



# Maryland Disability Determination Services Medical Relations News

2019

## MEDICAL RELATIONS STAFF

E. Caroline Mason  
Medical Relations Director  
410-308-4336  
[elizabeth.c.mason@ssa.gov](mailto:elizabeth.c.mason@ssa.gov)

Carol Harsel  
Medical Relations Supervisor  
410-308-4337  
[carol.harsel@ssa.gov](mailto:carol.harsel@ssa.gov)

Cindi Cannon  
ERE IT Functional Analyst  
410-308-4349  
[cindi.cannon@ssa.gov](mailto:cindi.cannon@ssa.gov)

Joyce Lee  
Medical Relations Officer  
410-308-4338  
[joyce.lee@ssa.gov](mailto:joyce.lee@ssa.gov)

### SCHEDULING UNIT

Bobbi Baker	410-308-4555
Katrina Brooks	410-308-4562
Sunny Hendley	410-308-4393
Nickole Manuel	410-308-4432
Navonne Scott	410-308-4433
Shaneka White	410-308-4325

## FOR THE RECORD

### SOCIAL SECURITY FACTS

- ⇒ Title II, Social Security Disability Insurance, is a program where a worker earns coverage for benefits by paying Social Security taxes on their earnings.
- ⇒ Title XVI, Supplemental Security Income (SSI) benefits, are paid to disabled individuals, including children, with limited income and resources.
- ⇒ Individuals must meet the definition of disability according to the Social Security Act. The law defines disability for an adult as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment (s) which can be expected to result in death or which has lasted or will be expected to last for a continuous period of not less than 12 months.
- ⇒ Under Title XVI, a child is considered disabled if he/she has a medically determinable physical or mental impairment (s) that causes marked and severe functional limitations and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A child can also get benefits under SSDI if they have enough quarters of coverage.
- ⇒ The Social Security website contains the Listing of Impairments. There are adult listings and childhood listings that contain the medical criteria used for adjudicating the disability claim. To access the listings, click on the link below:  
<https://www.ssa.gov/disability/professionals/bluebook/>
- ⇒ Evidentiary Requirements – In order to establish disability, specific medical evidence is needed from an “acceptable medical source”. The link below provides information on “acceptable medical sources”, the role of the claimant, when a consultative examination is necessary and the requirements of the consultative examination report. <https://www.ssa.gov/disability/professionals/bluebook/evidentiary.htm>



## Your Role as a CE Provider

You play an important role in the disability determination as the CE provider. Your detailed report provides the disability examiner with the additional evidence that is critical to making a fair and accurate disability determination.

### As a CE provider, you should...

- start the exam by explaining to the claimant that your role in the disability process is to conduct the exam or testing requested by the DDS
- inform the claimant you will not be making the determination on their claim and cannot prescribe treatment or medication
- review our authorization and any supporting documentation prior to the exam
- notify our office if there is a problem with your fax machine
- notify Caroline Mason, the Medical Relations Director, of any change in your license status including probation, suspension or disciplinary actions taken by the state licensing authority
- submit your signed report and invoice within 14 days of the exam or notify the disability examiner if you expect a delay

### As a CE provider, you should not...

- perform additional testing without approval from the disability examiner
- give advice, suggestions or make statements the claimant may find offensive

We value the service you provide to our agency and thank you for your continued service and participation on our CE panel!

## Scheduling... All in a Day's Work



The Scheduling Unit is comprised of four schedulers, an office clerk, an administrative aide and a supervisor. Our job is to schedule and reschedule all CE appointments for all claimants who reside in Maryland. We manage over 400 providers and have scheduled over 47,000 exams so far in Fiscal Year 19 which ends September 30, 2019.

For our block providers, we cannot guarantee that we will fill in all time-slots as this depends on our current volume. We will not schedule any claimants less than 10 days prior to the CE date, unless we contact you directly. Once that 10 day window rolls around, you will know we will not be adding any additional claimants to that day. There is no need to call or email if the day is not filled.

Once we have scheduled the exam and letters have gone out, rearranging the schedule or changing appointment times creates an additional workload. Consideration needs to be made to other factors involved such as an interpreter or transportation issue.

Please do not cancel or reschedule an appointment directly with the claimant. The DDS examiner must be contacted by the claimant or provider for any changes.

- \* If the claimant has already cancelled or did not show up for a previous exam, the examiner may move forward with a determination on the claim and not reschedule the exam.
- \* For auditing purposes, the invoice has an authorization number created for the specific date and time. If the date and time of the exam is changed, we must create a new authorization number.

If you are not currently registered to use the Electronic Records Express (ERE) website, please consider signing up. The website is free and easy to use, cost effective and is a way to manage your scheduled exams.

See the link below for information on the website: <https://www.ssa.gov/ere/> or contact Cindi Cannon at 410-308-4349 or [Cindi.cannon@ssa.gov](mailto:Cindi.cannon@ssa.gov)



## ERE Tips

### Paper Claims

Occasionally, we have a claim in our office that is in a paper format. CE authorizations on paper claims cannot be sent electronically via the ERE website. Therefore, you will receive the authorization in the mail.

- ◇ When you receive the paperwork, be sure to note the appointment date and time and add it to your schedule as it will not propagate to the ERE queue
- ◇ Have the paperwork available the day of the exam
- ◇ The report can still be uploaded via the ERE website. For instructions on how to submit a paper report, log in to your ERE account and click on **? User Resources** on the right side of the page. Select the **"Send CE Report"** option.

### Invoice

The barcoded invoice page can be submitted two ways:

- ◇ Scan the invoice to your computer and upload it with the CE report. Be sure the invoice is the first page and use the "Add additional file" option to attach the CE report
- ◇ Fax the invoice to the toll free number located on the top right of the page **(866-891-7952)**
- ◇ When using the ERE website to notify of a broken exam, remember to fax your invoice for payment
- ◇ Do not fax more than 5 invoices at one time to avoid fax errors which prevents successful transmission

### ERE Helpful Resources

After logging on to the website, you will see **System Notices** at the top left of the page. You can click on the **Sign Up for Email ERE System Notifications** to receive messages on ERE system status

On the right side of the page, you will see a link titled **? User Resources**. Clicking on this link will open Provider User Instructions.



## Fiscal Reminders

- \* Use the current date when signing and submitting the invoice
- \* Use **black** ink for the signature
- \* Maintain your fax machine so invoices are legible
- \* Be sure you are submitting the correct invoice with the correct date and time as sometimes the same claimant is rescheduled
- \* An office manager or fiscal staff can sign the invoice with permission from the provider
- \* If the claimant does not show up for the scheduled appointment time or the provider is not given 24-hours notice that the exam must be cancelled, you **must submit the invoice to be paid for a broken exam**
- \* Do not highlight, cross out or shade out the claimant's name, SSN or appointment date on the invoice
- \* Do not submit a screenshot of the invoice page as this results in a poor quality image which cannot be read by our system

### Electronic Funds

If you are not receiving your funds electronically, consider doing so. Direct deposit is a faster way to receive payments. This electronic option allows you to easily reconcile payments.

To register for this service you will need to complete an EFT form and fax or mail the form along with a voided check to the Comptroller's Office. The next step is to register your account on the Comptroller of Maryland website. Once registered, you will be able to monitor your payments using Vendor Services.

For more information on this service, email Cindi Cannon at [cindi.cannon@ssa.gov](mailto:cindi.cannon@ssa.gov)





## Cooperative Disability Investigations Program

If you did not know already, the Maryland Disability Determination Services (DDS) has been fighting disability fraud since the inception of Maryland's Cooperative Disability Investigation (CDI) unit in 2014. As of May of this fiscal year, the Maryland DDS CDI unit has been responsible for saving close to \$800,000. By the end of the fiscal year, the number of savings will continue to increase. So far this year, the CDI unit has successfully investigated 16 fraudulent claims. The unit continues to receive numerous fraud referrals from our examiners, doctors, field office representatives, and the public.

You, as the medical professional who performs the consultative examination, are on the front lines in seeing our claimants. You have the opportunity to observe the claimant and report possible fraud. You may also see notification in the comments section of your CE authorization if the claim is flagged as a "fraud or similar fault" claim.

The consultative examinations tend to provide a valuable opportunity for our investigator to conduct surveillance. The investigator might call a day or two in advance to introduce themselves and let you know of their presence in and around the office. Our investigator tries to observe the claimant as they enter the evaluation and will try to follow the claimant afterwards. You can assist our investigations by documenting any observations in the waiting room to include the claimant's mannerisms before and after the exam.

In many cases, the CE surveillance is crucial for the investigation and is the only chance the investigator can observe the claimant.

Therefore, it is important that you **do not change** the appointment date or time. If a change is unavoidable, it is important that you alert the disability examiner in advance, so our investigators can adjust accordingly.

If a claimant is not under investigation and you suspect the claimant is not being truthful with his or her statements or is exaggerating limitations, please call one of the numbers below:

- The DDS examiner
- The DDS fraud analyst, John Quattrociocchi, at 410-308-4441
- The disability fraud hotline at 1-800-269-0271



### March 2019 CDI Case of the Year

A 53 year old woman was investigated by the Detroit CDI Unit. She was receiving benefits due to seizures and tremors affecting her functioning. During a CE, she was limping, had a dragging gate and used a cane. She was unable to extend the fingers on her left hand limiting her arm movement. Previous medical records indicated she lived an active life and enjoyed surfing and snow skiing.

Surveillance showed the woman entering a local fitness facility. As part of the investigation, investigators participated in Zumba dance classes with the woman and recorded her dance moves. She showed no limitations in the hour and a half class and at the end of the class put on tap shoes and danced for 15 minutes.

Based on the investigation, her benefits were stopped which resulted in SSA savings of \$121,906 and non-SSA savings of \$68,638.00.

# Mini-Mental State Exam Tips and Reminders



## Eric Roskes, MD

The Folstein Mini-Mental State Exam (MMSE) is a brief cognitive screen that can be used to identify cognitive impairment and track its progress over time. Done well, it serves as a reasonable test of cognition that can help identify individuals who need more in-depth testing.

As a medical consultant at DDS (and in other settings), I have identified a number of problems in the administration and scoring of the MMSE. At times, the tester simply mis-scores the test, giving credit where points should be deducted, or vice-versa. It is very important for you to calculate the score correctly so that DDS does not need to request a correction.

Some errors, however, appear to reflect a misunderstanding of the testing protocol itself. The most common mistakes I've seen at DDS include:

- Misunderstanding of the purpose of the serial-sevens/DLROW test. This test is designed to assess concentration and attention, and is NOT about the subject's mathematical or spelling ability. If the person cannot or will not serially subtract, he is to be offered WORLD as an alternative. If he scores a zero on serial-sevens, but spells DLROW correctly, he is to be given five points. Failure to offer the spelling alternative invalidates the test.
- Mis-scoring of the attention/concentration test itself:
  - If the person says "DLORW", he should be given 3 points, for the three letters in their correct locations.
  - If the person says "93-85-78-71-64", he should be given 4 points, for the four correct subtractions.

In both of these instances, the person made mistakes, but stayed on task, demonstrating

imperfect skill but pretty good attention to the task.

- Use of three words in the memory test that can be related to one another, serving as a "clue" for the subject. For example, do not use "red" and "rose" in the same list, as these can be remembered as a single object by the subject.
- Missing subtle neuropsychiatric deficits: If the person is unable to copy the pentagons, I suggest that brief further assessment be done, such as a clock drawing test. While this is not part of the MMSE, it can help us understand whether we should consider the possibility of neurologic or neuropsychiatric pathology.
- Missing illiteracy: if the subject cannot spell, or read, or write, it will be helpful to know if he has had limited educational attainment. People are often ashamed to admit this, so it would be helpful to inquire gently as to their ability to read.

I have the following two suggestions:

1. I have recommended to the Medical Relations Office (MRO) that we modify the CE process to require the production of the actual test form with your reports. Some of you already provide this, and others do not routinely do so but rather summarize the test in your write-up. At times, I've reviewed reports that include both the form and the summary, and the summary inaccurately reflects the raw data on the form, causing confusion and a return to you to correct your report. Going forward, we will ask that you send the form itself, and simply write the total score – as calculated on the form – in your report.
2. Please keep a copy of the MMSE instructions in your office. I find it helpful to review these periodically to ensure that I am not drifting from the validated procedure. While the test remains under copyright, the instructions are readily available, and I encourage you to reference them on occasion.

Thank you for all of your hard work on behalf of our claimants. We cannot do this work without your participation!



## CE Provider Recruitment Needs

If you have any colleagues who may be interested in doing CE's for us, please have them send an email to:  
[carol.harsel@ssa.gov](mailto:carol.harsel@ssa.gov)

Currently we are looking for:

- \* Bilingual Speech/Language Pathologists
- \* Bilingual Psychologists
- \* Child Psychologists who are willing to see very young children using Bayley Scales
- \* Psychologists and Speech Language Pathologists in remote areas

## Maryland DDS Consultant Recruitment

As part of the disability adjudication process, the Maryland Disability Determination Services (DDS) employs Physicians, Psychiatrists and Psychologists. This is a professional position responsible for providing consultative medical services and a review of medical records in accordance with regulations of the Social Security Administration (SSA).

At the present time, there is a position available for a part-time Psychiatrist, a child Psychiatrist, and a Medical Specialist. These positions are posted on the Maryland State Government website. For more information, please use the link below:  
<https://jobapscloud.com/MD/>

**Filter Open Jobs**

**Location** - enter Baltimore County  
**Department** - enter MD State Department of Education

**Search**

For additional information, contact the Division of Rehabilitation Services (DORS) Personnel Office at 410-554-9391

## Electronic Initiatives

The Maryland DDS started the transition from paper case files to electronic cases in 2005. In order to prepare for the transition to the electronic world, we notified our CE providers of their role in our September 2005 newsletter...

### The Time is Now...

**As we previously shared, effective October 1, 2005, we will no longer provide return envelopes with your CE authorization letters. Reports must be submitted via either fax or the SSA secure website!**



We have come a long way since 2005!

Over the last several years, we have been sending out our annual Medical Relations newsletter via email to all providers with an active email address.

When referring to our newsletter, we have had several providers say they never received it. For this reason, we are mailing the newsletter this year.

After the newsletter is mailed, we will be doing an email test. If we have an email address on file for you, you will receive an email with the newsletter attached within two weeks of receiving it in the mail:

- If you receive the email, please respond to let us know you received it
- If you do not receive an email, please email [cindi.cannon@ssa.gov](mailto:cindi.cannon@ssa.gov) to let us know you did not receive it. Please check to see if our email went to your spam folder
- If you have a new email address, please notify Cindi at [cindi.cannon@ssa.gov](mailto:cindi.cannon@ssa.gov)

The newsletter provides a lot of important information and we want to be sure each of our CE providers is receiving it. If you have additional providers in your practice, please be sure to share it.

Thank you for your help with this project!



# Codes and Cues in Psychiatric Interviews in Agency Affiliated Assessment Settings

Kiu Eubanks Smith, PhD



As assessment providers, we have intrinsic perceptions of what is appropriate, normal and acceptable as a form of communication in professional and medical settings. Even as we are aware of the need for cultural competency, we may consciously or subconsciously feel ambivalent about actually doing it. Or, we might just not know how. We also have both perceived and implemented power. Power over the tone, pace, location and duration of the assessment. Power to adjust all of those factors to align with their own preferences. Acting contrary to this pre-existing power requires deliberate and intentional decisions at every step of the assessment process.

Take a look at the (fictional) example narrative below:

**Dr:** Please list words that begin with the letter F

**Client:** freak, phresh, phat, phly

**Dr:** Come on now, I need test like words, like in school

**Client:** Lol ARD (all right then)

Forces (from Nike AF1s), Fort (from Fortnite), Flight, Fun, Forest (from Forest Park neighborhood)

Had I scored his responses without making the direct request that he adjust his language, the results would have indicated a significantly lower level of skill that was actually present.

With clients presenting with a diverse range of cognitive ability, communication skills and mood symptoms, this type of navigation can be challenging. Especially when the added layers of gender identity and age/generational language patterns are included. Take a look at this second narrative:

**Client:** My momma always told me she had bipolar but I thought she was *just paranoid*

**Dr:** Paranoid?

**Client:** Yea like always *tryna be mental*. Like just get your life together & stop making excuses for your BS.

**Dr:** She had difficulty with her own day-to-day life?

**Client:** man she ain't nevrerr had her stuff together. I mean she would try to for a little while then start *spazzing out, taking pills*. Asking why y'all keep asking me to do all this. All what? *Get a &^%\* job* and take care of your kids?

**Dr:** Well, maybe that was *her bipolar*...how *it showed up*...not being able to maintain

**Client:** I guess. I mean she definitely had issues.

**Dr:** And you?

**Client:** I mean I'm *moody sometimes* but not bipolar

This clinical interview was for a mother who was at risk of being incarcerated for repeated shoplifting, and who did not recognize her clinical symptoms to be bipolar disorder. Looking closely at the dialogue, a few clinical themes emerge:

1. The assertion of having a bona fide mental illness was considered attention seeking, exaggerated and an excuse not to fulfill one's responsibilities
2. A life long history of day to day impairment was never formally treated
3. Her mothers' immediate family did not recognize the years of failed attempts at maintaining employment and using opiates as related to self-medication for a legitimate neurochemical imbalance
4. The client has unresolved emotional content related to her mother's illness that affects her willingness to admit her own symptoms are more than just "being moody sometimes"

To get to that understanding, from a linguistic point of view, the italicized phrases are examples of culturally informed word choice that contributed to establishing trust and rapport:

1. Understanding that “just paranoid” is not a reference to paranoid schizophrenia or delusional thoughts
2. Accurate interpretation of “tryna be mental” as “acting” like she had a real mental illness when she didn’t
3. Inhibiting a prejudiced response to the knowledge that her mother had a substance abuse addiction (the response could be verbal or passive via a change in facial expression)
4. Interpreting the use of expletives as indicative of hurt/trauma instead of listing it in the MSE as “verbal aggression” or “hostility”
5. Saying “her bipolar” instead of “her mood disorder” or “her bipolar disorder” – the use of the word “disorder” or other formal term can communicate judgement or being labeled by the medical establishment, especially for a client who has not already come to terms with their or their parents clinical diagnosis
6. Logging “moody sometimes” as the clients chosen phrase for her own bipolar symptoms

When you, as an examiner, have a cultural/regional/generational similarity with the examinee, these types of adjustments can be second nature and may seem obvious or even elementary. For those, however, who do not have the shared set of meanings or the experience working with clients from that demographic, those same adjustments can and do lead to rift, rupture and inaccurate classification. And, even when similarities are present, with the rapid expansion of informal language in social media and music, generational differences can pose significant challenges as well.

Effectively navigating misunderstandings due to culturally informed language **is not based solely or even primarily on factual knowledge** of every slang term, vernacular expression, social media abbreviation and regional dialect. A provider could drive themselves crazy trying to search for and learn all the variations that present themselves. They could also sound real special trying to use straw that ain’t came from the haystack in their daddy’s barn. (See how I totally messed that one up?)

So, rather than turning yourself into the multicultural dictionary of all terms, start with the most important components of effective intercultural and interracial communication in assessment settings

### 1. Trust and Competence:

One of the first things clients walking into any clinical assessment want to know is “Does this person know what they are doing?” and “Can I trust him or her enough to give authentic responses to very personal questions?” For claimants in a CE setting, these feelings are exacerbated by the “high stakes” nature of gaining or losing benefits based in part on the outcome of the assessment. With this in mind, how do you, as an examiner, communicate in a way that facilitates that you are trustworthy and competent?

Do you make eye contact when appropriate? Brush past them and go to your office? Do you greet claimants in a relaxed yet professional manner? Or are you stiff and overly formal? Do you explain what a clinical assessment is and how it can be useful to determine the correct services? Or just start with no explanation? Do you have any information posted or in brochure format with your education and credentials? Or assume that they should already know you are the “expert” in the room?

### 2. Warmth/Politeness

Once the claimant feels that you are qualified and trustworthy, the next step is their decision to actually answer the assessment questions. Excluding those who are deliberately malingering, the expression of interpersonal warmth and politeness can open the door to authentic expression of clinical symptoms. Interpersonal warmth can be expressed by asking non-clinical questions:

Did you find the office ok?

How much time do you have, do you have to get to work or pick up your children?

Is this your first time doing an assessment, do you have any questions?

Is there anything you want me to know before we start?

We are going to be here XX hours. If you need a break let me know.



Seems simple, right? Well, while these basic questions are **sometimes automatic with people we are comfortable with they may not be when we are subconsciously anxious or ambivalent about how to speak to someone from a different background.** Because the process of communicating warmth is often subconscious and subtle, it can be useful to ask a colleague to observe the first 10 minutes of the CE and then give feedback on whether or not there are variations in your dialogue that correlate with familiarity, or lack thereof. One can also create a mental checklist that includes comments/questions intended to express warmth, and commit to using them for every client. The omission of this part of the interview can lead to a client “shutting down” before the clinical assessment even begins, which impacts accuracy.

### 3. Non Judgement of Differences in Presentation

A new client came in once with her nails done in two shades of pink with white roses on the pinkies and purple crystals. Ten minutes into the assessment, I said “Oh those are cute!” She smiled and visibly relaxed. It’s the same when interviewing White clients who have clearly never been to the neighborhood where the office is located or worked with a person of color as a provider – mentioning the latest football scores if they have on a jersey or asking how was it driving all the way to Baltimore?

Finding an authentic way to acknowledge and affirm where this person is coming from is a method of communicating non-judgement. Not right away but gradually and indirectly over the course of the assessment you can say something to communicate acceptance of where the client is coming from. Of course, the examples you give should be authentic and based on what is actually happening in the room – pay attention to how the client presents him/her self and **connect with their presentation** and not your assumption of what they will find familiar or relevant.

Had it been “oh I like the new bling” or “hey those nails are banging” that would have been inauthentic and forced. It’s about connection, not caricature.

### 4. Humility/Acknowledgement of limitations

Lastly, there is immense power in humility. In a cross-cultural exchange in which you truly do not know what someone is trying to say, or you cannot think of any genuine experiences you have had in their community, just say so.

- I’m sorry, but I don’t know that word and I want to get this right.
- I want to give you the best possible service and will mess it up if we don’t get what the other person is saying.
- As you can see, I am (Nigerian, a man, a middle aged woman) and may not get all of your references. Not to be offensive but can you explain what you mean so I get it without writing down the wrong thing?
- It shouldn’t be this way for you but it is and we need to do this right. Can you say more about what “insert misunderstood phrase” means to you?

The key with these types of admissions is to focus on the ultimate goal of serving the client so that their needs are appropriately met. It’s not about them being confusing or you demanding they speak in a way that feels more comfortable. It involves expression of our limitations, even as doctors, in completing a clinical task. It can be done with humor, if you really have good rapport, or with simple sincerity if the humor is not known to be effective versus offensive. Try simple first, and the humor will come with experience with that demographic.

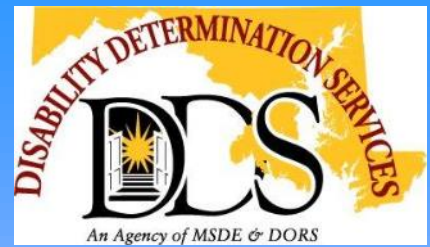
This is not by any means the “final word” on any of this. Just a reflection of experiences and elements that hopefully helps us all reach our goals of effective service.



# **Disability Determination Services**

**Maryland State Department of Education**

**Division of Rehabilitation Services**



## **We're Moving...**

**Our new office is currently under construction  
We will be moving from  
Lutherville, Maryland to Hunt Valley, Maryland  
Don't worry...our phone numbers will stay the same  
Our new address will be:**

**211 Schilling Circle  
Hunt Valley, MD 21031**

