RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION

1. REASON FOR ISSUE: 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) by a secure Web site using a standard health summary protocol. ***NOTE:*** *The URL is provided by SSA when the local Department of Veterans Affairs (VA) Medical Center Health Information Manager (HIM) registers for the SSA Web site.*

2. SUMMARY OF MAJOR CHANGES: This revised VHA Directive has been updated to reflect the current name of ROI software, to eliminate the reference to ICD-9, and to add the disabilities component to the Appendix.

3. RELATED ISSUES: VHA Handbook 1907.06, Management of Release of Information.

4. RESPONSIBLE OFFICE: The Director, VHA, Health Information Management (10P2) is responsible for the content of this Directive. Questions may be addressed to 217-649-3691.

5. RESCISSIONS: VHA Directive 2010-009, dated February 25, 2010, is rescinded.

6. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of February 2020.

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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) by a secure Web site using a standard health summary protocol. ***NOTE:*** *The URL is provided by SSA when the local Department of Veterans Affairs (VA) Medical Center Health Information Manager (HIM) registers for the SSA Web site.* **AUTHORITY:** 38 U.S.C. 5701, 7332; 38 CFR 1.460 – 1.469, 1.475 – 1.479.

2. BACKGROUND:

a. 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. VA has tried a number of avenues to improve response time and ease the burden of processing these requests (e.g., contracts with copy companies, allowing SSA staff on-site to copy).

b. Since 2006, VA medical facilities have been able to use a SSA Web site as a secure means for electronically responding to these authorized SSA-DDS requests using a standard set of national health summary components in Veterans Health Information Systems and Technology Architecture (VistA) and Computerized Patient Record System (CPRS). Appendix A details the requirements that must be met for the ROI data transmissions from VHA to SSA-DDS. This process allows VHA to expedite requests to SSA-DDS, avoid printing and mailing, and help reduce both VHA labor and disability claim processing time. ***NOTE:*** *The SSA Electronic Records Express (ERE) Security Fact Sheet can be located at http://vaww.vhahim.va.gov/. This is an internal VA Web site, not accessible to the public.*

c. 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. A signed SSA authorization, Form SSA-827, Authorization to Disclose Information to the Social Security Administration (SSA), meets this requirement including the specific permission to disclose 38 U.S.C. 7332-protected health information.

3. POLICY: It is VHA policy that requests for ROI from SSA be answered in a timely, complete, accurate, and secure manner. As of January 1, 2010, use of the secure SSA Web site is mandatory for responding to requests from SSA when the information requested can be provided using the SSA-DDS Health Summary.

4. RESPONSIBILITIES: The facility Chief, HIM, or Privacy Officer is responsible for:

a. Working with the respective state SSA-DDS Medical 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.*

b. Initiating contact with the SSA-DDS PRO, and:

(1) Determining local modification, as needed, to the Health Summary components; for example, ensuring the content and volume of information sent to SSA-DDS is sufficient and appropriate.

(2) Assisting VA medical facilities in obtaining access to the secure SSA Web site and selecting the optimal business process for receiving the requests from SSA.

c. Submitting the request(s) for passwords for each ROI clerk that routinely needs access to the SSA Web site.

(1) SSA-DDS assigns individual user identification (ID) and passwords to each ROI clerk, as needed.

(2) For security reasons, the Web site's electronic outbound request functionality requires that only one VHA staff person at a facility be assigned a user ID and password. Electronic outbound request functionality allows VHA to receive and respond to requests from SSA-DDS. ***NOTE:*** *If VA employees answering SSA-DDS requests for release of information leave VA employment or change positions, the Chief, HIM, or Privacy Officer, must immediately notify SSA-DDS PRO to inactivate that person's access. This process is to be delineated in local policy or processes as to who makes the notification to ensure responsibility for action.*

d. Working with the facility Office of Information and Technology (OI&T) support person, usually a Clinical Application Coordinator (CAC), to establish and implement the SSA-DDS Health Summary, VA SSA-DDS Standard (see Appendix A), to respond to SSA-DDS requests for ROI. This summary encompasses 2 years of various health information (with occurrence limits) 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 VA facility may not). Facilities need to negotiate use of those components, in lieu of those in Appendix A, with their local SSA-DDS PRO.*

e. Implementing the use of the SSA ERE Web site to release the VA SSA-DDS Standard to SSA-DDS. This includes ensuring each request for health care information from SSA-DDS has a valid authorization prior to disclosure and that only authenticated documents are released. Authentication validates an entry in the health record as complete or verified depending on the CPRS package. Unauthenticated documentation is considered "Incomplete" and, in CPRS, is subject to revision and potential deletion by the author, therefore is not released until authenticated. ***NOTE:*** *Obtain the most recent ERE Web site User Guide from the local SSA-DDS PRO.*

(1) Multiple requests for individual patients may be transmitted without exiting the SSA ERE web site. Facilities are to use either the "Send Response for Individual Case" option on the SSA web site, or, for maximum efficiency, the "Electronic Outbound Requests" (eOR) protocol. ***NOTE:*** *See the ERE Web site User Guide for more details.*

(2) If the requested information is a combination of paper and electronic information, the electronic portion needs to be submitted as soon as possible, and use the Web site's comment

feature to note that the paper health information will be mailed or faxed separately. ***NOTE:*** *If the paper information is less than 30 pages, it can be faxed to SSA with the bar-coded request as the cover page.*

(3) If no records exist in CPRS, a negative response needs to be submitted using the SSA ERE Web site. The Reason, Comments, and Summary Fields allow input of additional information regarding the submission.

(4) Upon SSA-DDS review of the standard summary, SSA-DDS may submit a second request for scanned documents (e.g., electrocardiograms (EKGs), pulmonary function tests (PFTs), audiograms). These documents may be submitted using the SSA ERE Web site's "Send Response for Individual Case" or by fax with the bar-coded request as the cover page.

f. Ensuring the SSA request and facility response to the request is entered into the DSS ROI Plus software to account for the disclosure. ***NOTE:*** *If the facility uses the DSS ROI Plus software to generate and save an electronic version of the VA SSA-DDS Standard Summary for uploading to the SSA ERE Web site using a health summary component, the SSA request will already be logged in the software.*

g. Providing final approval of the ROI to SSA.

NOTE: *It is recommended that the designated VHA Point of Contact (POC) and SSA-DDS PRO monitor this process closely in the beginning to ensure the business and systems processes are being implemented properly.*

5. REFERENCES:

a. VistA Health Summary User Manual, available at http://www.va.gov/vdl/application.asp?appid=63.

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

APPENDIX A

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

This Appendix outlines the standard set of national health summary components in Veterans Health Information Systems and Technology Architecture (VistA) and Computerized Patient Record System (CPRS) that must be met for the release of information (ROI) data transmissions from the Veterans Health Administration (VHA) to Social Security Administration (SSA) and its affiliated State Disability Determination Services (DDS). 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 this attachment, with their local SSA-DDS Professional Relations Officer (PRO).

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 are to be numbered with the patient's name in header. If using the Health Summary component in the DSS-ROI Plus software, the patient's name appears in the lower left. The page number shows in the lower right, lower left, or lower center of the document dependent upon the custom settings of the user.

e. The title of the summary for each VA medical center is to read **"[VA Medical Center site] VA SSA-DDS Standard" so that the header on each page includes, e.g.:**

******* CONFIDENTIAL [VA Medical Center 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 needs records prior to the established limit of this summary. Each DDS needs to devise a simple, but easily seen alert when they require records prior to the established window and give the date(s) requested. If a date range is given, falling completely or partially inside the established standard limit, prepare the Standard Summary. However, a second file, where only the added older dates override the established limit of the Standard summary, must also be created. **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. Electrocardiograms (EKGs) and pulmonary function tests (PFTs) tracings and audiograms are found in separate VA systems such as VistA Imaging or the Marquette Universal System for Electrocardiography (MUSE). Currently these systems are not fully interfaced with 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 through the SSA Electronic Records Express (ERE) 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.

i. If one of the following components is not available locally, use the best available substitute (with same limits). All local modifications are to be agreed upon by both the state DDS and VA medical facility.

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, which includes address, phone number, age, sex, race, ethnicity, mean test, 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. This 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. The potential value is in lieu of consultative examination.
4	**OE (Outpatient Encounters)** Display long text narrative Limits: Time = 2 years Occurrences = 150 *(whichever comes first (WCF))*	Concise listing of all outpatient events including date, outpatient diagnosis (International Classification of Diseases (ICD), and procedure (Current Procedural Terminology (CPT)) for each event. The complete VA record needs to have a detailed Compensation and Pension or Progress Note (PN) for each OE. If number of PNs exceeds occurrence limit, OE helps to target possible follow-up for older encounters.

Order	Component Acronym, Name, and Limits	Description
5	**DS (Disabilities)**	Provides information from the MAS package about a patient's eligibility code and eligibility status (Verified), and rated disabilities, including the disability percentage and whether the disability is service connected or non-service connected.
6	**GAF (Global Assessment Functioning)** Limits: Time = 2 years Occurrences = no limit	This displays score taken from the GAF Scale to evaluate the psychological, social, and occupational functioning on a hypothetical continuum of mental health or illness. Also displayed is date of assessment and name of health care professional giving the score. This is a potential indicator of longitudinality and decompensation.
7	**DCS (Discharge Summaries)** Limits: Time = 4 years Occurrences = 5 *WCF*	Inpatient discharge summaries, including report text for the time period.
8	**C&P (Compensation and Pension Exams)** Limits: Time = 4 years Occurrences = 5 *WCF*	C&P examinations for Veterans benefits.
9	**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).*	This includes: date and time, title, and text of note. ***NOTES:*** *-- The 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.*
10	**SR (Surgery Report)** **(OR (operating room)/NON (non operating room)** Limits: Time = 2 years, Occurrences = 10 *WCF*	This contains reports of operative procedures and non-operative procedures. Includes: date, specialty, pre and post operative diagnosis, procedures performed, surgeon's dictation, and indications for procedure.
11	**SCD (Spinal Cord Dysfunction)** Limits: N/A	This includes patient registration status, highest level of injury, information source for SCD, completeness of injury, and extent of paralysis.
12	***MEDF (Medical Full Report)** Limits: Time = 2 years, Occurrences = 15 *WCF* ***If unavailable locally, determine best alternative (e.g., Clinical	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.

	Procedures-Brief (CPB)).	
Order	**Component** **Acronym, Name, and Limits**	**Description**
13	**IP (Imaging Profile)** CPT modifiers = No Limits: Time = 2 years, Occurrences = 10 *WCF*	This contains information from Radiology or Nuclear Medicine and includes: study date, procedure, status, report status, staff and resident interpreting physicians and history, report, diagnostic text and impression.
14	**CY (Cytopathology)** Limits: Time = 2 years, Occurrences = 10 *WCF*	This includes: collection date and time, specimen, gross description, microscopic exam, brief clinical history, and cytopathology diagnosis.
15	**EM (Electron Microscopy)** Limits: Time = 2 years, Occurrences = 10 *WCF*	This includes: collection date and time, specimen, gross description, microscopic exam, brief clinical history, supplemental report, and EM diagnosis.
16	**MIC (Microbiology)** Limits: Time = 2 years, Occurrences = 10 *WCF*	This 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 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.
17	**SP (Surgical Pathology)** Limits: Time =2 years, Occurrences = 10 *WCF*	This includes: collection date and time, specimen, gross description, microscopic description, brief clinical history, supplemental report, frozen section, and surgical path diagnosis.
18	**ON (Oncology)** Limits: Time = 2 years, Occurrences = NA	Selected data elements from the Oncology Primary file.
19	**CH (Chemistries and Hematology)** Display comments = Yes Limits: Time = 2 years Occurrences = 20 *WCF*	This includes: collection date and time, specimen, test name, results (with flag, either High, Low, or Critical), units, and reference range.