief of Acquisition Management requested an opinion from the RRB General Counsel on the medical liability insurance requirements for medical consultants. The RRB's General Counsel issued a legal opinion on September 15, 2015, affirming the contract requirement that the medical doctors that perform under this contract must maintain medical liability insurance.

The RRB did not have controls to ensure that doctors preparing medical opinions were currently licensed or maintained the proper medical liability insurance. Ineffective management controls over the contract awards process allowed contract terms requiring current medical licenses and proof of medical liability insurance not to be enforced.

During our audit, we independently verified that the seven contract doctors had current licenses in the state of Illinois. We also independently verified that none of the doctors were currently excluded by the Department of Health and Human Services.

Because the RRB did not verify insurance prior to the contract, the agency faced increased risk, which could have been mitigated if controls had been enforced. The RRB did not monitor the licenses of doctors preparing opinions during

⁷ FAR Subpart 1.602-2.

⁸ FAR Subpart 42.302.

calendar year 2014, the scope of the audit. Medical opinions may have been prepared by doctors that were not properly licensed and the RRB may have been held liable for actions of the contractor because the proper insurance was not maintained.

Recommendations

We recommend that the Office of Administration develop controls to ensure that:

13. contract requirements concerning initial license and insurance specifications are met prior to awarding the contract;
14. current licenses are maintained by the medical services provider; and
15. proper insurance is maintained.

Management's Response & Our Comments

With regards to Recommendation 13, OA concurred and stated that the RRB and the current contractor accomplished obtaining proof of licenses via the solicitation and proposal process. OA further stated that they do not concur with having the contractor meet the insurance requirements such as the FAR clauses and the RRB provisions in the solicitation regarding the contractor's provision of certificates of liability insurance specifically allow for provision of insurance certificates post award of the contract and prior to the start of performance of the services. They stated that the RRB awarded the current contract on September 16, 2015 and OA will provide copies of physician licensure and insurance certificate documents to the OIG. OIG maintains that during the term of the contract no insurance certificates were obtained and physician licenses were never rechecked.

With regards to Recommendation 14, OA concurred and stated it will provide one copy of the updated physician licensure and the plan, with the COR in DBD to monitor contractor maintenance of physician licensure.

With regards to Recommendation 15, OA concurred. They stated that they had a further comment. The comment was that the Office of Administration/Acquisition Management (OA/AM) group will provide copies of current corporate and physician medical liability insurance and the plan with the COR in DBD to monitor contractor maintenance of physician licensure. The OIG maintains that the concurrence of this recommendation is partial because the recommendation is to ensure that proper insurance is maintained. The plan to monitor physician licensure will not satisfy this recommendation.

The RRB Did Not Effectively Monitor Timeliness

During our sample case review, we found that the RRB's controls for monitoring the timeliness of individual medical opinions and for monitoring the contractor's performance related to timeliness were ineffective. Although the RRB has many controls

in place to calculate the timeliness of individual medical opinions and the overall timeliness of the contractor’s performance, it does not have a contract mechanism, such as monetary penalties, to enforce the timeliness standards set forth in the contract.

The timeliness standard for an individual opinion was specified in the contract. The contract outlined that the contractor shall render the advisory medical opinion within five business days from when the opinion was requested. The RRB had sole authority in determining acceptability of medical opinions. If RRB personnel deemed the case to be urgent, it will be completed within two business days. The contractor would achieve these timeliness standards in at least 95 percent of the cases.

We found that the RRB’s controls for monitoring the timeliness of individual medical opinions were ineffective. In our sample case review of 226 cases, we conducted tests of 5 timeliness controls including the dates opinions were requested and returned, as evidenced on both the medical opinion request form and input into FMIS. See Table 2 for the control tests conducted and the number of deficiencies identified.

Table 2: Timeliness Control Tests

Control Test for Timeliness	Deficiencies Identified
Did the medical opinion request form indicate the date when the request was sent to the contractor?	6
Did the anticipated due date on the request form match the due date in FMIS?	7
Did the medical opinion indicate the date when the medical opinion was received by the RRB?	3
Did the medical opinion actual return date on the form match the return date input in FMIS?	10
Was the medical opinion received by the RRB within five business days of the request? Or, if the case was marked urgent, was the medical opinion received by the RRB within two business days?	13

As shown in Table 2, we observed control weaknesses over how the dates were entered on the medical opinion request form and when entered into FMIS. Agency management told us that these weaknesses occurred because staff was not always familiar with the new FMIS system or they entered the dates incorrectly.

We also found that the RRB did not have effective controls to monitor the contractor’s overall performance related to timeliness, and they did not enforce the overall timeliness of the contractor’s performance. During our case review, we independently calculated timeliness and found that 13 of the 226 cases, or 6 percent, were late. The contract stated that medical opinions rendered by the contractor needed to meet timeliness standards in at least 95 percent of the cases. Based on these results, the contractor was timely for only 94 percent of the cases and did not meet the overall timeliness standard of 95 percent.

The RRB produced monthly reports showing the contractor's overall timeliness percentages. These reports are compiled using data extracted from FMIS. We found that these reports did not present a clear picture of how timeliness was tracked and measured. The RRB did not know if the percentages presented in their reports were accurate. In addition, when the overall percentage for opinions returned to the RRB fell below 95 percent, the RRB did not hold the contractor accountable for not achieving the timeliness standard. The RRB could not hold the contractor accountable because the contract did not specify ramifications for when the contractor did not achieve the overall timeliness standard.

Because of ineffective controls, the RRB did not know if the medical opinions were meeting the timeliness standard specified in the contract. Moreover, they have no means to enforce the timeliness standards set forth in the contract.

Recommendations

We recommend that the Office of Programs:

16. strengthen the controls for determining the timeliness of individual medical opinions; and
17. develop new controls to assess the contractor's performance related to timeliness.

Management's Response & Our Comments

With regards to Recommendation 16, OP concurred and stated that the FMIS COR will work with the FMIS vendor staff to determine the level of effort and time required to produce either a standard or ad hoc report to support the data requirements. OP stated that they will need to modify the current contract to fund the work and then the vendor will have to allocate technical support to create the report. OP stated that once they have received all of the necessary elements from the FMIS COR, OP will determine whether an alternate sampling approach is needed.

With regards to Recommendation 17, OP concurred and stated that the FMIS COR will work with the FMIS vendor staff to determine the level of effort and time required to produce either a standard or ad hoc report to support the data requirements. OP stated that they will need to modify the current contract to fund the work and then the vendor will have to allocate technical support to create the report. OP stated that once they have received all of the necessary elements from the FMIS COR, OP will determine whether an alternate sampling approach is needed.

We recommend that the Office of Administration:

18. develop effective contract ramifications for instances where timeliness standards are not met.

Management's Response & Our Comments

With regards to Recommendation 18, the OA concurred and explained that there were contract provisions to remedy contractor deficiencies in timeliness standards. OA stated that the RRB does not pay the contractor for deficient medical opinions that do not meet contract quality standards nor for resubmitted opinion reports, due to the initial report not meeting contract quality standards on the first submission, until the resubmitted, and now late, report meets contract quality standards. Secondly, they stated that the RRB COR and contracting officer, as rating officials for the RRB on the Contractor Performance Assessment Report (CPAR) System (CPARS) will rate the contractor appropriately lower on the Performance Evaluation Factor of "Timeliness" on the Contractor's Annual CPAR on the Consultative Medical Opinion Services Contract. They stated that the RRB contracting officer and COR will continue to assess and issue these CPARS ratings on "Timeliness", among other factors, as well as all other CPARS report evaluation factors each year through the end of the contract. They stated that CPARS reports are used by government agencies to evaluate past performance in consideration for new contract awards. They further stated, lastly, the OA/AM group will, in concert with the contract COR in OP/DBD, review and develop other potential contractual remedies to employ with the contractor, to address contractor failure to meet timeliness standards. However, the OIG states that the agency does not know if the contractor is timely. The actions proposed to be taken for recommendations 16 and 17 need to be strengthened to ensure the RRB knows if the contractor meets timeliness standards in order to take appropriate action.

Table 3: Glossary of Terms

Disability Term	Definition
Continuing Disability Review	Continuing disability reviews (CDR) are conducted after disability benefits are awarded by the RRB. CDRs may be conducted to assess the current medical condition. An earnings review may trigger a CDR when certain events occur, such as a third party report of an annuitant's work.
Disabled Adult Child	An unmarried disabled child over age 18, if the child became totally and permanently disabled before age 22, is entitled to a survivor annuity.
Dual Freeze	A career railroad employee may be granted a dual freeze, sometimes called a joint freeze, when applying for a disability annuity. The dual freeze determination includes a requirement that the employee meets the definition of disability under the Social Security Act, meaning an inability to work in any substantial gainful activity. When a career employee files a claim for disability and has some likelihood for Social Security benefits being paid, the dual freeze determination is processed jointly by the Social Security Administration and the RRB.
Listing of Impairments	A claimant's condition may be determined to be one that is specified in the Listing of Impairments. Regulations maintain a Listing of Impairments that may be considered when determining a disability for an RRB claim. The listing defines common medical conditions, such as, chronic heart failure, and how to review medical evidence for these conditions. The determination of disability for a medical condition in the Listing of Impairments must be found to either meet or equal the listing. The claimant's condition meets the listing when the impairment manifests as described in the medical criteria for that impairment listing. The claimant's condition equals the listing when the medical findings for the claimant are at least equivalent to those specified in the listing.
Occupational Disability Annuity	A railroad employee may qualify for an occupational disability if the employee is permanently disabled for work in their regular railroad occupation. In addition to a medically disabling condition, eligibility depends on if the railroad employee has at least 240 months of railroad service, or if age 60, 120-239 months of railroad service.

Disability Term	Definition
Onset Date	The date when the disability is deemed to have begun. A medical condition that is disabling must be established as of a specific date. For both occupational disability and total and permanent disability, the annuity cannot begin earlier than the first day of the sixth full month following the month in which disability onset occurs.
Reconsideration	When an initial disability decision is made and the claimant disagrees with the decision, the claimant may ask for a reconsideration of that decision.
Residual Functional Capacity	Residual functional capacity (RFC) assessment is based on whether the claimant's impairment(s) cause(s) physical and mental limitations that affect what the claimant can do in a work setting. The RFC is an assessment of what the claimant can do despite his or her limitations. The assessment of the claimant's RFC for work is not a decision on whether the claimant is disabled, but is used as the basis for determining the particular types of work the claimant may be able to do despite his or her impairment(s).
Single Freeze	A career railroad employee may be granted a single freeze when applying for a disability annuity. The single freeze determination includes a requirement that the employee meets the definition of disability under the Social Security Act, meaning an inability to work in any substantial gainful activity. When a career employee files a claim for disability and has no potential for Social Security benefits being paid, the RRB claims examiner may make the single freeze determination.
Total and Permanent Disability	A claimant may qualify for a total and permanent disability if permanently disabled for all types of work.
Widow(er)	A widow(er) between ages 50-59 may receive an annuity if the widow(er) is totally and permanently disabled and unable to work in any regular employment. The disability must have begun within seven years after the employee's death or within seven years after the termination of an annuity based on caring for a child of the deceased employee.

Figure 2: Medical Opinion Form

NAME _____ CLAIM NUMBER _____

PART I - TREATING OR EXAMINING SOURCE STATEMENT(S)

For the purposes of this form, **occasionally** means occurring from very little to up to one-third of an 8-hour workday, cumulative not continuous; **frequently** means occurring from one-third to two-thirds of an 8-hour workday, cumulative not continuous; and **constantly** means occurring more than two-thirds of an 8-hour workday.

A. Does the claimant meet/equal the listing?

YES (go to Part II, complete Items A-D. In Item A cite how the claimant met or equaled the listing)

NO (go to Item B)

B. Regarding the claimant's physical capacities, are the treating or examining source statements that are in the file complete and consistent with the medical evidence?

YES (go to Part II, complete Items A-D. In Item A cite which doctor's RFC applies and explain why you disagree with the remaining treating or examining source severity assessment(s) in file)

NO (complete the rest of the form. In Part II justify your assessment and explain why you disagree with all treating or examining source severity assessment(s) in file)

C. EXERTIONAL LIMITATIONS

None Established (go to Item D)

Exertional limitations are noted below

1. Lifting/Carrying

<p>a. <u>Occasionally</u></p> <p>Objects weighing:</p> <p><input type="checkbox"/> up to 10 pounds</p> <p><input type="checkbox"/> up to 20 pounds</p> <p><input type="checkbox"/> up to 50 pounds</p> <p><input type="checkbox"/> up to 100 pounds</p> <p><input type="checkbox"/> more than 100 pounds</p>	<p>b. <u>Frequently</u></p> <p>Objects weighing:</p> <p><input type="checkbox"/> up to 10 pounds</p> <p><input type="checkbox"/> up to 25 pounds</p> <p><input type="checkbox"/> up to 50 pounds</p> <p><input type="checkbox"/> more than 50 pounds</p>
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2. Standing/Walking
With normal breaks for a total of:

Less than 2 hours in an 8-hour workday

At least 2 hours in an 8-hour workday

At least 6 hours in an 8-hour workday

3. Sitting
With normal breaks for a total of:

Less than 6 hours in an 8-hour workday

At least 6 hours in an 8-hour workday

4. Special Limitations Apply to Standing, Walking, or Sitting

Unable to walk on uneven terrain

Must periodically alternate sitting and standing to relieve pain or discomfort

Medically required handheld assistive device is necessary for ambulation

Form G-137 SUP (08-11)

PLEASE INITIAL ANY ERASURES OR WHITE-OUTS MADE ON THIS FORM

Figure 2: Medical Opinion Form (continued)

NAME _____ CLAIM NUMBER _____

5. Pushing/Pulling (including operation of hand and/or foot controls)

Unlimited, other than as shown in 1., above

Limited in upper extremities (describe in detail the type of limitations)

Limited in lower extremities (describe in detail the type of limitations)

D. POSTURAL LIMITATIONS

None established (go to Item E)

Postural limitations are noted below

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Constantly</u>
Climbing (Ladder/Rope/Scaffold)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing (Stairs/Ramp)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe specific type of physical activity where balancing is limited in the space provided below.
(e.g. on a ladder, ascending/descending stairs, standing/walking)

E. MANIPULATIVE LIMITATIONS

None Established (go to Item F)

Manipulative limitations are noted below

		<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Constantly</u>
Reaching all directions (including overhead)	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling (gross manipulation)	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingering (fine manipulation)	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling (skin receptors)	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form G-137 SUP (08-11)

PLEASE INITIAL ANY ERASURES OR WHITE-OUTS MADE ON THIS FORM

Figure 2: Medical Opinion Form (continued)

NAME _____ CLAIM NUMBER _____

F. VISUAL LIMITATIONS

None Established (go to Item G)
 Visual limitations are noted below

	<u>Limited</u>		<u>Unlimited</u>
	<u>Right</u>	<u>Left</u>	
Near acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Far acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depth perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Field of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. COMMUNICATIVE LIMITATIONS

None Established (go to Item H)
 Communicative limitations are noted below

	<u>Limited</u>		<u>Unlimited</u>
	<u>Right</u>	<u>Left</u>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H. ENVIRONMENTAL LIMITATIONS

None Established
 Environmental limitations are noted below

	<u>Must Avoid All Exposure</u>	<u>Must Avoid Concentrated Exposure</u>	<u>Must Avoid Moderate Exposure</u>	<u>Unlimited</u>
Extreme cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wetness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes, Odors, Dust, Gases, Poor Ventilation, Etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hazards (machinery, heights, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Description:				

Form G-137 SUP (08-11)

PLEASE INITIAL ANY ERASURES OR WHITE-OUTS MADE ON THIS FORM

Statistical Sampling Methodology and Results

This appendix presents the methodology and results of our statistical sampling tests for estimation sampling and one-step acceptance sampling of the effectiveness of internal controls over the medical opinion process and the value of the medical opinions in the disability determination process.

Scope

Our samples were selected from consulting opinion payment vouchers (CPV) processed in FMIS for calendar year 2014 based on the document date. A CPV is generated in FMIS when a medical opinion is ordered, documented, and accepted by the RRB claims examiner. The universe of CPVs with a document date in calendar year 2014 was extracted from FMIS and contained 3,511 records.

Review Methodology

We conducted two types of attribute sampling during this audit. First, we used estimation sampling to estimate the rate of occurrence of errors. We also used one-step acceptance sampling to perform control tests and determine if the control was operating as intended.

Estimation Sample: The estimation sample assumed an error rate of 10 percent, which resulted in a sample size of 226 from the total population of 3,511. The universe error rate utilized was 5 percent. This sampling technique allowed the audit team to project a minimum number of errors that may be in the universe. A random number generator was applied to the universe of 3,511 records to randomly select 226 of those records. For each randomly selected record, a claim number was associated with it and that claim number was used to locate the disability claim folder.⁹ See Appendix IV for a summary of the types of disability decisions represented in the 226 sample cases reviewed.

One-Step Acceptance Sample: The one-step acceptance sample used an error rate of 5 percent. It directed a sample size of 151 cases from the total population of 3,511 with an acceptance number of 3. This sampling technique allowed the audit team to determine if a control was functioning as intended because the number of errors was less than the acceptance number—three or fewer in the sample. Thus, if a control test applied to the sample produced four or more sample cases that were found to fail the control test; the control is found to not be operating as intended. From the 226 disability claim folders identified for the estimation sample, the first 151 of those tested are in the one-step acceptance sample.

⁹ At least 26 cases selected randomly for the sample were disability cases where the claimant worked for the Long Island Rail Road.

Results of Review

Estimation Sampling: We reviewed a statistically valid sample of 226 CPVs, drawn from a population of 3,511. A description of the internal controls tested and the results of our review are shown in Table 4. For each internal control tested in which an exception was found, we can project to the universe an estimate of the minimum number of errors with a confidence level of 90 percent. When no exception was found for a specific control test, no projected minimum is made.

One-Step Acceptance Sample: We performed a statistically valid sample of 151 CPVs, drawn from a population of 3,511. The sample items were a subset of the estimation sample. The list of internal controls tested is shown in Table 4. Each test was performed on all 151 sample cases. The column titled 'Control Pass-Fail' is populated with a "Pass" when the number of errors is three or less; the column contains 'Fail (#n)' when the acceptance threshold of three is exceeded. The (#n) after the entry 'Fail' is a numerical entry to keep the count of the number of controls that failed during the tests. Based on our testing, we can say with 95 percent confidence that 8 of the 13 controls tested are not operating as intended.

Table 4: Sample results for Estimation and One-Step Acceptance Samples

Internal Control Tests on Medical Opinions	Estimation Sample Results				One-Step Acceptance Sample Results		
	Number of Cases Tested	Exceptions Observed in Sample Cases	Projected Min Number of Errors & Projected Percent of Errors in Universe		Number of Cases Tested	Exceptions	Control Pass-Fail
Is a medical opinion in file?	226	0					
Was the medical opinion request properly authorized?	226	0					
Did the claim number on the outside of claim folder match the claim number on the medical opinion request form?	226	2	10	.3%			
Was the doctor who prepared the medical opinion included on the listing of authorized doctors?	226	0					
Did the medical opinion request indicate the date when the request was sent to the contractor?	226	6	49	1.4%	151	4	Fail (#1)
Did the anticipated due date on the request form match the due date in FMIS?	226	7	63	1.8%	151	3	Pass
Did the medical opinion indicate the date when the medical opinion was received by the RRB?	226	3	17	.5%			
Did the medical opinion actual return date on the form match the return date input in FMIS?	226	10	98	2.8%	151	3	Pass
Was the medical opinion received by the RRB within five business days of the request?	226	11	112	3.2%	151	7	Fail (#2)
Was the medical opinion received by the RRB within two business days of the request if the case was marked urgent?	226	2	10	.3%	151	0	Pass
Did the doctor complete all required sections of the medical opinion?	226	126	1,804	51.4%	151	86	Fail (#3)
Was the medical opinion signed and dated by the doctor?	226	4	28	.8%	151	3	Pass
Did the doctor properly complete the medical opinion with a clear and legible referenced explanation that identified evidence used as the basis of the medical opinion?	226	15	161	4.6%	151	11	Fail (#4)

Appendix III

Internal Control Tests on Medical Opinions	Estimation Sample Results				One-Step Acceptance Sample Results		
	Number of Cases Tested	Exceptions Observed in Sample Cases	Projected Min Number of Errors & Projected Percent of Errors in Universe		Number of Cases Tested	Exceptions	Control Pass-Fail
Was the medical evidence cited in the medical opinion current and dated within the most recent 12 months?	226	6	49	1.4%	151	6	Fail (#5)
Did the medical opinion contain a clearly documented conclusion statement?	226	146	2,120	60.4%	151	98	Fail (#6)
Was all current relevant medical evidence in case file used in the medical opinion?	226	53	698	19.9%	151	39	Fail (#7)
Did RRB claims examiner reject the initial medical opinion? If yes, is the second opinion in the case file?	226	0			151	0	Pass
Was the medical opinion signed and dated by the RRB claims examiner?	226	7	63	1.8%	151	4	Fail (#8)
Was there evidence in the claim file of who authorized the medical opinion for payment?	226	0					
Was person who authorized the medical opinion for payment someone with the proper authority?	226	0					
Did the doctor resolve conflicting evidence and medical opinions?	226	87	1,204	34.3%			

Disability Case File Characteristics for Sample Cases

This appendix presents disability case characteristics for the 226 sample cases. Table 5 presents the types of disability determination for which a medical opinion was requested in the 226 sample cases. Table 6 presents categories of the medical ailments identified for the claimants in each of the 226 cases. Each table has columns as follows:

- Description – the description of each type of disability determination for which a medical opinion was requested or the medical ailment in the disability case file for the statistical random sample.
- Number of Cases – the number of sample cases, of the 226 total cases, that have the characteristic described in the description column.
- Approved – a number that represents the approvals of the action for which the medical opinions were requested.
- Denied – a number that represents the denials for the medical opinions represented. A denial action for a medical opinion does not necessarily prevent or terminate a benefit payment. For example, if the paid medical opinion is for a freeze, and the freeze is denied, this action does not prevent or terminate a benefit payment, which is subject to appeal.
- Split – a number where the medical opinion was requested for two actions, when one action was approved and the other action was denied.
- Pending – the number of cases where the file did not contain evidence that a decision was made. Often, the cases classified as pending involve cases where there was a request to obtain more medical evidence.

Table 5: Characteristics of Sample Cases

Description of Disability Decision Types	Number of Cases	Approved	Denied	Split	Pending
Occupational	1	1			
Occupational and Dual Freeze	14	10	1	3	
Occupational and Single Freeze	12	11		1	
Total & Permanent (T&P)	15	12	2		1
T&P and Single Freeze	3		1		2
T&P and Dual Freeze	42	23	14	3	2
Single Freeze	65	44	18		3
Dual Freeze	36	30	6		
Child	13	8	3		2
Widow	18	12	5		1
Continuing Disability	3	2			1
Reconsideration, T&P, Dual Freeze	2		2		
Reconsideration, T&P	1	1			
Reconsideration and Widow	1		1		
Total	226	154	53	7	12

Table 6: Medical Ailments – Approved/Denied

Description of Medical Ailments in Disability Case Files	Number of Cases	Approved	Denied	Split	Pending
Medical skeletal, back, orthopedic	106	64	34	3	5
Meets/Equals Listing	60	52	4	3	1
Other	42	31	11		
Psychiatric	14	6	4	1	3
No ailment described	4	1			3
Total	226	154	53	7	12

For medical ailment categories listed in the description column, the sample cases were categorized in a general way by information found in the disability case file as follows:

- Medical skeletal, back, orthopedic: the diagnosis involved the spine, joints, discs, or arm and leg problems.
- Meets/Equals Listing: the claimant's ailment met or equaled an impairment listed in the 'Listing of Impairments'. The claimant's ailment met the listing when the impairment manifests as described in the medical criteria for that impairment listing. The claimant's condition equaled the listing when the medical findings for the claimant are at least equivalent to those specified in the listing.
- Other: the diagnosis involved other problems, such as, prostate cancer, diabetes mellitus, and macular degeneration.
- Psychiatric: the primary diagnosis was psychiatric.
- No ailment described.



UNITED STATES GOVERNMENT

MEMORANDUM

January 19, 2016

TO : Heather J. Dunahoo
Assistant Inspector General for Audit

FROM : Keith B. Earley 
Director of Administration

SUBJECT: Draft Report – Control Weaknesses Diminish the Value of Medical Opinions in the RRB Disability Determination Process

Thank you for the opportunity to review the Office of Inspector General's draft audit report entitled "Control Weaknesses Diminish the Value of Medical Opinions in the RRB Disability Determination Process." We have reviewed the draft report and are providing the following comments to the recommendations directed to the Office of Administration:

OIG Recommendation #13

Contract requirements concerning initial license and insurance specifications are met prior to awarding the contract.

The Office of Administration concurs with obtaining the proof of license prior to award. RRB and Contractor IMA Group accomplished this via the solicitation and proposal process.

The Office of Administration does not concur with having the contractor meet the insurance requirements as the FAR clauses and the RRB provisions in the solicitation regarding the contractor's provision of certificates of liability insurance specifically allow for provision of insurance certificates post award of the contract and prior to the start of performance of the services. The RRB awarded the contract to IMA Group on 9/16/2015.

The Office of Administration/Acquisition Management (OA/AM) will provide copies of physician licensure and insurance certificate documents by February 29, 2016.

Target Completion Date: February 29, 2016

OIG Recommendation #14

Current licenses are maintained by the medical services provider.

The Office of Administration concurs with the recommendation with the following comment. The OA/AM will provide the following:

- one copy of updated physician licensure; and
- the plan, with the COR in Disability Benefits Division (DBD) to monitor contractor maintenance of physician licensure.

Target Completion Date: February 29, 2016

OIG Recommendation #15

Proper insurance is maintained.

The Office of Administration concurs with the recommendation with the following comment. The OA/AM will provide the following:

- copies of current corporate and physician medical liability insurance; and
- the plan, with the COR in DBD, to monitor contractor maintenance of physician licensure.

Target Completion Date: February 29, 2016

OIG Recommendation #18

Develop effective contract ramifications for instances where timeliness standards are not met.

The Office of Administration concurs with the recommendation with the following comment. The OA/AM and the Office of Programs' Disability Benefits Division (OP/DBD) already have contract provisions to remedy contractor deficiencies in timeliness standards. RRB does not pay the Contractor for deficient Consultative Medical opinion reports that do not meet contract quality standards. RRB/OP/DBD does not pay Contractor for resubmitted opinion reports, due to the initial report not meeting contract quality standards on the first submission, until the resubmitted, and now late, reports meet contract quality standards. Secondly, the RRB COR and CO, as rating officials for RRB on the Contractor Performance Assessment Report (CPAR) System (CPARS) will rate the contractor appropriately lower on the Performance Evaluation Factor of "Timeliness" on the Contractor's Annual CPAR on the Consultative Medical Opinion Services Contract. The RRB CO and COR will continue to assess and issue these CPARS ratings on "Timeliness", among other factors, as well as all other CPARS report

evaluation factors each year through the end of the contract. CPARS reports are used by Government agencies to evaluate past performance in consideration for new contract awards. Lastly, OA/AM will, in concert with the contract COR in OP/DBD, review and develop other potential contractual remedies to employ with the contractor, to address contractor failure to meet timeliness standards. The RRB OA/AMD, in concert with the OP/DBD staff, will provide the plan, of other contractual remedies available to be employed with the contractor, for ongoing deficiency in meeting performance timeliness standards, by February 29, 2016.

Target Completion Date: February 29, 2016

cc: Jeffrey Baer, Director of Audit Affairs
Paul Ahern, Chief of Acquisition Management



UNITED STATES GOVERNMENT

MEMORANDUM

February 5, 2016

TO: Heather J. Dunahoo
Assistant Inspector General for Audit

FROM: *Crystal Goseman*
MT Michael A. Tyllas, Ph.D., LCSW
Director of Programs

SUBJECT: Draft Report – Control Weaknesses Diminish the Value of
Medical Opinions in the RRB Disability Determination

This is in response to your memorandum of January 5, 2016, requesting comments on the Control Weaknesses Diminish the Value of Medical Opinions in the Railroad Retirement Board (RRB) Disability Determination draft report.

The audit's scope is a review of paid medical opinions in calendar year 2014. The provider, Consultative Examinations Ltd (CEL), is no longer a contractor for the RRB. Effective December 1, 2015, RRB entered into a contract with Industrial Medicine Associates, P.C. (IMA) for medical opinions.

The Office of Programs' comments to the Office of Inspector General's (OIG) Recommendations # 1 - 12 and # 16 - 17 in the subject report are below. Responses to recommendations are inclusive of the clarification meeting with OIG held on January 25, 2016. After the meeting, Office of Programs received a revised recommendation #7 as cited below.

The Office of Administration is responding under separate cover to those recommendations that it has received.

Recommendation #1: *Modify the medical opinion form to require the doctor to provide a documented conclusion on the medical severity of the claimant's medical ailments*

Response: The Office of Programs does not concur. During a meeting held with the OIG on January 25, 2016, the auditors clarified that the medical opinion should include a Residual Functional Capacity (RFC) conclusion (i.e., are the limitations sedentary, light, or medium). The overall RFC determination is an administrative determination that is required under the Code of Federal Regulations (CFR) to be made by the examiners, not a medical source. Furthermore, the claims examiners have to consider factors such as age, education and past work experience. These are vocational factors that are not within the expertise of medical sources (see CFR 220.112).

Recommendation #2: *Revise procedures to instruct RRB claims examiners to ensure that all medical evidence cited is current, prior to accepting the medical opinion*

Response: The Office of Programs concurs. This recommendation is based on a review of cases where the medical opinion cited older evidence rather than evidence from the most current 12 months. The Disability Claims Manual (DCM) reference cited in the draft report is one of many procedure references examiners use to adjudicate claims. The Code of Federal Regulations, CFR 220.36 outlines the considerations for determining a period of disability. The cited medical evidence in the opinion is one of many factors. The older evidence may be the most relevant for supporting the established severity. Claims examiners will be reminded to confirm that any newer evidence does not conflict with the cited medical opinion evidence. The Office of Programs proposes to issue reminders to examiners by March 31, 2016.

Recommendation #3: *Ensure that medical opinions resolve all conflicting medical evidence*

Response: The Office of Programs does not concur. Medical opinions are used to resolve significant differences in medical findings (see DCM 13.10.1.3). The Office of Programs disability examiners ensure that opinions received resolve conflicting relevant medical evidence for the primary impairment prior to authorizing payment to the contractor.

Recommendation #4: *Improve procedures for medical opinion review and acceptance so that RRB claims examiners do not accept opinions that lack the appropriate information*

Response: The Office of Programs concurs. The medical opinion form includes sections for doctors to provide information regarding the impairment evaluated and the resulting limitations. The information may have been provided in Part II A of Form G-137 SUP. This section captures the medical consultant's comments. The current contractor was retained on December 1, 2015, and has been instructed to ensure that doctors are including documentation throughout the form of where detailed information can be found. However, the Office of Programs will issue another reminder to the current contractor and examiners of the proper completion of the form. This will be completed by March 31, 2016.

Recommendation #5: *Modify the medical opinion form to elicit required information from medical doctors*

Response: The Office of Programs does not concur. A revision of the form is not necessary because Part II A of Form G-137 SUP captures this information. The current contractor was retained on December 1, 2015, and has been instructed to ensure that doctors are including documentation throughout the form of where detailed information can be found. However, the Office of Programs will issue another reminder as stated in our response to Recommendation #4 above.

Recommendation #6: *Update procedures to direct the RRB claims examiners to ensure that the medical doctors provide a clear legible referenced explanation to the supporting evidence*

Response: The Office of Programs concurs. The Office of Programs will provide a reminder to staff to obtain legible explanations from the medical opinion providers. This will be completed by March 31, 2016.

Recommendation #7: *We recommend that the Office of Programs update procedures for RRB*

claims examiners to ensure that all current applicable medical evidence, that has been received in support of the disability-based claim, is referenced by the doctor in the medical opinion, before they accept the medical opinion for payment.

Response: The Office of Programs does not concur. The recommendation suggests that “all” current applicable evidence be referenced in the doctor’s medical opinion. The contract specifications for medical opinions state that the specifics needed to resolve conflicting evidence are included “if possible.” In addition, the examiners are trained to agree, accept, pay, and use opinions that appropriately address relevant medical evidence for the primary impairment.

Recommendation #8: *Update RRB procedures to instruct the RRB claims examiner to meet with the doctor when onsite if the RRB claims examiner is not certain that enough medical evidence is in the file*

Response: The Office of Programs does not concur. Procedure in the current DCM Part 4.11.2 Note to File states that examiners can request advice by contacting the onsite medical doctor when they are not certain that the evidence provided is sufficient. Since December 2015, the Office of Programs has required examiners to log and track their consultations with the onsite doctor, who visits twice per week. In addition, claims examiners receive extensive medical and programmatic training to make a determination of disability eligibility. They are also aware of the resources at their disposal. Doctors do not make the decision and examiners are not required to seek the advice of a doctor on every case. According to CFR 220.12, as mentioned in the response to Recommendation 1 above, the examiner is responsible for making the decision about whether a claimant meets the statutory definition of disability.

Recommendation #9: *Retrain the RRB claims examiner to thoroughly review and prepare the file, prior to ordering a medical opinion*

Response: The Office of Programs concurs. During initial examiner training, all claims examiners are instructed to review and prepare the files prior to ordering a medical opinion. We will complete reminder training with all disability examiners by June 30, 2016.

Recommendation #10: *Update procedures to instruct RRB claims examiners to ensure that the medical opinion form is signed and dated by the doctor in order to be accepted*

Response: The Office of Programs concurs. This issue occurred with the prior contractor, who was replaced in December 2015. The current contract has an on-site physician who reviews the medical evidence prior to a disability determination by an examiner. This issue was specifically addressed with the new contractor, and the Office of Programs emphasized the necessity of properly signed and dated medical opinions. By June 30, 2016, the Office of Programs will review a random sampling of cases to confirm that the forms are properly signed and dated.

Recommendation #11: *Update procedures to instruct RRB claims examiners to indicate their acceptance or rejection of the medical opinion, and to require them to sign and date the form*

Response: The Office of Programs concurs. The procedure is already in place. The Office of Programs proposes to remind staff that prior to approving payment in FMIS that they sign and date the form. This will be done by March 31, 2016.

Recommendation #12: *Take action to recover amounts improperly paid for medical opinions that did not meet the contract requirements for the term of the medical services contract*

Response: The Office of Programs does not concur. No action to recover payments made for these medical opinions should be taken. The Office of Programs has seven days to either accept or reject medical opinions. The claims cited in the OIG audit were processed in calendar year 2014. The medical opinions were accepted because we agreed with the assessment. As a result, we paid and used the opinions in the adjudication of claims. The overall determination for the claims was determined to be adequate. The current contractor providing medical opinions began on December 1, 2015. They will be given a copy of the finalized audit report to ensure that accepted recommendations are incorporated into performance expectations.

Recommendation #16: *Strengthen the controls for determining the timeliness of individual medical opinions*

Response: The Office of Programs concurs. The FMIS COR will work with CGI staff to determine the level of effort and time required to produce either a standard or ad-hoc report to support the data requirements. We will need to modify our current contract to fund the work and then CGI will have to allocate technical support to create the report(s). Once we have received all of the necessary elements from the FMIS COR, we will determine whether an alternate sampling approach is needed. The target completion date is March 31, 2016.

Recommendation #17: *Develop new controls to assess the contractor's performance related to timeliness*

Response: The Office of Programs concurs. The FMIS COR will work with CGI staff to determine the level of effort and time required to produce either a standard or ad-hoc report to support the data requirements. We will need to modify our current contract to fund the work and then CGI will have to allocate technical support to create the report(s). Once we have received all of the necessary elements from the FMIS COR, we will determine whether an alternate sampling approach is needed. The target completion date is March 31, 2016.

If you have any questions regarding the above comments, please contact Deputy Director Crystal Coleman of my staff at extension 3310.

cc: Crystal Coleman, Deputy Director of Programs
Sherita Boots, Director of Disability Benefits Division
Karl T. Blank, General Counsel
Janet Hallman, Director of Programs Evaluation and Management Services
Jeff Baer, Director of Audit Affairs