Opportunities for Ohioans with Disabilities (OOD)
Division of Disability Determination (DDD)

Ohio DDD
Independent Physical Consultative Examination (CE) Guidelines

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Ohio
Opportunities for Ohioans with Disabilities

SOCIAL SECURITY ADMINISTRATION
USA

Ohio DDD Guidelines for Independent Consultative Examinations of Social Security Administration Claimants

Table of Contents

Ohio DDD Guidelines for Independent Consultative Examinations of Social Security Administration Claimants

Introduction

The Social Security Administration (SSA) states that independent consultative examiners of SSA disability claimants "must have a good understanding of SSA's disability programs and their evidence requirements." These Guidelines are provided to contribute to your understanding of SSA's disability programs and the role of the independent examiner.

Additional references include SSA's publication, Consultative Examinations: A Guide for Health Professionals, referred to as "The Green Book" and accessible at http://www.socialsecurity.gov/disability/professionals/greenbook. The Green Book includes general program information, but emphasizes requirements for consultative exams.

For more specific program information, SSA's Disability Evaluation Under Social Security, referred to as The Blue Book (and "the Listings"), is accessible through www.socialsecurity.gov/disability/professionals/bluebook. The Blue Book discusses in detail SSA's disability programs and how program criteria are applied in evaluating mental and physical disability claims. Unlike the Green Book, the Blue Book does not focus on the role of the independent examiner. The Blue Book identifies and discusses the conditions considered by SSA most likely to result in disability.

SSA's Disability Programs

SSA provides disability benefits under two programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

SSA's disability programs provides benefits for qualifying applicants found mentally or physically incapable of work. There is no short-term disability or partial disability component to SSA's disability programs. SSDI and SSI are permanent total disability programs only. A claimant can allege mental disability, physical disability or both.

SSA's medical criteria for deciding whether an individual is disabled are the same across the SSDI and SSI programs. SSA's medical criteria, however, are not necessarily the same as criteria applied by other government disability programs or by private sector disability plans. For the professional conducting independent evaluations of SSA claimants, the evaluation process is the same whether the claimant is applying for SSDI, SSI or both.

The main purpose of SSA's disability programs is to determine disability benefit eligibility and disburse benefits to disabled individuals. SSA's disability programs are not involved in formulation or provision of treatment.

The Claim Process

The SSA disability claim process begins when the claimant files a claim through SSA. A claim can be filed in person at the local SSA field office, or by mail, phone, or through SSA's website.

SSA verifies nonmedical eligibility requirements which may include age, employment, or Social Security coverage information. SSA also takes a statement of disability from the claimant. SSA recognizes that people can be disabled by physical conditions, by mental conditions, or by combinations of physical and mental conditions.

The claimant's self-report is not enough to establish disability. The program is medically-based, and requires medical evidence of disability. The claimant is responsible for providing sources of treating and evaluating clinicians who can provide evidence of his or her condition(s) and evidence of any resulting physical or mental functional limitations for work.

Once SSA establishes nonmedical eligibility, takes the statement of disability, and gathers contact information on treating or evaluating clinicians, then SSA shifts jurisdiction of the claim to the Disability Determination Service (DDS) in the state where the claimant resides. SSA has arrangements with each of the 50 states under which each state operates a DDS. DDSs are federally-funded, state-run agencies that adjudicate SSA disability claims. ***In the state of Ohio, the DDS is Opportunities for Ohioans with Disabilities, Division of Disability Determination*** (DDD).

Claim adjudication involves the DDS gathering and evaluating evidence, and determining whether the claimant is disabled under the meaning of the law and SSA regulations.

Ohio is the 5th largest disability determination agency in the country and maintains one of the lowest cost-per-case rates in the nation.

Claim adjudication begins with the DDS compiling the evidence in the claim. The DDS reviews the claimant's statement of disability and may seek to clarify details if needed, usually by phone and/or by written questionnaire. With the claimant's permission, the DDS requests records from the clinicians identified as providing past or current treatment or evaluation services. Evidence in a claim also can include non-clinical information such as educational records, statements by third parties familiar with the claimant's functioning, and other types of information.

At the DDS, a disability claims adjudicator develops the claim. An in-house consultant, psychologist, or speech and language pathologist may consult on the claim depending on the conditions under consideration. The adjudicator and any consultants working on the claim comprise the adjudicative team.

When evidence in a claim is inadequate for DDD to reach a determination, DDD may arrange and pay for an independent consultative examination (CE) of the claimant. Depending on the issues in the claim, a licensed physician or a certified speech and language pathologist might conduct the evaluation. The independent examiner evaluates the claimant in person and submits the results to the DDD in a written report. This becomes part of the claim evidence, reflecting an expert opinion on a medico-legal issue. The adjudicative team considers the report along with all other evidence in the file to reach a determination based on SSA policy.

In Federal Fiscal Year 2015, the Ohio DDS processed **191,607** disability claims.

Once the evidence is compiled, the adjudicator conducts a structured evaluation of the evidence. The consulting physician, psychologist, or speech and language pathologist interprets medical evidence within his or her field of expertise. The team considers all of the available evidence to determine whether any impairment is established, and if so, whether any work-related functional limitations result from it.

During this process, medical source opinions in the evidence are weighed. Weight is assigned based on the quality and consistency of the objective evidence offered by the professional in support of his or her opinions.

The adjudicative team formulates an assessment of the claimant's abilities and limitations under SSA's physical and mental work functional ability criteria. The disability decision is a legal determination based on relevant physical, psychological, speech and language evidence, as well as on educational, psychosocial, and other non-medical factors as required by SSA. Through this adjudicative process, the DDS determines whether the claimant is disabled according to policy and law.

In Federal Fiscal Year 2015, DDD had the highest net accuracy rate of any disability determination agency in the country.

BUSINESS PROCESS PROCEDURES

Examinee Referral Process, Vouchers & Authorized Procedures

Before receiving any evaluation requests from DDD, you will have identified to DDD available dates and times in your schedule. Your appointment notification will come via Electronic Records Express (ERE).

DDD Medical Administration schedulers will work from the schedule you provided. When a claimant is scheduled for evaluation, DDD generates a voucher reflecting the claimant's identifying information, the evaluation date and time, and all authorized procedures. Authorized procedures are listed on the voucher with the corresponding CPT code and payment rate. DDD will notify you of the scheduled evaluation by forwarding the voucher to you via ERE.

Only evaluation procedures listed on the voucher are authorized. Only authorized procedures should be conducted. If you believe an additional or alternative procedure is essential, any change will require authorization by phone from a Professional Relations Officer (PRO) or the DDD Medical Administration Department at 1-800-282-2695. The PRO can quickly pull-up the claimant's file, consider your request, and provide a timely response. Payment will not be rendered for unauthorized procedures.

The DDS bar-coded voucher serves to inform you of a scheduled appointment, authorized proceedures, any special instructions or alerts, and serves as the cover page for your report to ensure that you are credited for payment.

Occasionally, DDD determines need for a special alert to the examiner regarding an evaluation. The special alert might indicate a history of suicidal statements or threatening statements by the claimant. Any special alert will appear on the voucher.

The voucher serves not only to notify you of the scheduled evaluation. It serves additional important functions. The voucher is to be used by you as the cover page for your completed report when you submit the report to DDD. Via the bar code on the voucher, the report can be directed to the correct file.

Additionally, the voucher serves to assure the submitted report is credited for payment to your name, tax ID, and address. It is your responsibility to inspect the voucher to assure your payment name, address, and tax ID are reflected accurately. Accurate independent examiner information on the voucher is essential for prompt and correct payment. To implement a change in your billing information, you must call Medical Administration 800-282-2695.

Interpreters

On occasion, an interpreter will need to be present for an examination. Consultants will receive advanced notice that an interpreter will be present. If you have any questions about an interpreter being present, please contact a Professional Relations Officer.

Rescheduling of Evaluations

If the location where an evaluation is to be conducted is closed due to weather or other unforeseen circumstances, the consultant is required to speak to a member of DDD's Medical Administration. A voicemail is not sufficient for this matter. The consultant is not permitted to contact the claimant regarding the rescheduling of an appointment. Medical Administration will be responsible for the rescheduling of the appointment.

If you have any questions about a scheduled examination, please contact your assigned Professional Relations Officer at 1-800-282-2695.

Signature Requirements

Acceptable medical sources in claims are defined by SSA as licensed psychologists and licensed psychiatrists, physicians, and other medical professionals. SSA indicates all consultative evaluation reports must be personally signed by the individual who actually performed the evaluation. The licensed consultant must examine the claimant, sign the report, and take overall responsibility for the report. Electronic Records Express (ERE) presents the option to sign the report electronically.

Time Requirements for Submitting Reports

Written reports of evaluations must be submitted to DDD **no later than seven (7) business days** following the date of the appointment. Timeliness is essential to ensure that we meet the needs of claimants.

Methods for Report Submission

Report submission methods include the Gateway fax or Electronic Records Express (ERE). The voucher must appear as the first page of the report to assure the report is assigned to the correct claim and credited to your name, address, and tax ID for payment.

Payment Schedule and Payment Method

The fee schedule for independent evaluations is available and may be obtained from any Professional Relations Officer at 800-282-2695.

It takes approximately 14-21 days from the time payment is approved in the DDD system until the check is issued. Payment will not be made for a report submitted without the voucher as the first page. Checks are mailed. At this time electronic deposit is not an option. If a problem with payment emerges, contact any Professional Relations Officer at 800-282-2695.

Referrals at the Appeals Level

On occasion you will evaluate a claimant whose claim is at the appeals level. In those situations, in addition to conducting a consultative evaluation and writing a report, you might be asked by DDD to complete a HA-1152 (Medical Source Statement of Ability To Do Work-Related Activities form). Authorization for completion of these forms will appear on the voucher accompanying the referral. Request for completion of these forms will have originated with the administrative law judge evaluating the appealed claim. The form is to be completed based on your evaluation of the claimant, and the completed form is to be signed and submitted with your report.

At-Risk Claimants

When an evaluation involves a claimant presenting a known or possible elevated risk, the consultative examiner will be notified by special alert on the voucher. Notification by the special alert might indicate the claimant has an infectious disease such as HIV+, TB, or hepatitis, or a history of making suicidal statements or threatening statements. It is important to review all vouchers for this and all other information prior to the claimant's appointment.

Occasionally in the course of conducting an evaluation an emergency may arise that requires the examiner to take action to implement professional duties to protect or report. In these situations, the consultant needs to inform DDD at the earliest opportunity by telephone of actions taken to implement the relevant professional duty.

Furthermore, should a consultant become aware of unexpected findings, i.e. elevated counts, nodules, etc., please notify a Professional Relations Officer immediately.

In the event a psychiatric or medical emergency arises during evaluation, appropriate referral or transport arrangements to the necessary evaluative/treatment facility should be made by the consultant. DDD cannot and will not be responsible for any costs involved. The claimant should be advised of this.

Potential Conflicts of Interest

If you or anyone in your office discovers an existing or prior relationship to the examinee, the evaluation should be brought to a close as quickly as possible while handling the matter respectfully for the examinee. DDD then needs to be informed as soon as possible.

Special Settings for Evaluations

In-Home Evaluations

In-home evaluations are very infrequent and only performed when arranged and pre-approved by DDD. The consultative examiner never decides to relocate a scheduled office evaluation to the claimant's residence. If a consultative examiner discovers information suggesting the claimant is physically or psychiatrically unable to attend an evaluation, the consultant must contact DDD as soon as possible with this information. DDD will determine whether need for an in-home evaluation is supported, and if so, DDD will reschedule the location of the exam. In the rare instance of an in-home evaluation, the report is expected to include the functional observations afforded by an in-home evaluation.

In-Jail / In-Prison Evaluations
Occasionally, an evaluation of an incarcerated claimant is required. Prior to requesting an evaluation of an incarcerated claimant, DDD will have confirmed with jail or prison staff that the facility permits external professionals to conduct mental evaluations of inmates for SSA disability claims.

Once within the facility, the consultant has an opportunity for naturalistic observations of the claimant's functioning and this information is expected to appear in the report. Details regarding whether the claimant was interviewed in a professional interview room or while in segregation and whether facility staff raised special concerns can be informative. Sometimes jail or prison staff will raise concerns about risk to the examiner in interviewing a particular inmate, or voice concerns about an inmate's mental capacity to participate informatively in evaluation. Sometimes the examiner will observe an examinee to behave remarkably differently with the examiner versus with facility staff. Inclusion of such information can contribute to claims adjudication.

Other Facilities
At times evaluations are needed in other non-office settings such as long-term care facilities or libraries. Consultative examiners willing and interested in conducting any of the special examinations mentioned above, should contact a PRO.

Confidentiality of Reports & Claimant Data

Independent consultants are to function in compliance with requirements of all applicable laws, regulations, and rules, and in compliance with the requirements of the applicable professional licensing board and other applicable professional oversight bodies pertaining to maintaining confidentiality of SSA claimant evaluations and the handling of claimant data.

Nationally, 3,527,038 disability decisions were made by disability determination agencies. 81% of all of these decisions were made at the DDS level.

For DDD purposes, records of the evaluation must be retained by the examiner for a minimum of one year. This requirement does not supersede any other records retention requirements such as those established by law.

In some cases the examiner is in possession of background materials regarding the claimant. Some examiners retain background materials with the report. If the examiner does not retain background materials and instead discards them, the materials must be shredded. Background materials are not to be re-released to any party.

Two separate laws, the Freedom of Information Act and the Privacy Act, have special significance for Federal agencies. Under the Freedom of Information Act, Federal agencies are required to provide the public with access to their files and records. This means the public has the right, with certain exceptions, to examine records pertaining to the functions, procedures, final opinions, and policy of Federal agencies.

The Privacy Act permits an individual or his or her authorized representative to examine records pertaining to him or her in a Federal agency. For SSA disability applicants, this means the individual may request to see the medical or other evidence used to evaluate his or her application for disability benefits under the Social Security Administration disability programs.

SSA screens all requests to see medical evidence in a claim file to determine if release of the evidence directly to the individual might have an adverse effect on that individual. If so, the report will be released only to an authorized representative designated by the individual.

Requests for Release of Reports to Parties Other than DDD

At times, independent examiners receive requests from various parties for direct release of reports of evaluations they have conducted on referral by DDD. These requests can come from claimants, psychologists or psychiatrists, attorneys, or family members, for example. The party may even present the examiner with a completed authorization to release information.

Reports of consultative exams conducted on referral by DDD are not to be released directly by the examiner to any party other than DDD.

Any party requesting a copy of a consultative exam needs to be directed to DDD Medical Administration. If DDD retains legal jurisdiction of the claim, DDD will process the request. DDD is unable to release the report from a claim not under its jurisdiction, so if the claim is under SSA's jurisdiction, DDD will refer the party making the request to the relevant SSA office. Any background records provided to the examiner by DDD are not to be released to any party.

Reports of consultative exams conducted on referral by DDD are not to be released directly by the examiner to any party other than DDD.

Incomplete Reports

DDD reviews CE reports to determine if the specific information requested has been furnished. DDD will contact the medical source for any missing information or to prepare a revised report when the report submitted is inadequate. When the consultant is asked for additional information or a revised report, the additional work product will be provided by the examiner at no additional cost to DDD. These addendum reports are important to adjudicating a claim and are expected to be received within 3 business days.

Complaints

On occasion, a complaint is received from a claimant. Every complaint is reviewed by a Professional Relations Officer and consultants will be notified in writing and will have an opportunity to respond.

Subpoenas & Depositions

In the event you receive a subpoena to appear in court or at an administrative hearing, or to give deposition, contact your assigned Professional Relations Officer. Depending on the circumstance, DDD may be able to give you immediate guidance, or DDD may need to seek legal advice from SSA. In the unlikely event you receive a subpoena from an administrative law judge with SSA's Office of Hearings and Appeals (ODAR), DDD will contact ODAR before giving you guidance. In that situation, the professional opinion typically is provided via "interrogatory" (see below) rather than by personal appearance. In the event you must testify, your sworn testimony should be limited to your direct knowledge of the facts concerning the claimant.

Interrogatories

If you receive a request for completion of an interrogatory report from an ODAR office, immediately contact your assigned Professional Relations Officer.

Personally Identifiable Information (PII)

What is PII?

PII is any personal information maintained by an agency, including:

- Any information used to distinguish or trace an individual's identity, e.g., name, Social Security Number, date/place of birth, mother's maiden name, and/or biometric records.
- Any other information that can be linked to an individual, e.g., medical, education, financial, or employment information.

How can you safeguard PII?

- Store confidential information in locked file cabinets or desk drawers.
- Prevent others from viewing PII on your computer screen.
- Consistently lock or log off your computer when you are away.
- Ensure that PII is appropriately destroyed (e.g., shredded using a crosscut shredder) when no longer needed.
- Train and remind support staff to safeguard PII.
- Do not send PII by email.

How to transport PII?

- Store PII on computing devices that are encrypted using National Institute of Standards and Technology standards.
- Lock PII in a briefcase or satchel.
- Do not leave briefcase, satchel, laptop, or computer in unlocked vehicle or in plain view in a locked vehicle.
- Secure briefcase, satchel, or laptop in trunk or other concealed storage area.

What should CE Provider do if PII loss is suspected?

- Immediately report the PII loss to the DDS. If you suspect PII loss outside of normal business hours, leave a voicemail or email your DDS contact.
- Contact local law enforcement if theft is involved.
- Apply state laws and licensing board requirements when reporting PII loss and notifying affected claimants.

What should make up the report to DDS?

- Your contact information.
- Description of suspected loss, e.g., nature of the loss, number of records, type of equipment or media.
- Approximate time and location of loss.
- Safeguards in place at time of loss.
- Other parties involved who have been contacted.
- Details about reports made to law enforcement.
- Any other pertinent information.

Protection of Personally Identifiable Information is important. You are required to immediately report any suspected loss of information - even if it is outside of normal business hours. Please contact your assigned Professional Relations Officer at 800-282-2695 to make this report. If PII is lost due to criminal activity, contact local law enforcement too.

Ohio DDD Guidelines for Independent Physical Consultative Examination of Social Security Administration Claimants

Role of the Independant Physical Consultative Examiner

When evidence in a claim is inadequate for DDD to reach a determination, DDD may arrange and pay for an independent consultative examination (CE) of the claimant. Depending on the issues in the claim, a licensed physician or a certified speech and language pathologist might conduct the evaluation. The independent examiner evaluates the claimant in person and submits the results to the DDD in a written report. This becomes part of the claim evidence, reflecting an expert opinion on a medico-legal issue. The adjudicative team considers the report along with all other evidence in the file to reach a determination based on SSA policy.

An independent evaluation of an SSA disability claimant is therefore a forensic process. It differs from a treatment evaluation in several ways:

1. In a typical treatment situation, the patient engages the examiner's services directly. In contrast, the DDD engages the consultative examiner to evaluate the claimant. Therefore, confidentiality is limited in that all parties enter into the arrangement agreeing that a report will be sent to the DDD as evidence in the claim. At least one adjudicative team will read the report. If subsequent appeals are filed, additional adjudicators, consultants, lawyer(s), the claimant, and an administrative law judge may ultimately review the report. See Business Process for additional discussion of confidentiality.
2. No therapeutic doctor/patient relationship is established at a CE and no treatment recommendations are given. This does not, however preclude informing a claimant of any urgent or unexpected findings that warrant follow-up with his or her treating physician (e.g. very high blood pressure). See Business Process for specific situations.
3. The perspective of the CE is one of neutrality: neither biased in favor of, nor opposed to the ultimate determination by the DDD regarding disability. Unlike the role of a treating clinician which typically is supportive and one of advocacy, the CE perspective is one of impartiality. If a situation arises that could be perceived as a conflict of interest (e.g. you personally know the claimant), decline to do the exam, notify the PRO/MedAdmin, and the individual will be rescheduled with another examiner.
4. Perhaps the most important difference is the consultative examiner's focus on whether any diagnosable disorder limits the claimant's functional capacities necessary for work. If the physician examiner concludes a diagnosable medical condition is present, then (s)he provides an opinion on whether - and if so, how - that condition limits the claimant's physical functional capacities.

General Instructions for Physical Consultative Exams (CE) Report Content

Regardless of the subspecialty, there are some general principles that apply to all physical consultative examinations. A CE report must be thorough and reflect accepted professional medical standards and practice. SSA expects evaluations to reflect your professional training and abilities. The detail and format for reporting the results of the medical history, physical examination, laboratory findings, and discussion of conclusions should follow the standard reporting principles for a complete medical examination. It should be in the form of a report, not a letter addressed to an individual or the agency. Some modifications are appropriate depending on the specialty (see next section for specifics), but the following general instructions apply to most physical consultative exams.

Documentation: Referral Source/Purpose of Exam/Background Materials

1. State clearly that the consultative examination was requested by DDD, to contribute evidence for the process of disability determination.
2. Document a discussion with the claimant to assure that there is understanding and agreement about the nature of the exam and the submission of a report to DDD.
3. Cite background materials received and reviewed during the course of the evaluation. Documenting this information at the beginning of the report will serve to orient all potential readers to the source and purpose of the document.

Complete History and Physical

This component of the forensic evaluation is quite similar to that of a therapeutic encounter for any new patient to a physician's practice. A CE is arranged due to a lack of sufficient evidence to make a disability determination, so it is important to be thorough in your evaluation of the claimant. Specific minimum requirements for a CE are delineated in the following sections, based on specialty. Beyond that threshold, the exam needs to be individualized for each claimant. This requires

pursuing appropriate follow-up questions (history) and findings (physical exam), guided by the claimant's allegations and conditions.

The chief complaint(s) should be followed by a history of present illness (HOPI) for each chief complaint. The HOPI should include information regarding: (source: Bluebook)

- the claimant's daily activities;
- the location, duration, frequency, and intensity of the symptom(s);
- precipitating and aggravating factors;
- role of medication (type, dosage, effects/side-effects); and/or
- any additional measures the claimant has used to relieve symptom(s).

The rest of the historical information required is detailed in each subsection, but again follows a typical format for any H&P: past medical/surgical history, current medications, social and family history, and a review of systems. If you choose to use a questionnaire for the latter, be sure to follow up directly with the claimant. The majority of the historical information should be gathered via face-to-face interaction.

The physical exam likewise should be thorough and include additional maneuvers/observations to evaluate the claimant's alleged condition(s). For example, sitting and supine straight leg-raising tests should be documented for individuals complaining of back pain, but are unnecessary for claimants alleging only asthma. It is essential to document absent or negative findings; a lack of documentation cannot be assumed to mean that findings were normal.

It is beyond the scope of these guidelines to address every potential allegation in terms of historical questions to ask and each pertinent physical finding to look for/exclude. Your knowledge and experience with differential diagnosis will guide your history taking and physical examination. Two examples follow:

- If a claimant alleges fibromyalgia, the evaluation for trigger points is expected.
- If a claimant alleges Reflex Sympathetic Dystrophy, skin changes should be documented.

These are just two examples that illustrate ways to individualize your physical exam as well as the importance of recording both positive AND negative findings in your narrative.

Some specialty exams do not require a "complete" history and physical. For example, consultative exams with ENT, cardiac, and vision specialists are focused on one particular organ system. Although these assessments are less comprehensive, the same principle applies: to thoroughly investigate the claimant's allegations and physical findings.

A Note about Templates

One of the most important requirements of a CE is that it ***MUST*** be individualized to reflect the specific claimant's allegations, current condition, and functional status. Templates can be useful as a tool to assure that no required elements of the report are omitted. However, the absence of any significant modifications to a template results in a "generic" report that clearly does not serve its intended purpose. If you use a template, make sure to use it only as a guide: all variations from the normal exam and any additional relevant information must be documented. Any corresponding "normal template statements" must be deleted to assure that data in the report are consistent.

Medical Source Statement (MSS)

In a therapeutic encounter, the typical History and Physical (H&P) is followed by a list of diagnoses and a plan for further testing, treatment, and/or follow-up recommendations. By contrast, in the CE report as requested by SSA, a Medical Source Statement follows the H&P. Briefly, the MSS consists of two components: diagnostic impression(s) and a functional assessment.

Foundation for the MSS:

The discussion of the medical evidence in this part of the report represents the core of the disability evaluation process. The basis for this discussion is the thorough, individualized history and physical as described above. It is important that the narrative clearly differentiate between the subjective (symptoms) and the objective (signs). Be sure to describe both positive and negative findings. Sometimes background material (collateral source information) will be included with the request for an exam; you should review, cite, and consider it along with your own exam when formulating your functional assessment. Assess the claimant's abilities and limitations based on all of these types of data: the history, all observations, collateral evidence, and results of relevant laboratory tests. When the evidence supports your assessment, the adjudicative team is able to rely more on your opinions. This provides a solid framework for the rationale used to make a final claim determination.

Components of the MSS:

1. The MSS should specify the nature and extent of the condition or disorder. Traditionally clinicians would label this Diagnoses or Assessment. It is acceptable to document some conditions as "probable" if absolute proof (e.g. PFS or MRI result) is unavailable, but evidence supports the diagnosis.

2. The MSS must also discuss any apparent discrepancies in the medical history or in the examination findings. As a

neutral observer, your role is to objectively evaluate *any and all* information available to you that could contribute to the functional assessment. Observations outside of the exam room can and should be included. If testing is a component of the exam, an opinion on effort and validity should be noted in the assessment.

3. Finally, the MSS for adults must reflect YOUR opinion of limitations in function that result from the condition or disorder, including:
    - Lifting/carrying/pushing/pulling
    - Sitting/standing/walking*
    - Posture (for example, climbing/stooping/bending/balancing/crawling/ kneeling/crouching)
    - Fine motor skills (that is, handling/fingering/gripping/feeling)
    - Overhead and forward reaching
    - Vision/hearing/speech
    - Environmental exposures (for example, heat/cold/humidity/noise/vibration)

**If an ambulatory aid is used or alleged, always document whether in your opinion it is medically necessary and if so, under what circumstances (indoors/outdoors, even/uneven terrain, short/long distances, etc).*

This should be your best assessment of what the claimant could do in the workplace during an 8-hour day, 5 days/week (normal breaks are assumed). Periods for activity typically are described as:

- Constant
- Frequent (2/3 of the workday)
- Occasional (1/3 of the workday)
- Never

More about the MSS:

For claimants under the age of 18, fitness for work is not relevant. Rather than using work-related activities, address function in a developmental context: see section G for details.

For claimants 18 and older, do not use vocational categories such as “light work” or “medium work.” These terms have different meanings in various contexts. Instead, specifically describe limitations and capabilities as they relate to the physical activities listed above (e.g. the claimant could occasionally lift 20#, could stand 6-8 hours in a normal workday, could occasionally reach overhead with the right upper extremity, etc).

The MSS you provide should address only the functional limitations that are attributable to physical diagnoses. Age, gender, and small body-type are not considered impairments by DDD, so do not ascribe limitations based on these factors. By contrast, obesity can be considered a physical impairment and if it imposes limitations, describe that in your MSS. If there are mental/psychological conditions alleged or suspected, it is reasonable to note this along with the physical diagnoses. However, licensed psychiatrists or psychologists are engaged separately to evaluate for any mental condition(s) and resulting (mental) functional limitations.

The conclusions of your report must be consistent with the objective clinical findings documented on examination as well as the claimant’s symptoms, laboratory studies, demonstrated response to treatment, and review of any outside records provided (i.e. all available information). If effort or cooperation are lacking, it is appropriate to comment on this. It is essential that you support your diagnostic and functional opinions adequately with data and reasoning. As part of the adjudicative process, your opinions will be weighed on that basis. Avoid comments or observations (e.g. about lifestyle or past criminal activity) that are not relevant to the H&P or MSS. Extraneous remarks that could be interpreted as disparaging or judgmental reduce the overall value of the report.

The MSS should not include an opinion as to whether the claimant is “disabled” under the meaning of the law. The CE’s role is to evaluate for the presence or absence of diagnoses and to assess current functional status. The adjudicative team considers the CE Report as well as other available longitudinal evidence. All of this information is then considered along with a variety of demographic, psychosocial, and economic factors based on SSA policy, to reach the legal determination of whether the claimant is disabled.

1151 FORM

There is an appeals process for claimants who are found NOT disabled by the DDD. At a later step in the appeals process, an administrative law judge (ALJ) may hear the claim for review. The ALJ has the perogative to ask for additional testing and/or exams. If a CE is requested, the ALJ might also ask for an 1151 form to be completed by the CE examiner. This is a structured Medical Source Statement form, addressing all of the activities noted above. Remember that this form should reflect *YOUR* opinion of the claimant’s functional capacity, not the claimant’s allegations. (See Business Process above)

Addenda/Feedback

If the DDD requires any clarification of the CE report (e.g. something is omitted or an internal inconsistency needs to be resolved), the DDD will contact you for an addendum. (See Business Process above)

Additionally, samplings of CE reports are routinely reviewed for quality, with an emphasis on the requirements noted above. If there are recurring problems or deficiencies found in the course of these reviews, feedback will be given.

Summary - the CE Report Must:

1. **Provide evidence that serves as an adequate basis for disability decision-making in terms of the condition it assesses. Symptoms (the claimant's self-report) and signs (anatomical, physiological abnormalities that can be observed) should both be included and they should be clearly distinguishable.**
2. **Be internally consistent. Are all the diseases, conditions, and complaints described in the history adequately assessed and reported in the clinical findings (e.g. Do the conclusions correlate the medical history, the clinical examination and laboratory tests, and explain all abnormalities)?**
3. **Be consistent with the other information available within the specialty of the examination requested (e.g. Did the report fail to mention an important or relevant complaint within that specialty that is noted in other evidence in the file? Examples include: blindness in one eye, amputations, pain).**
4. **Be adequate as compared to the standards set out in the course of a medical education. (Source: Greenbook) The submission should be in the form of a report (not a letter) to the DDD.**

A. Internal Medicine CE Report Requirements

SPECIFIC CE Requirements by Specialty

The following sections list the specific CE requirements according to type of exam or specialty. Each list reflects minimum requirements. The specific order is not as important as making sure all the required elements are included in the report. It is expected that additional information and findings will be pursued and documented to thoroughly assess the claimant's specific allegations and findings. See Complete History and Physical above. If a form is required for a particular specialty exam, follow all instructions on that form and complete it in its entirety. The particular form(s) needed are listed among the requirements of each specialty along with a reference to the location of a sample blank form. Forms used by more than one specialty are in Appendix J. The forms associated with only one specialty or with Ancillary Testing will be found within the respective subsections.

NOTE: *always review the voucher before seeing the claimant: this will assure that you read any notes regarding specific requests for information and findings. It also shows what, if any testing is requested and will be reimbursed. If you believe additional testing or a change in testing is appropriate (e.g. a different joint should be x-rayed), be sure to contact DDD first for pre-approval.* ***There will be no reimbursement for testing done without prior approval.***

Documentation:

Identify the Claimant.
Document referral source and purpose of exam
Cite any medical records/documents reviewed during the course of the evaluation.

History/Subjective

List all chief complaints;
Elaborate on each complaint in the History of Present Illness;
Document past medical and surgical history;
List all medications;
Document family history;
Document social history; and
List results of the Review of Systems.

Physical/Objective

(Note: do not perform breast, rectal, or pelvic exams)

Measure vital signs (including height, weight, BP, etc.);
Measure visual acuities (near/far, both with/without glasses);
Describe claimant's general presentation, appearance and gait;
Examine the head, eyes, ears and throat;
Examine the neck;
Examine the lungs;
Examine the heart;
Examine the abdomen;
Examine the back and spine;
Examine the extremities and measure ranges of motion;
Perform a neurological examination; and
Examine the skin.

Enter the Manual Muscle testing results in the Neuromuscular Data Sheet Form: See J1.
Enter the Range of Motion testing results in the Neuromuscular Data Sheet Form: See J1.
Review results of x-rays or other tests performed in your office.
Provide a Medical Source Statement (diagnoses and functional assessment).
If requested, complete 1151 Form: See J2
Proofread.
Signature.

B. Musculoskeletal/Orthopedic CE Report Requirements

Documentation:

Identify the claimant.
Document referral source and purpose of exam
Cite any medical records/documents reviewed during the course of the evaluation.

History/Subjective

List all chief complaints;
Elaborate on each complaint in the History of Present Illness;
Document past medical and surgical history;
Describe claimant's usual daily activities and ability to perform activities of daily living;
List all medications;
Document family history;
Document social history; and
List results of the Review of Systems (Focus on Musculoskeletal and Nervous Systems).

Physical/Objective

Measure vital signs (including height, weight, BP, etc.);
Describe claimant's general presentation, appearance and gait;
Examine the back and spine;
Examine extremities and peripheral joints: measure ranges of motion;
If amputated extremity: describe stump, skin, suitability for prosthetic; and
Perform a Neurological Examination.

Examine the skin/burn effects: describe sensitivity, effect on joint motion.
Enter Manual Muscle Testing results in Neuromuscular Data Sheet: See J1.
Enter Range of Motion results in Neuromuscular Data Sheet: See J1.
Review results of x-rays and other tests performed in your office.
Provide a Medical Source Statement (diagnoses and functional assessment).
If requested, complete 1151 Form: See J2.
Proofread
Signature

C. Neurological CE Report Requirements

Documentation:

Identify the claimant.
Document referral source and purpose of exam
Cite any medical records/documents reviewed during the course of the evaluation.

History/Subjective

List all chief complaints;
Elaborate on each complaint in the History of Present Illness;
Document als elements of medical and surgical history;
Describe claimant's usual daily activities and ability to perform activities of daily living;
List all medications;
Document family history;
Document social history; and
List results of review of systems.

Physical/Objective

Measure vital signs (including height, weight, BP, etc.);
Measure visual acuities (near/far, both with/without glasses);
Describe claimant's general presentation, appearance and gait;
Examine the head, eyes, ears and throat;
Examine the neck;
Examine the back and spine;
Examine extremities and measure range of motion;
Perform a Neurological Examination; and
Examine the skin

Enter Manual Muscle testing results in Neuromuscular Data Sheet: See J1.
Enter Range of Motion results in Neuromuscular Data Sheet: See J1.
Review results of x-rays and other tests performed in your office.
Provide a Medical Source Statement (diagnoses and functional assessment).
If requested, complete 1151 Form: See J2.
Proofread
Signature

D. Limited Cardiac Exam Report Requirements

Documentation:

Identify the claimant.
Document referral source and purpose of exam
Cite any medical records/documents reviewed during the course of the evaluation.

History/Subjective

Describe all complaints relative to CV system (chest pain, SOB, claudication, palpitations, etc.)
Past medical/surgical History
Current medications
Review of systems
Social history
Family history

Physical/Objective

General appearance;
Measure vital signs; Lungs; Heart, Vascular System (pulses, neck, skin, +/- edema, etc.)
State an opinion re: presence/absence of angina.
Estimate Claimant's functional class (NYHA).
Determine if there are any contraindications (see below) to performing an XST and document whether the claimant can safely undergo an exercise stress test. *IF ONE WAS SCHEDULED, and IF CONTRAINDICATED, notify OOD Medical Administration and advise claimant not to attend any scheduled XST.*

Additional Testing if requested

ECG (provide tracings)
ETT (the physician supervising the ETT will make the final decision as to whether the claimant's medical condition will allow him or her to tolerate safely the stress involved.
See Ancelary Testing (section I, 3 D, E, and/or F).

Complete required cardiac form: See J3.
Medical Source Statement
If requested, complete1151: See J2. Limit your opinions to the areas relevant to the conditions assessed by your exam.
Proofread
Signature

The following are some, but not all, of the contraindications to an exercise stress test for disability determination purposes:

- Difficulty walking
- Difficulty balancing
- Significant mental retardation, cognitive impairment, or mental illness
- Acute myocardial infarction in the past three months
- Unstable angina (any rest or nocturnal pain believed to be angina)
- Aortic stenosis
- Significant heart failure (all class IV and some class III)
- Aortic dissection
- Pulmonary embolus
- Pulmonary hypertension
- Left main coronary artery stenosis
- Electrolyte imbalance
- Severe hypertension
- Tachydysrhythmias
- Bradydysrhythmias
- Hypertrophic cardiomyopathy
- High grade A-V block

E. Otolaryngological/Audiometric Testing CE Report Requirements

Documentation:

- Identify the claimant.
- Document referral source and purpose of exam
- Cite any medical records/documents reviewed during the course of the evaluation.

History/Subjective

- List All Otolaryngological complaints;
- Elaborate on each Otolaryngological complaint in the History of Present Illness;
- Document pertinent elements of medical, surgical, family and social histories and medications;
- In children, obtain specific age-appropriate information; and
- Conduct an Otolaryngological review of systems.

Physical/Objective

- Describe claimant's general presentation, appearance and gait;
- Examine the head;
- Examine the mouth, nose and throat;
- Examine the ears. Remove cerumen if present. This is necessary for acurate audiometric testing;
- Examine the neck;
- Perform Brief Neurological Examination, if pertinent
- ***WITHOUT** Cochlear Implants*:
  - Air and bone pure tone audiometry for adult claimants
  - Speech Audiometry for adult claimants
  - Age-Appropriate Hearing Assessment for Children
- ***WITH** a Cochlear Implant:*
  - HINT Testing for adult Claimants (HINT testing in quiet, in sound field with cochlear implant in place and functioning properly)
  - Age-Appropriate Hearing Assessment for Children WITH Cochlear Implants
  - Address validity of Audiometric Testing
- Interpretation of Audiometric Testing
- Special Requirements for Claimants with Vertigo and/or Imbalance
  - Presence/absence of nystagmus
  - Romberg results
  - Cerebellar signs

List Otolaryngological Diagnostic Impressions.
Provide a Functional Statement of Ability to Speak, Hear and Communicate (unaided). Also, address any other functional limitations attributable to a condition that is present (vertigo/balance issues).
If requested, complere 1151 Form: See J2. Limit your opinions to the areas relevant to the conditions assessed by your exam.
Proofread
Signature

*(*SSA does not have a specific form for ENT/Audio to use – it is left to the discretion of the examiner how to present the information in the CE report.)*

F. Ophthalmological/Optometric CE Report Requirements

(All SSA requirements related to equipment are not included in this document: Please contact your Professional Relations Officer/Medical Administration for more detailed information)

By filling out the ophthalmological/optometric forms for DDS, most of the specific report requirements listed below will be provided. Your documentation of any discrepancies (if present) is of particular importance. It is critical that you address whether the acuities and fields recorded can reasonably be expected to result from the medical condition of the claimant. If perimetry is not consistent with other findings, perform confrontational fields. Any other relevant observations such as vision-related behaviors need to be noted. Describe how the claimant navigates in an unfamiliar environment, whether he or she is able to reach for a pen that is handed to him/her, etc.

Documentation:

Identify the claimant.
Document referral source and purpose of exam
Cite any medical records/documents reviewed during the course of the evaluation.

History/Subjective

List All Ophthalmological/Optometric complaints;
Elaborate on each Ophthalmological/Optometric complaint in the History of Present Illness;
Document pertinent elements of medical, family and social histories and medications; and
In children, obtain specific age-appropriate information.

Physical/Objective

Describe claimant's general presentation, appearance and gait, and vision-related behaviors;
Examine the head;
Measure uncorrected visual acuities;
Measure best corrected visual acuities (distance and reading) by manifest refraction;
Examine the pupils, extraocular muscles and external eye;
Test visual fields by confrontation;
Measure Intraocular Pressures: If pressures are high, or if glaucoma has been diagnosed, give C/D ratios;
Perform dilated Funduscopic Examination (unless contraindicated or clmt refuses) and describe any pathology;
Measure perimetry in one of two ways: Goldmann alone, or Humphrey 30-2 with SSA test kinetic); and
In children, perform age-appropriate vision assessment.

Comment on validity of acuities and perimetry.
Note a description of the claimant's cooperation with visual examination.
Note whether visual behaviors are consistent with testing results.
List Ophthalomological/Optometric diagnostic impressions.
Provide a Functional Statement ("Medical Source Statement") of claimant's ability to see.
Specifically state if claimant meets legal criteria for statutory blindness.
Most of the above information will be recorded on the required forms:

- Ophthalmological Consultative Examination Form (F1. below)
- Ophthalmological Consultative Examination Without Perimetric Fields Form (F2. below)
- Ophthalmological Consultative Examination: Children up to Five Years of Age (F3. below)

If requested, complete 1151 Form: See J2. Please limit your opinions to the areas relevant to the conditions assessed by your exam.
Proofread.
Signature.

FORMS:
1. Ophthalmological Consultative Examination Form
2. Ophthalmological Consultative Examination Without Perimetric Fields Form
3. Ophthalmological Consultative Examination: Children up to Five Years of Age

G. Pediatric CE Report Requirements

H&P

The basic requirements are listed below. The most critical element of a pediatric assessment is considering the issue(s) under investigation relative to developmental expectations. Both historical information as well as physical exam findings should be evaluated within the framework of developmental expectations. On physical exam, the initial general presentation should be emphasized. Fine and gross motor milestones are particularly important to assess a younger child. Describe your observations of how the child is able to navigate in the exam room, get on and off the exam table, etc. If a child is too young to walk, describe the highest observed level of movement (sits upright, lifts head, etc). Comment on symmetry, note any scars, devices (G-tube), and assess how the child interacts with you as well as the accompanying adult. General visual functions and behaviors should be assessed; this is especially important if clmt is under 2 years. Unless specifically requested, omit the genitourinary exam; it is not necessary for DDD purposes. Overall, it is best to avoid a predominantly negative exam (e.g. a list of findings that were not present). Rather, make sure your report content includes descriptive observations and impressions of signs that were present during your assessment.

Regarding vital signs: When documenting weight and height, do so to the nearest ounce and fraction of an inch (English) or the nearest 0.1kg and cm (metric) respectively. This is important in children age 2 or younger. Head circumference is indicated when child is age 3 or younger, or has a neurologic or mental impairment. Measure BP if child is 6 or older (or if specifically requested).

MSS

The MSS is based on evidence and should be supported by symptoms, signs and findings. Document your diagnoses here, followed by any functional limitations attributable to those diagnoses. For pediatric claimants, this should describe your opinion about the functional capacities in the following, compared to children his or her age who do not have impairments:

- Acquiring and using information;
- Attending and completing tasks;
- Interacting and relating with others;
- Moving about and manipulating objects;
- Caring for oneself; and
- Health/physical well–being.

<u>Report Requirements:</u>

Identify the child and the accompanying adult and relationship to child.
Document referral source and purpose of exam
Cite any medical records/documents reviewed during the course of the evaluation.

<u>History/Subjective</u>

List all chief complaints;
Elaborate on each complaint in the History of Present Illness;
Document birth and early medical history;
Detail developmental milestones;
Document pertinent elements of medical, surgical, family and social histories and medications; and
Conduct a thorough review of systems.

<u>Physical/Objective</u>

Measure vital signs;
Describe child's general presentation, level of activity, and gait or motor quality;
Describe the child's behavior, interactions with CE, accompanying adult;
Examine the head, eyes, ears and throat;
Examine the neck;
Examine the lungs;
Examine the heart;
Examine the abdomen;
Observe and examine the back and spine;
Examine the extremities;
Perform a Neurological Examination, including gait, muscle tone; and
Examine the skin.

Complete Denver Developmental Survey if ordered.
Provide a Medical Source Statement (diagnoses and functional assessment).
Proofread and Signature

H. Speech and Language Pathology CE Report Requirements

Overview

The report should present and interpret evidence supporting all diagnoses related to speech and language. The conclusions should accurately assess the claimant's current functional and developmental status with respect to speech and language issues. Document both positive and negative findings; the adjudicative team (readers of your report) cannot assume that unreported elements are normal. Comment on the validity/reliability of your findings and indicate any factors that influenced the results (understanding, cooperation, etc).

The completed speech evaluation summary cover sheet must accompany your report narrative. This cover sheet provides an overview of your observations and the contents of your evaluation. It is important for the non-SLP readers of your report to have this form completed in its entirety. *Do not write "see report" on the summary sheet.*

When a claim includes adequate language evidence, but little speech articulation evidence, a limited intelligibility assessment is requested. This requires that you report your observations of the child's speech skills only, without the need for a language evaluation. When completing a limited intelligibility assessment, the only areas to be considered are shown on the Intelligibility Assessment form.

All evaluations, testing, conclusions and the writing of the report must be performed by a fully Ohio-licensed and certified speech and language pathologist, or a speech and language pathology trainee in his or her certifying training (under the supervision of a fully Ohio-licensed speech and language pathologist). In this case, the supervising speech and language pathologist must agree with the findings and conclusions of the trainee and cosign the report. Signatures must identify educational degree, certification, and/or licensure credentials.

Report Requirements

(Children from birth to age 3)

Documentation:

Identify the child and the accompanying adult and relationship to child.
Document referral source and purpose of exam.
Cite any medical records/documents reviewed during the course of the evaluation.

Record all alleged speech and language problems, abnormalities or deficits.
Review developmental milestones for speech and language.
Identify significant birth and postnatal history related to hearing.
Identify significant birth and postnatal history related to developmental delays in other areas.
Report participation in previous and/or current speech-language therapy.
Identify family history of speech, language, hearing, genetic or developmental issues.
Conduct comprehensive speech evaluation.
Administer appropriate comprehensive language testing.
Provide detailed conclusions.
Complete the Speech Evaluation Summary Cover Sheet. See H1A.
Complete the Limited Speech Intelligibility Assessment Form if requested. See H1B.
Proofread.
Signature.

(3 years of age and older)

Documentation:

Identify the child and the accompanying adult and relationship to adult.
Document referral source and purpose of exam.
Cite any medical records/documents reviewed during the course of the evaluation.

Record all alleged speech and language problems, abnormalities or deficits.
Review developmental milestones for speech and language.
Identify significant birth and postnatal history related to hearing.
Identify significant birth and postnatal history related to developmental delays in other areas.
Report participation in previous and/or current speech-language therapy.
Identify family history of speech, language, hearing, genetic or developmental issues.
Conduct comprehensive speech evaluation.
Include a current assessment tool (if needed).
Administer appropriate comprehensive language testing.
Comment on child's overall receptive and expressive language skills (based on spontaneous conversation).

Discuss development of conversational skill as it relates to child's chronological age (based on spontaneous language sample).
Discuss child's development of narrative skill relative to child's chronological age.
Provide detailed conclusions.
Complete the Speech Evaluation Summary Cover Sheet. See H1A.
Complete the Limited Speech Intelligibility Assessment Form (if requested). See H1B.
Proofread.
Signature.

Reference Materials for Speech & Language

1. **Forms**
   A. Speech Evaluation Summary Cover Sheet
   B. Limited Speech Intelligibility Assessment Form

2. **Acceptable Standardized Tests**
   Speech:
   Goldman Fristoe Test of Articulation 2
   Arizona Articulation Proficiency Scale
   Bankson Bernthal Test of Phonology

   Fluency:
   Stuttering Severity Instrument 3

   Language:
   Test of Adolescent and Adult Language
   Test of Language Development Primary 4
   Test of Language Development Intermediate 4
   Test of Early Language Development 3
   Receptive Expressive Emergent Language Test 3
   Rossetti Infant Toddler Scale
   Preschool Language Scale 5
   Clinical Evaluation of Language Fundamentals 5
   Clinical Evaluation of Language Fundamentals Preschool 5
   Hawaii Early Learning Profile
   Oral and Written Language Scales 2
   Comprehensive Assessment of Spoken Language

I. Ancillary Testing

Reminder: always get pre-approval before adding any ancillary tests. In order to get reimbursement, all testing must be approved in advance.

1. Radiographs (X-Rays)

X-rays are to be done only by personnel who are properly trained and certified. All required safeguards should be in place. Do not X-ray claimants if they are pregnant or could be pregnant. Ensure that a licensed radiologist interprets and signs off on all X-rays done for DDD. In the event of a serious or unexpected finding, call DDD with that information and follow-up with a fax of the report (see Business Section for procedural details).

2. Pulmonary

PFS:

Follow all instructions on SSA's PFS reporting form. There are questions to ask the claimant and document prior to proceeding with PFS. For example, if the claimant is acutely ill or has been treated for an acute exacerbation within the prior 14 days, the test needs to be rescheduled. In that situation, call DDD and document the reason that the test was not performed.

When conducting PFS, it is crucial to elicit the claimant's maximum effort with detailed instruction and vigorous coaching. At least 3 trials before BD and 3 trials after BD need to be done to assure valid effort (</= 5% variability). IF the pre-BD FEV1 and FVC are above 70%, do not do post-BD testing. DDD requires time/volume tracings of at least 3 trials pre-BD, and 3 trials post-BD when indicated. The numeric results need to be documented as well as the graphic tracings. All of this evidence should be included in your report to DDD.
Complete the PFS summary sheet accurately, documenting BEST results with corresponding % predicted values. Your interpretation should include an assessment of validity, noting any factors that influenced this. Send all pages of the PFS report to DDD, including the calibration data.

DLCO:

See instructional sheet for SSA requirements in DLCO testing. The mean value (DLCO) of at least two acceptable measurements should be reported with the inspired volume clearly marked. Tests are deemed acceptable if they are within 10% of each other (or 3 ml CO, whichever is larger) and the IV needs to be at least 90% of claimant's best FVC.

A. PFS Report Form
B. Correcting Ambient Temperatures to Body Temperature Pressure Saturated (BTPS) Table
C. Diffusing Capacity (DLCO: include forms, specifications)
D. Instruction Sheet for Diffusing Capacity of the Lungs
E. Arterial Blood Gases Studies(At Rest) Form (procedures/precautions)

3. Cardiovascular Tests

Any forms associated with the following tests include specific instructions for protocols. Safety is of utmost importance to SSA. Read the form thoroughly before proceeding with testing, then make sure the form is completed in its entirety.

A. Resting Electrocardiograms (12-lead, use your standard office equipment/print-out)
B. Resting Doppler-Measured Blood Pressure Study of the Legs and Great Toe Form.
*C. Exercise Testing Form
D. Cardiac Treadmill Exercise Testing Form
*E. Exercise (and Resting) Doppler-Measured Blood Pressures of Legs, Great Toes (form)
*F. Exercise Arterial Blood Gas Studies Form
G. Pulse Oximetry Form (for children under 12)

(Exercise testing is ALWAYS preceded by Limited Cardiac Exam (see D. above) - see J3)*

4. Blood Work

Follow all safety guidelines, rules, laws, and principles as established by state and federal regulatory agencies. Include the actual laboratory printouts with your report.

J. Appendices (combined)

1. Neuromuscular Data Sheet

Be **COMPLETE** and **CONSISTENT**.

Complete this form in its entirety. Instructions are on the form. Where required, add descriptions to supplement your responses. For example, if muscle testing is not reliable, check that box and in the space provided, describe why. If handwritten, this must be easily readable. *Do not write, "See narrative."*

Fill out this form with the same intention to reflect the individualized exam that you show in the narrative. Be sure that the information on this data sheet is consistent with your narrative report. If there are discrepancies between the narrative and this data sheet, an addendum will be required. This will cost you valuable time and will unnecessarily delay the claim.

2. 1151 form

3. Limited Cardiac Exam Form