

**New York State  
Office of Temporary & Disability Assistance**

**CONDITIONS  
GOVERNING  
REFERRALS FOR  
CONSULTATIVE  
EXAMINATIONS**



**NEW YORK STATE**

**OFFICE OF TEMPORARY & DISABILITY ASSISTANCE  
(OTDA)**

**DIVISION OF DISABILITY DETERMINATIONS  
(DDD)**

The Division of Disability Determinations adjudicates claims for Social Security Disability Insurance and Supplemental Security Income Disability under an agreement with the Social Security Administration (SSA).

As part of the adjudicative process, disability analysts obtain medical evidence from claimants' treating sources. When this information is unavailable or insufficient to make a determination, the disability analyst will order a consultative exam (CE). The information from this medical examination is used to assist DDD in making a determination of disability under federal guidelines.

These are the Conditions Governing Referrals for Consultative Examinations.

**I. QUALIFICATIONS**

1. Organizations must be in full compliance with appropriate federal, state, and local operating requirements.
2. All physicians, psychologists, speech-language pathologists and certified social workers performing examinations must be licensed and currently registered in New York State.
3. The consultative examination provider assures DDD that all support staff (nurses, technicians, etc.) who assist in conducting a consultative examination are licensed or certified, when applicable, and have appropriate experience and training in performing specified services.
4. All physicians, psychologists, speech-language pathologists, certified social workers or other health care providers must be approved by DDD before performing any examinations or ancillary testing. Application for approval may be made by completing a Consultant Enrollment Form (OTDA-4095).
5. Secondary sources used to perform ancillary testing must also complete the enrollment process with DDD.
6. Any physician, psychologist, speech-language pathologist, certified social worker or other health care provider currently disciplined, sanctioned, censured or suspended by any government regulatory agency will not be allowed to participate in our program.

**II. PREMISES**

1. The premises must comply with all Federal, State and Local health laws and with all City, County and State fire and building codes.
2. The premises must be made available for inspection by DDD personnel.
3. All equipment necessary to perform requested services must meet all health, safety, and infection control requirements, be maintained in good working order, and kept clean according to manufacturer's guidelines.
4. The waiting room must be of sufficient size to ensure adequate seating for claimants. The facility shall have drinking water, toilet facilities and telephones available for claimants. Restrooms must be suitable and appropriate supplies and wash-up facilities must be maintained at all times.
5. The premises must be accessible to handicapped individuals and have secondary means of egress.
6. Premises must constitute a professional office environment and be clearly identified with a sign to the general public describing the particular practice/specialty provided.

**III. EXAMINATIONS AND ANCILLARY TESTING**

1. The following represent DDD's most frequently requested examinations and ancillary testing. These exams and tests must be performed according to accepted professional standards and practices in the medical field with the provider assuming full responsibility:

EXAMINATIONS	TESTS
Internal Medicine	X-rays
Orthopedic	Resting ECG
Neurological	Treadmill Exercise ECG
Psychiatric	Pulmonary Function Studies
Psychological Testing	Doppler including Doppler after Exercise
Pediatric	Audiogram
Speech-Language	Speech Discrimination
Ophthalmological	
Otolaryngological	

Blood specimens, when ordered, shall be drawn as part of the examination process and referred for testing to a clinical laboratory certified by New York State, or on premises if approved by DDD.

2. All equipment used in ancillary testing must provide results as specified in our reporting guidelines, meet all health, safety and infection control requirements, and be properly calibrated and maintained in good working order.
3. Background information will be provided with each referral, when available. Only after you have reviewed the background information, taken the history and performed the examination can you authorize completion of those ancillary tests requested which are not medically contraindicated. Tests which are medically contraindicated should not be performed and the medical reason should be documented in your report.
4. Claimants or designated DDD staff will call your office to schedule an appointment. The consultant is expected to provide an appointment date within ten (10) calendar days of the issuance of our referral and return the completed report to the appropriate DDD office within seven (7) days of the examination. Should the claimant miss two (2) scheduled appointments, the consultant should contact the DDD Disability Analyst on how to proceed.
5. The consultant is expected to provide the claimant with travel directions to and from the facility. Should the issue of travel reimbursement be raised the consultant should inform the claimant to contact the DDD Disability Analyst.
6. No examination or test should be initiated or conducted on claimants under the influence of alcohol or drugs if such conditions could significantly affect the accuracy of the examination or test. If this situation occurs, call the DDD Disability Analyst to discuss how to proceed.

## **APPENDIX W**

7. Unless the consultant is also the claimant's treating source, he/she should not recommend treatment or a change in treatment directly to the claimant but should include such suggestions in the report. However, in circumstances where the evidence shows a medical condition that is legally reportable or which could be injurious to the health or safety of the individual or others, or where the individual has made a threat against himself/herself or others, the consultant should take action consistent with sound and accepted medical practice including notification to the claimant, claimant's representative/family, or claimant's treating source as appropriate. Any emergency treatment and/or information provided should be specified in the report and immediately reported to DDD. The New York State OTDA is not liable for payment of expenses associated with emergency medical treatment.
8. The consultant is expected to explain the purpose of the examination. During the course of the examination, the claimant's privacy must be maintained. Arrangements must be offered for female staff to be present before any examinations of female claimants are performed.
9. DDD requires the following minimum times for the duration of the examination with the physician/psychologist/speech-language pathologist: physical examination 20 minutes, psychiatric examination 30 minutes, psychological evaluation 45 minutes, speech-language evaluation 1 hour. When scheduling appointments, the consultant must allow sufficient time to take a complete case history, perform the examination and administer the required tests. Waiting time must be kept to a minimum.
10. In the event that additional tests (other than those requested by DDD) may be indicated during the course of the examination, prior approval for such testing must be obtained by telephone from DDD while the claimant is still at the examining site. Any changes approved by DDD must be reflected on the voucher. DDD cannot pay for unauthorized services.
11. Consultative examinations must not be performed in a claimant's home unless specifically requested by DDD.
12. Consultant cannot refuse to provide service to any referral from DDD without prior approval from DDD.
13. No assurances are given with respect to the volume of referrals.
14. Claimants with questions regarding their disability claim must be directed to contact the Disability Analyst.
15. Please notify your Medical Relations Office if you know you will be away from your office for more than 2 weeks.

**IV. REPORTING REQUIREMENTS**

1. The consultant must provide a typed narrative report on office stationery to include the history, physical examination, results and interpretations of requested tests, diagnosis and prognosis. The reported results must conform to accepted professional standards and practices in the medical field for a complete and competent examination.
2. In addition to the actual medical facts, the report should also include a statement which describes the individual's ability to do work related activities based on your findings. For individuals less than 18 years of age, there should be a statement describing the individual's ability to perform age appropriate activities and behave in an age appropriate manner. Opinions such as "patient is unable to work" or "patient is disabled" must not be included in the report.
3. The consultant's report must address all items on the consultative examination reporting requirement form(s) provided by DDD. Original tracings, x-ray interpretations, laboratory findings, charts and graphs must be attached to the narrative report. Also attach any medical reports or test results brought to the examination by the claimant.
4. The following identifying information must appear on the first page of the typed narrative report: claimant name and Social Security Number, DDD Analyst personal identification number (PIN), module/unit, order and voucher number (this information can be found on the order and voucher, CE-7), date of examination and report.

Each subsequent page of the report and any other attachments (e.g. tracings) must have the claimant's name and Social Security Number.

5. A 24-hour free transcription service is available for your convenience. Instructions will be provided.
6. Medical staff must be made readily available for telephone discussions to clarify or answer questions regarding the report, for occasional educational contacts, and to respond to complaint investigations. On occasion, medical staff may be required to testify at the SSA Office of Hearings and Appeals.
7. Copies of all reports, tracings, lab results, and x-ray films must be maintained for a minimum of one (1) year. Also see Section VII item 11 for fiscal inquiries.
8. Contact your Medical Relations Officer if you are interested in establishing an electronic interface.

**V. SIGNATURE REQUIREMENTS**

1. The physician's name must be typed at the end of the report and all reports must be personally reviewed and signed by the physician who actually performed the examination.
2. The examining physician's signature on a report annotated "not proofed" or "dictated but not read" is not acceptable.
3. The physician's rubber stamp signature or the physician's signature entered by another physician or other person is not acceptable.
4. Properly signed consultative examination reports telefaxed directly from your office to DDD are acceptable.

**VI. CONFIDENTIALITY**

1. Complete confidentiality of claimant information must be maintained.
2. Examination/test results must not be divulged to anyone including the claimant, their representative, or treating source or used in any study or publication without the express written approval of DDD except as specified in Section III, item 7.
3. The claimant can have a copy of the consultative examination/test report sent to his or her treating source or representative by signing an "Authorization to Release" CE-9 form (previously sent to the claimant) and returning it to DDD.
4. It is the responsibility of DDD or SSA to release consultative examination reports.
5. Third party service providers (transcription, messenger, etc.) must be made aware that claimant confidentiality must be maintained and that disclosure of claimant information is prohibited.
6. Should a consultant receive a request for disclosure or release of the consultative examination report or a subpoena, please call the Medical Relations Officer for your region.

**VII. FINANCIAL REQUIREMENTS**

1. An order and voucher form (CE-7) will be issued with each consultative examination requested by DDD. Reimbursement will be provided at DDD's established fee. Phlebotomy services are included as part of the basic examination fee and are not reimbursed separately.
2. The consultant whose name appears on the order and voucher form (CE-7) must perform all of the requested services and may not assign them in whole or in part to any other source. Services that the consultant refers to a secondary source approved by DDD will be designated on a separate CE-7 with that secondary source listed as payee. In arranging or assisting the claimant in setting up appointments for tests, the consultant is responsible for forwarding the corresponding CE-7 to their secondary source (e.g., Radiology Dept., Pulmonary Lab, laboratory). Secondary sources must also be enrolled with DDD.
3. Claimants or other third party insurers, including governmental sources, shall not be charged for any services requested by DDD. The consultant is also responsible for notifying the secondary source that the claimant is not to be billed.
4. Consultants are independent agents and not employees of the OTDA. Consultants must accept full liability for all claims resulting from services rendered.
5. Consultants may be required to repeat an examination/test without additional reimbursement should DDD find it to be incomplete or not performed according to disability program requirements.
6. DDD cannot authorize payment for broken/missed appointments.
7. Prior approval from DDD is needed to authorize payment for additional services not originally requested.
8. The consultant will be notified by phone and in writing when examinations/tests are cancelled by DDD. DDD cannot provide payment for services performed after the date of cancellation.
9. Checks can only be issued to the payee designated on the CE-7 voucher. The payee ID number represents your Federal Tax ID Number or Social Security Number under which you are providing medical services. This payee ID number must be the ID number of the payee designated on the CE-7. Any changes to this number must be reported to DDD.
10. All fiscal records shall be maintained. Each claimant's record should include the order and voucher number located on the top section of the CE-7 as this is the information you will need in order to identify payments upon receipt of our check.
11. All fiscal inquiries may be directed to our toll-free number: 1-800-833-3306. Requests for outstanding payments must be submitted with a copy of the report and a completed voucher.

## APPENDIX W

For further information, contact our **Medical Relations Officer** at one of the following Offices:

### NYS Office of Temporary & Disability Assistance Division of Disability Determinations

- Albany – John McGovern**  
P.O. Box 165  
Albany, NY 12260-0165  
Toll Free: 800-522-5511  
(518) 473-9320 Fax: (518) 473-9315  
E-MAIL: [John.F.McGovern@ssa.gov](mailto:John.F.McGovern@ssa.gov)
  
- Buffalo – David Zajdel**  
P.O. Box 5030  
Buffalo, NY 14205-5030  
Toll Free: 800-522-5511  
(716) 847-5007 Fax: (716) 847-3508  
E-MAIL: [David.Zajdel@ssa.gov](mailto:David.Zajdel@ssa.gov)
  
- Manhattan – James Gallagher**  
PO Box 5191  
Bowling Green Station, NY 10274-5191  
Toll Free: 800-522-5511  
(212) 240-3456 Fax: (212) 240-3370  
E-MAIL: [James.F.Gallagher@ssa.gov](mailto:James.F.Gallagher@ssa.gov)
  
- Binghamton – Gary Deming**  
P.O. Box 9009  
Endicott, NY 13761-9009  
Toll Free: 800-522-5511  
(607) 741-4195 Fax: (607) 741-4205  
E-MAIL: [Gary.Deming@ssa.gov](mailto:Gary.Deming@ssa.gov)

**NYS Office of Temporary & Disability Assistance  
Division of Disability Determinations**

DDD-4095 [09/02]

**\*CONSULTANT ENROLLMENT FORM**

**APPLICANT INFORMATION**

CONSULTANT NAME		LAST		FIRST		DATE OF BIRTH			MO	DAY	YR
CORPORATE GROUP NAME (IF DIFFERENT)						APPLICATION DATE			MO	DAY	YR
FED EMP ID NO.		SOC SEC NUMBER		LANGUAGES SPOKEN							
LICENSE NO.	REGISTRATION END DATE	MO	DAY	YR	STATE	PAYEE ID NUMBER	(LEAVE BLANK)				

**ATTACH COPY OF CURRENT REGISTRATION**

**EDUCATION AND TRAINING**

	NAME AND ADDRESS OF INSTITUTION (City and State or Country if outside USA)	DATES				DEGREE/SPECIALTY
		FROM		TO		
		MO	YR	MO	YR	
MEDICAL						
INTERNSHIP						
RESIDENCY						
FELLOWSHIP						
ADD'TL TRAINING						

**If Foreign Medical School Graduate, E.C.F.M.G. Number:**

U.S. SPECIALTY BOARD CERTIFICATION(S) NAME OF BOARD	CERTIFICATION DATE		
	MO	DAY	YR

**NYS WORKERS COMPENSATION BOARD INFORMATION**

<b>WCB Code Letters:</b>		<b>Board Eligibility:</b>	
Have you ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare or by any other Federal or Federally assisted program in any State?	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	I have read the Conditions Governing Referrals for Consultative Examinations and agree to abide by its requirements and I certify that all statements completed herein and attached documents are accurate.  _____ SIGNATURE OF CONSULTANT  _____ DATE SIGNED
Have you ever been convicted of stealing, welfare fraud, public assistance fraud, Medicaid or Medicare fraud in any State?	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	
Has your license ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	
Is there currently pending any proceedings that could result in the above stated sanctions?	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	

**\* For medical groups, partnerships, P.C.'s, etc., this cover page must be completed for each physician, psychologist or social worker who will be performing examinations for DDD.**

**PLEASE COMPLETE REVERSE SIDE**

**PAY TO ADDRESS/CORRESPONDENCE ADDRESS:**

ATTENTION STREET				TELEPHONE NUMBER	
CITY	STATE		ZIP CODE		

**SERVICE ADDRESS INFORMATION:**

ATTENTION STREET				TELEPHONE NUMBER	
CITY	STATE		ZIP CODE		

EXAMINATIONS	TESTS	TEST EQUIPMENT MANUFACTURER	MODEL/AGE

**SERVICES TO BE REFERRED TO OUTSIDE SECONDARY SOURCE**

PROVIDER NAME	ADDRESS	TELEPHONE NUMBER	SERVICES

**REFERRAL/OFFICE INFORMATION**

Number of referrals able to accept per Age Range Limitations?

Willing to accept all referrals?  Yes  No

Willing to do home visits?  Yes  No

Languages spoken other than English:

Scheduling or referral Limitations:

	<b><u>NAME</u></b>	<b><u>DAYS/HOURS CAN BE REACHED</u></b>
Office Administrative Contact	_____	_____

Physician Contact	_____	_____
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Specify any licensure/certification standards met (Article 28, 47, etc.) \_\_\_\_\_