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RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy and procedures for the release of information (ROI) to the Social Security Administration (SSA) and its affiliated State disability determination services (DDS) via a secure Web site using a standard health summary protocol. **NOTE:** URL is provided when SSA grants access to Web site.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) has historically received a large number of requests for copies of individual specific health information from SSA along with proper authority for the release of the requested information. Many of these requests are very broad in nature. Over the years, VA has tried a number of avenues to improve response time and ease the burden of processing these requests (i.e., contracts with copy companies, allowing SSA staff on-site to copy).

b. Sites are now able to use the SSA web site as a secure means for electronically responding to these authorized requests using the standard SSA national health summary components in Veterans Health Information Systems and Technology Architecture (VistA) and/or Computerized Patient Record System (CPRS). This process allows VHA to expedite requests to SSA-DDS, avoid printing and mailing, and help reduce disability claim processing time. **NOTE:** The SSA Electronic Medical Evidence Security Fact Sheet can be located at <http://vaww.vhaco.va.gov/him/ReleasingInfoSSA.asp>

c. A written authorization signed by the individual to whom the information or record pertains is necessary and must comply with all applicable authorization requirements in VHA Handbook 1605.1.

3. POLICY: It is VHA policy that requests for release of information from SSA be answered in a timely, complete, accurate, and secure manner.

4. ACTION: The Facility Chief, Health Information Manager (HIM) and/or Privacy Officer. The facility Chief, HIM, or Privacy Officer is responsible for:

a. Working with the respective state SSA-DDS Medical and/or Professional Relations Officer (PRO) to prepare and implement utilization of the SSA Web site to respond to SSA-DDS requests for health information. **NOTE:** Contact information for each local PRO can be found at <http://www.ssa.gov/disability/professionals/procontacts.htm>.

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- b. Initiating contact with the SSA-DDS PRO. The SSA-DDS PRO is responsible for:
 - (1) Helping to determine local modification as needed to the Health Summary components;
 - (2) Assisting VHA facilities in obtaining access to the Web site; and
 - (3) Working with VHA facilities to reach a mutual agreement on date of implementation.
- c. Submitting the request(s) for passwords for each ROI clerk that routinely needs access to the SSA Web site. SSA individually assigns access codes to each clerk. **NOTE:** *If VA employees answering SSA-DDS requests for release of information leave VA employment or change positions, the Chief, HIM and/or Privacy Officer must immediately notify SSA to inactivate that person's access.*
- d. Establishing and implementing the SSA-DDS Health Summary “VA SSA-DDS Standard Summary” (see Att. A) to respond to SSA-DDS requests for ROI. This summary encompasses 2 years of various health information and 4 years of discharge summary and compensation and pension exams. SSA-DDS must send a separate request specifying the date range if information is needed prior to this time frame. **NOTE:** *A facility may discover local components that offer more complete information due to utilization of the various Vista packages (i.e., one VA facility may utilize the Medical Reports package whereas another facility may not.) Facilities need to negotiate use of those components, in lieu of those in Attachment A, with their local SSA-DDS office.*
- e. Implementing use of the SSA Electronic Medical Evidence (EME) Web site to release the VA SSA-DDS Health Summary to SSA-DDS. Only authenticated documents will be released. **NOTE:** *See SSA-DDS User's Guide at <http://vaww.vhaco.va.gov/him/ReleasingInfoSSA.asp> for guidance on how to capture the Health Summary.*
 - (1) Multiple requests may be transmitted without exiting the SSA EME Web site. Facilities are to use the “Send Response for Individual Case” option on the SSA Web site. This permits more than one file to be uploaded for one individual, and also permits multiple requests to be uploaded during a single log-on.
 - (2) If the requested information is a combination of paper and electronic information, submit the electronic portion as soon as possible and use the Web site's comment feature to note that the paper health information is mailed separately. **NOTE:** *Do not delay sending the electronic information in order to send the paper information simultaneously.*
 - (3) If no records exist in CPRS, submit a negative response using the SSA EME Web site. The Reason Field, Comments Field, and Summary Field will display for comments.

(4) Upon SSA-DDS review of the standard summary, SSA-DDS may submit a second request for scanned documents (i.e., Electrocardiograms (EKGs), Pulmonary Function Tests (PFTs), audiograms). These documents may be submitted using the SSA EME Web site.

f. Ensuring the response to the request in the DSS ROI Record Management software is logged upon release of the information. *NOTE: If the facility uses the DSS ROI Record Management software to generate and save an electronic version of the VA SSA-DDS Standard Summary for uploading to the SSA EME Web site, the SSA request will already be logged in the software.*

g. Ensuring that an accounting of the ROI is captured either by the DSS ROI Record Management software, or manually as specified in VHA Handbook 1605.1.

h . Final approval of the ROI to SSA.

5. REFERENCES

a. VistA Health Summary User Manual, available at
http://www.va.gov/vdl/VistA_Lib/Clinical/CPRS-Health_Summary/HSUM2_7 UM.doc.

b. VHA Handbook 1605.1, Privacy and Release of Information.

6. FOLLOW-UP RESPONSIBILITY: Director, VHA Health Information Management is responsible for the content of this Directive. Questions may be addressed to 760-777-1170.

7. RESCISSION: None. This VHA Directive expires May 31, 2011.

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ATTACHMENT A

**DEPARTMENT OF VETERANS AFFAIRS (VA) AND SOCIAL SECURITY
ADMINISTRATION (SSA) AND ITS AFFILIATED STATE DISABILITY
DETERMINATION SERVICES (DDS) STANDARD SUMMARY**

1. Important Notes

- a. Components are listed in the desired order of presentation.
- b. Limits (time and occurrence) are noted for each component.
- c. Do not suppress print of components without data.
- d. Pages should be numbered with patient name in header.
- e. The title of the summary for each Department of Veterans Affairs Medical Center should read "[VAMC site] VA SSA-DDS Standard" so that the header on each page will include, e.g.:
***** CONFIDENTIAL [VAMC site name] VA SSA-DDS STANDARD SUMMARY pg. 1

- f. Use this SSA-DDS Standard Summary to respond to all initial DDS requests for records. Occasionally, DDS will need records prior to the 2-year limit of this summary. Each DDS will need to devise a simple but easily seen alert when they require records prior to the 2-year window and give the date(s) requested. If a date range is given that resides all or part inside the standard 2-year limit, prepare the Standard Summary, but also create a second file where only the added older dates override the 2-year limit of the Standard summary. Do not prepare one combined summary for both time periods, because the Standard occurrence limits may prevent display of the older information.
- g. DDS occasionally requests certain images to document disability. EKG and PFT tracings and audiograms are found in separate Department of Veterans Affairs (VA) systems such as Veterans Health Information Systems and Technology Architecture (VistA) Imaging or MUSE. Currently these systems are not fully interfaced with the Computerized Patient Record System (CPRS) system. To search for such images on every request would slow down the progress and efficiency of the Standard Summary process. As a relatively small percentage of all claims require these images, they can be requested by a carefully targeted second request, when needed. Once the images are located, they can be printed and then scanned and transferred via SSA Electronic Medical Evidence Web site or faxed (with the bar-coded request DDS request letter) to the DDS' designated fax server. **NOTE:** Over time, the capability to pull these images will be reassessed along with the other records for the summary.
- h. Verify that formatting transfers to SSA-DDS correctly and avoids large white spaces.

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i. If one of the following components is not available locally, use the best available substitute (with same limits). All local modifications should be agreed upon by both the State DDS and the VA Medical Center.

2. Components. The standard extract of health records to select using the Health Summary Protocol of VistA and CPRS.

| Order | Component Acronym, Name, and Limits | Description |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | BDEM (Brief demographics) Limits: not applicable (NA) | Brief patient demographic information. Includes address, phone number, age, sex, race, ethnicity, mean test, and eligibility code and known VA facilities that have provided care. |
| 2 | PLL (All Problems List) or PLA (Active Problems) and PLI (Inactive Problems) Display ICD text =Yes, Display provider narrative =Yes Limits: NA | All known problems, active (PLA) and inactive (PLI) for a patient. Includes provider narrative, date of onset on active problems, date problem resolved on inactive, date last modified, responsible provider and all active comments for the problems (caution: list may be incomplete). |
| 3 | CVF (Future Clinic Visits) Limits: NA | Displays future appointment dates and what VA component the patient will see. Potential value in lieu of consultative examination. |
| 4 | OE (Outpatient Encounters) Display long text narrative Limits: Time = 2 years Occurrences = 150 <i>(whichever comes first (WCF))</i> | Concise listing of all outpatient events including date, outpatient diagnosis (International Classification of Diseases-9th edition- (ICD-9), and procedure (Current Procedural Terminology (CPT)) for each event. The complete VA record should have a detailed Compensation and Pension or Progress Note (PN) for each OE. If number of PNs exceeds occurrence limit, OE will help target possible follow-up for older encounters. |
| 5 | GAF (Global Assessment Functioning) Limits: Time = 2 years Occurrences = no limit | Displays score taken from the GAF Scale to evaluate the psychological, social, and occupational functioning on a hypothetical continuum of mental health and/or illness. Also displayed is date of assessment and name of health care professional giving the score. Potential indicator of longitudinality and decompensation. |

| <u>Order</u> | <u>Component Acronym, Name, and Limits</u> | <u>Description</u> |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6 | DCS (Discharge Summaries) Limits: Time = 4 years Occurrences = five WCF | Inpatient discharge summaries, including report text for the time period. |
| 7 | CP (Compensation and Pension Exams) Limits: Time = four years Occurrences = five WCF | Compensation and pension exams for Veterans' benefits. |
| 8 | PN (Progress Note) Limits: Time = 2 years Occurrences = 40 WCF NOTE: Occurrences can be reduced to 30, if the PNs can be pulled selectively (see description). | Includes: date and time, title, and text of note. NOTES: -- Need to assess local VA capabilities to distinguish types of PN and exclude unneeded PN (e.g., inpatient notes (captured in DCS), nurses notes, telephone triage, physical therapy) as possible. -- Outpatient PNs that exceed the occurrence limit are highlighted in OE for follow-up request as needed. |
| 9 | SR (Surgery Report) (OR (operating room)/NON (non operating room) Limits: Time = 2 years, Occurrences = 10 WCF | Contains reports of operative procedures and non-operative procedures. Includes: date, specialty, pre and post operative diagnosis, procedures performed, surgeon's dictation, indications for procedure. |
| 10 | SCD (Spinal Cord Dysfunction) Limits: N/A | Includes patient registration status, highest level of injury, information source for SCD, completeness of injury and extent of paralysis. |
| 11 | *MEDF (Medical Full Report) Limits: Time = two years, Occurrences = 15 WCF *If unavailable locally, determine best alternative (e.g., Clinical Procedures-Brief (CPB)). | This component provides a full report of procedures (e.g., Electrocardiogram (ECG), Pulmonary Function Tests (PFT), sleep studies) as defined by the Medicine View file. |
| 12 | IP (Imaging Profile) CPT modifiers = No Limits: Time = 2 years, Occurrences = 10 WCF | Contains information from Radiology and/or Nuclear Medicine. Includes: study date, procedure, status, report status, staff and resident interpreting physicians and history, report, diagnostic text and impression. |
| 13 | CY (Cytopathology) Limits: Time = 2 years, Occurrences = 10 WCF | Includes: collection date and time, specimen, gross description, microscopic exam, brief clinical history, and cytopathology diagnosis. |

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| Order | Component Acronym, Name, and Limits | Description |
|--------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 14 | EM (Electron Microscopy) Limits: Time = 2 years, Occurrences = 10 <i>WCF</i> | Includes: collection date and time, specimen, gross description, microscopic exam, brief clinical history, supplemental report, and EM diagnosis. |
| 15 | MIC (Microbiology) Limits: Time = 2 years, Occurrences = 10 <i>WCF</i> | Includes: collection date and time, collection sample, site and specimen, specimen comment, tests, urine screen, sputum screen, sterility control, sterility results, comments for reports, smear and/or prep, acid fast stain Parasite Report, organism(s), Mycology Report, Bacteriology Report, Mycobacteriology Report, Gram Stain Result, Culture and Susceptibility, Antibiotic Serum Level, and remarks. |
| 16 | SP (Surgical Pathology) Limits: Time =2 years, Occurrences = 10 <i>WCF</i> | Includes: collection date and time, specimen, gross description, microscopic description, brief clinical history, supplemental report, frozen section, and surgical path diagnosis. |
| 17 | ON (Oncology) Limits: Time = 2 years, Occurrences = NA | Selected data elements from the Oncology Primary file. |
| 18 | CH (Chemistries and Hematology) Display comments = Yes Limits: Time = 2 years Occurrences = 20 <i>WCF</i> | Includes: collection date and time, specimen, test name, results (with flag, either High, Low, or Critical), units, and reference range. |