

Documenting Disability

Simple Strategies for Medical Providers

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This project was funded through a Cooperative Agreement
with the Bureau of Primary Health Care,
Health Resources and Services Administration,
U.S. Department of Health and Human Services.

Health Care for the Homeless
Clinicians' Network

December 2004

Documenting Disability: Simple Strategies for Medical Providers

Documenting Disability: Simple Strategies for Medical Providers was developed with support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

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O'Connell JJ, Quick PD, Zevin BD, Post PA (Ed.). *Documenting Disability: Simple Strategies for Medical Providers*, 54 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2004.

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PREFACE

This manual is a guide to documenting medical impairments in support of applications for the Social Security Administration's (SSA) disability benefits programs. It is primarily intended for health care providers in the United States serving individuals with disabilities who are homeless or marginally housed.

The original version, *Determining Disability: Simple Strategies for Clinicians* by James J. O'Connell, MD, was published in 1997 by the Health Care for the Homeless (HCH) Clinicians' Network, National Health Care for the Homeless Council. This version, based on the 2003 edition of the SSA's Listing of Impairments, updates the prior publication. An expanded bibliography refers readers to a variety of resources where more detailed information can be found.

The purpose of this manual is to inform clinicians about SSA's disability criteria and to explain how they can expedite the disability determination process. The authors contend that health care providers should play an active role in routinely documenting their patients' medical impairments. By understanding the process of applying for SSA disability benefits and the requirements for providing evidence in support of a disability claim, providers can do so more efficiently and effectively. They can also use the process of disability evaluation and advocacy to engage individuals who are homeless in primary care and mental health/substance abuse services.

Two basic strategies are recommended to support applications for disability assistance:

- 1) Refer explicitly to medical criteria for disability specified in the SSA's Listing of Impairments.
- 2) For patients whose impairments do not meet or equal the level of severity specified in a medical Listing, document activities the patient can and cannot do. This strategy is most effectively accomplished in collaboration with a multidisciplinary clinical team that includes a social worker and/or vocational counselor.

We hope this document will promote stronger therapeutic relationships between health care providers and homeless people. Most importantly, we hope that its use will enable persons with disabilities to obtain the financial supports they need to achieve stability and improve quality of life.

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¹ Members of Tom Waddell Health Center/Homeless Programs who also participated in the development of this curriculum include Dr. Barry Zevin; social workers Jay Sheffield and Amy Cole; psychologists Dr. Donna Douglass Griffith and Dr. Marc-Ellyn Garth; case managers Nancy Ibarra, Charles Owens, Richard Martinez, and Earl Wiley; and nurse practitioner Masa Rambo. They also worked in collaboration with attorneys Katie Danielson, Lisa Jensen, and Yvonne Mere of the San Francisco Bar Association’s Homeless Advocacy Project (HAP).

ACKNOWLEDGEMENTS AND DEDICATION

The National Health Care for the Homeless Council expresses its gratitude to the clinicians listed above, who were primarily responsible for developing and revising this manual. For their help in reviewing and commenting on drafts prior to publication, we also extend special thanks to the following individuals:

- Sarah Anderson, JD, Greater Boston Legal Services;
- David Buchanan, MD, Head, Section of Social Medicine, Department of Medicine, Cook County Hospital and Assistant Professor of Medicine, Rush University, Chicago, Illinois;
- Dave Ettinger, JD, Legal Aid Society of Middle Tennessee;
- Jean Hochron, MPH, Director, Office of Minority Health, and Jennifer L. Fagan, Public Health Advisor, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services;
- Troy Tashiro Kaji, MD, Richmond Health Center, Contra Costa County, California;
- John N. Lozier, MSSW, Executive Director, National Health Care for the Homeless Council;
- Michael McGeary, Institute of Medicine;
- Peter H.D. McKee, JD, Douglas, Drachler & McKee, LLP, Seattle, Washington;
- Yvonne Perret, MA, MSW, Executive Director, Advocacy and Training Center, Cumberland, Maryland; and
- Jeremy Rosen, JD, Director for Homelessness and Mental Health, Volunteers of America, Alexandria, Virginia.

Finally, we are grateful to members of the National Council's Medicaid Reform Committee who provided valuable insight as the manual was being revised and evaluated for its usefulness to medical providers in Health Care for the Homeless clinics. Committee members were: Douglas Berman, Policy Analyst, Care for the Homeless, New York City; David Buchanan, MD, Cook County Hospital, Chicago, Illinois; Vincent Keane, MDiv, Chief Executive Officer, Unity Health Care, Inc., Washington, D.C.; and Robert Taube, PhD, MPH, Executive Director, Boston Health Care for the Homeless Project, Boston, Massachusetts.

The Medicaid Reform Committee was chaired by the late Susan L. Neibacher, MS, Executive Director of Care for the Homeless, New York City. Susan was a tireless advocate for meeting the health care needs of her homeless neighbors. Her wisdom and guidance will be sorely missed, and this publication is dedicated to her memory.

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EXECUTIVE SUMMARY

This manual was written to inform clinicians about appropriate documentation of medical impairments in support of their patients' applications for Federal disability benefits. It includes:

- A brief introduction to the major Federal disability programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI);
- A description of the sequential evaluation process utilized by the Social Security Administration (SSA) and its agents to determine eligibility for SSI and SSDI;
- A brief description of the Adult Listing of Impairments used by SSA, how to use them, and where to find this information online;
- Guidance in documenting residual functional capacity for disabled patients who do not meet criteria specified in the Listing of Impairments;
- Guidelines for writing effective letters supporting disability claims and examples of successful letters; and
- References to other helpful guidance for clinicians in appropriately documenting disabilities.

The manual describes efficient and effective approaches to documenting disability used by primary care providers serving poor and homeless adults. Disability determination for children, comprehensive information about mental health problems that independently qualify many people as disabled, and numerous legal and technical questions regarding eligibility for SSI and SSDI are not addressed in this manual. Readers are referred to resources where information about these topics can be obtained.

Eligibility for SSI and SSDI is determined by a government agency that has an agreement with SSA in each State. In evaluating initial disability claims, these disability determination services (DDSs) use a 5-step evaluation process that requires answers to the following questions:

1. Is the applicant engaged in substantial gainful activity?
2. Does the applicant have a severe impairment?
3. Does the applicant suffer from an impairment which meets or equals the severity of a listing?
4. Can the applicant do any of his/her past relevant work?
5. Can the applicant do other work that exists in the national economy, given his/her residual functional capacity, age, education, and work experience?

Key terms upon which the evaluation hinges are defined in the manual.

Diagnostic information supplied by medical providers is considered at Steps 2, 3, 4, and 5 of the sequential evaluation process. In most cases, applicants for SSI or SSDI and clinicians supporting their disability claims should be working with a social worker or vocational counselor to assure that additional required information is provided and that the application is properly prepared.

At Step 3 of the sequential evaluation process, objective data documenting certain medical conditions can automatically qualify a patient for disability benefits, eliminating the need for Step 4 or Step 5 judgments. The criteria for establishing these conditions are precisely defined in SSA's *Listing of Impairments*. This manual encourages clinicians to utilize the Listing of Impairments whenever possible, to expedite disability determinations for patients who meet one or more of these criteria.

At Step 4 of the sequential evaluation process, DDS staff are asked to determine the applicant's residual functional capacity (work-related activities that s/he can still perform despite functional limitations). Clinicians can provide a realistic basis for this assessment of their patients' functional capacity by specifying what the patients can and cannot do.

At Step 5 of the sequential evaluation process, SSA considers diagnostic information related to residual functional capacity and then determines whether a person can do other work.

Providing this information can be unnecessarily time-consuming and difficult if it is not already well documented in clinic notes or the medical record. For that reason, the authors of this manual encourage a multidisciplinary team approach to documenting disability as a routine part of clinical practice, with the medical provider as a central part of that team. This is especially important for individuals with disabling medical conditions that do not clearly meet criteria specified in (or equivalent to) the Listing of Impairments.

Clinicians who understand the sequential evaluation process, who use the Listing of Impairments, and who appropriately document medical impairments and their effects on functional capacity, observed over time, can quickly and accurately provide the medical documentation necessary to support disability claims.

INTRODUCTION

The Importance of Disability Assistance

There is increasing awareness of the role of disability in precipitating and prolonging homelessness. The fact that people with disabilities constitute the “chronically homeless” population in America is extremely troubling.² People living without homes suffer extraordinary and well-documented health risks associated with poverty, overcrowding, and poor access to health care. Any national strategy to end and prevent homelessness must include adequate financial supports that allow persons with disabilities to secure housing and meet other basic needs, including health care.

The most important sources of assistance for Americans with disabilities are two Federal programs administered by the Social Security Administration (SSA) – Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI and SSDI constitute a safety net for persons with disabilities, providing both cash assistance (monthly checks) and eligibility for health insurance (Medicaid and/or Medicare).

Facilitating applications for disability benefits is perhaps the single most important intervention that clinicians can offer to minimize the health risks associated with poverty and to assure a better quality of life for many homeless people. Helping a previously uninsured patient obtain health insurance coverage also benefits the health care provider.

The Central Role of Medical Providers

Medical evidence of health conditions that result in severe functional impairments is required to establish eligibility for SSI or SSDI. Patients rely upon clinicians to provide this medical evidence. Unfortunately, many homeless people who should qualify for these benefits do not receive them due to insufficient medical evidence of their impairments.

Some clinicians worry that by becoming involved in the disability determination process they might compromise their responsibility to advocate for their patients. They might also have the false impression that providing medical evidence to the government subverts their primary function as health care providers. Such ethical dilemmas can be resolved through a clear understanding that the medical provider’s proper role includes providing documentation of impairment, and the government agencies’ role is to determine disability.

As clinicians, we understand that physical and mental impairments can prevent individuals from participating in the work force and living independently. We also understand that with appropriate health

² According to the federal definition, a chronically homeless person is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years” (Collaborative Initiative to Help End Chronic Homelessness, notice of funding announcement (NOFA), 2000).

care and social supports, many disabling health conditions can be stabilized and quality of life can be improved. As medical professionals, we are obligated by the ethical principle of beneficence to “do good” and avoid harm. As health care providers, we are the best sources of evidence for the existence of medically determinable impairments and their consequences for our patients. A number of us have cared for homeless individuals in shelters and on the streets. In many cases, we are the only medical practitioners who have observed their living situations at first hand and met their health care needs over time. Thus, **helping patients with disabilities obtain financial and medical assistance is well within our purview as health care professionals.**

“SSA regulations place special emphasis on evidence from treating sources because they are likely to be the medical professionals most able to provide a detailed longitudinal picture of the claimant’s impairments and may bring a unique perspective to the medical evidence that cannot be obtained from the medical findings alone or from reports of individual examinations or brief hospitalizations. Therefore, timely, accurate, and adequate medical reports from treating sources accelerate the processing of the claim because they can greatly reduce or eliminate the need for additional medical evidence to complete the claim.”

SSA, *Consultative Examination Guide*: <http://www.ssa.gov/disability/professionals/greenbook/ce-evidence.htm>

This powerful statement captures the essence of what we as clinicians should be striving to do for our homeless patients, who have much more difficulty completing SSI/SSDI applications than do stably housed persons.

Even if the importance of helping homeless patients obtain SSI/SSDI benefits is acknowledged, many clinicians dread the process of documenting disability, which they consider mysterious, onerous, time-consuming, and hopelessly complex. The era of managed care, with its demands for productivity and efficiency, has amplified their frustration. At the same time, the demand for determination and re-determination of disabilities has significantly increased as other income supports have deteriorated; substance use disorders have been eliminated as a basis for disability; and private health insurance coverage has become even more exclusive and unaffordable. Community Health Centers, Health Care for the Homeless projects, and other safety net providers have been deluged with requests for assistance with disability claims.

Much time is spent retrieving and reviewing medical records and composing medical evaluations, often without a clear understanding of the criteria against which a disability claim will be judged. When called upon to write letters supporting applications for Federal disability assistance, many providers erroneously assume that simply confirming medical diagnoses is sufficient to document disabilities.

‘Disability’ is an administrative/legal determination made by an agency (such as SSA or an insurer), not a medical diagnosis. It is the conclusion of an administrative process conducted by a disability determination service. Statutes and regulations make it clear that SSA decides if a person is disabled, not medical providers. The role of clinicians and others is to provide documentation, or evidence of

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disability. In other words, medical professionals are asked to provide the facts – diagnoses and functional limitations – that are necessary to determine disability. That’s why a simple statement such as “my patient is disabled” is not sufficient.

“Only after studying the disability criteria specified in the SSA Listing of Impairments did we realize that what we had previously documented in letters supporting disability claims rarely addressed these criteria. Now that we know and understand what is necessary to document impairments associated with medical disorders, we make a point of including the salient points in our chart notes.”

— Jim O’Connell, MD, Boston Health Care for the Homeless Program

Persons seeking disability assistance for chronic conditions such as diabetes, asthma, or low back pain often know they are impaired but do not understand the application process. Clinicians can carefully review the Listing of Impairments with their patients and arrive at a mutual understanding of the likelihood that disability benefits will be approved. In that way, if more information is needed, or if more studies are required, the patient will understand the reasons. Trust and mutual respect are critical, as this process often requires the patient to reveal a detailed and painful history to fill voids in the medical record. **Documenting disability, long the bane of the busy clinician and the overwhelmed patient, can become the cornerstone of a trusting therapeutic relationship that promotes patient adherence to the plan of care.**

For these reasons, **we strongly recommend that treating physicians write letters of support for disability claims, whenever possible.** To facilitate this process, the clinical team should routinely document their patients’ medical impairments in office charts and medical records. Careful specification of medical disorders that meet SSA disability criteria and thorough documentation of functional impairments that result from disabling health conditions, observed over time, are essential elements of providing quality health care – especially for patients at highest risk of falling through the cracks in our fragmented health and social service systems.

This manual was written by medical providers experienced in the care of individuals with disabilities who are homeless. It explains exactly what is expected of clinicians who are asked to provide medical evidence supporting their patients’ disability claims, and how to do so in the most efficient and effective ways.

FEDERAL DISABILITY PROGRAMS

The Social Security Administration administers two major programs for people with disabilities, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). To qualify for benefits, applicants must meet both non-medical and medical disability criteria. The medical standards for disability are the same for both programs, while the non-medical standards are different.

Supplemental Security Income (SSI)

SSI (Title XVI of the Social Security Act) is a Federally financed, needs-based program that guarantees a national income level for eligible individuals who are aged, blind or disabled and have limited income and resources.³ In most States, persons who qualify for SSI are also eligible for Medicaid.⁴

Most States provide optional supplemental payments to some or all SSI recipients, to help them meet needs not fully covered by Federal SSI payments.⁵ These supplemental payments vary from State to State and reflect differences in regional costs of living. Supplementary payments may be made directly by the State or combined with the Federal SSI payment, by mutual agreement of SSA and State agencies (SSA Handbook §2181). SSI payment levels are also affected by the beneficiary's living arrangement (obligation to pay for shelter). This means that homeless individuals are usually paid less than individuals who have rental liability.

³ The maximum federal SSI payment for 2005 is \$579 per month for an eligible individual (\$869 for an eligible individual with an eligible spouse). The actual SSI monthly payment is calculated by subtracting the beneficiary's monthly countable income from the maximum Federal amount for a given calendar year and by adding any supplementary payment provided by the State in which the beneficiary resides.

⁴ In 32 States and the District of Columbia, SSI eligibility results in automatic Medicaid coverage. In 7 other States (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah), a separate application for Medicaid is required, but the same disability criteria are used as in the Federal SSI program. In these States, the State Medicaid agency makes the eligibility determination rather than the local SSA field office. In 11 States (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia), at least one standard for disability-based Medicaid eligibility is more restrictive than the Federal SSI standard. That is, there is a narrower definition of disability or a lower income or assets threshold, and/or more restrictive methods are used to count income or assets. These States are authorized to use standards that were already in place before SSI was implemented in 1972. In Massachusetts, disabled persons can qualify for Medicaid without applying for SSI, under a State demonstration program. (SSA Policy Site: POMS Section SI 01715.010 Medicaid and the SSI Program, 2/16/2001; Post, 2001, p. 11.)

⁵ As of July 27, 2004, only 6 States did not pay an optional supplement to any SSI beneficiaries: Arkansas, Georgia, Kansas, Mississippi, Tennessee, and West Virginia (SSA. Understanding Supplemental Security Income SSI Benefits: <http://www.socialsecurity.gov/notices/supplemental-security-income/text-benefits-ussi.htm>). Of the 45 States with optional SSI supplementation programs, some provide supplemental payments to all SSI recipients (e.g., Massachusetts and Illinois), while others limit payments to certain beneficiaries (e.g., Maryland provides supplements only to those living in a care home or assisted living facility; Washington supplements SSI payments only for recipients who are blind, or over age 65, or in foster care, or participating in the State's Developmental Disability Program, or who were grandfathered into the Federal SSI program, and explicitly excludes residents of public emergency shelters for the homeless (State Assistance Programs for SSI Recipients, January 2002 (released August 2004): http://www.ssa.gov/policy/docs/progdesc/ssi_st_asst/2002/index.html).

Social Security Disability Insurance (SSDI)

SSDI (Title II) provides monthly cash benefits for persons with disabilities who have a recent work history. Unlike SSI, an individual's income and assets do not affect eligibility. To qualify for SSDI, an individual must meet the Social Security disability standard and must be fully insured for disability benefits – i.e., have worked in a specified number of the past 40 calendar quarters, depending on the age of the applicant. In general, SSDI beneficiaries are eligible for Medicare after they have received SSDI benefits for 24 months. They may also be eligible for Medicaid (e.g., for coverage of premiums/cost sharing, prescription drugs, or other services, depending on the State plan).

The benefit amount for SSDI is calculated based on the individual's work history. Applicants who don't have enough work credits to qualify for SSDI but meet the SSA disability standard may qualify for SSI. Persons with an extensive work history may receive substantially more money under SSDI than is available to SSI recipients. If the dollar amount of the SSDI benefit is less than the benefit available under SSI, SSDI beneficiaries may also receive an SSI supplement.

SSA Definition of Disability

To qualify for SSI or SSDI an individual must be determined disabled according to the Federal definition:

A disabled adult is defined as:

“... an individual [age 18 or older who is] unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”

(42 U.S.C. §1382c(a)(3)(A); 42 U.S.C. §423(d)(1)(A))

To satisfy this definition, disability claimants must have enough **medical evidence** of a physical or mental impairment from their treating physician or from a consulting physician authorized by the agency that makes disability determinations for the Social Security Administration in each State.⁶ Sufficient medical evidence consists of “signs (objective findings by a medial provider), symptoms (subjective complaints by the claimant), and laboratory findings” to substantiate the disability claim (Morton, 2003, Chapter I).

⁶ Allowance (approval) rates for SSI/SSDI applications vary widely from State to State. In Massachusetts (which has a higher allowance rate for disability claims than most other States), a review of disability claims submitted to the DDS in Boston, July 2002 – September 2004, revealed that only 29 percent of claims from homeless people were allowed, compared to 38 percent of claims from non-homeless people; denials were 2.3 times more likely than allowances for homeless claimants, compared to 1.5 times more likely for non-homeless claimants. The Massachusetts DDS Advisory Committee appointed a Homeless Subcommittee to investigate barriers encountered by homeless claimants in applying for SSDI/SSI benefits. Data collected by that group indicate that disability determinations are often delayed when homeless claimants fail to list contact information for all medical providers, and that higher percentages of homeless than non-homeless claims are denied due to insufficient medical evidence or failure to keep appointments for consultative evaluations. (Sarah Anderson, JD, Greater Boston Legal Services; Post, 2001, Appendix D, pp. xv–xvi)

DISABILITY DETERMINATION PROCESS

Steps through the Application Process

1. **Intent to File** Individuals applying for Social Security benefits first have to notify the Social Security Administration of an intention to file. This can be done in person, by phone, or online at <http://www.socialsecurity.gov/applyforbenefits>. For SSI, the clock starts ticking at this point.
2. **Application** The next step is filing an application with SSA. If the application isn't complete within a certain time after notification of the intent to file, the case will be closed. SSA responds to verbal or written inquiries about eligibility for SSI or SSDI by giving the individual an appointment to apply. If the appointment is missed, SSA should send the individual written notice that an application must be filed to receive an initial determination. In the case of SSI, an application filed within 60 days of the notice date will be treated as if it were filed on the date of the verbal or written inquiry (20 CFR 416.340 and 416.345). In the case of SSDI, an application filed within six months of the notice date will be treated as if it were filed on the date of the written inquiry (verbal inquiries do not count) (20 CFR 404.630).
3. **Presumptive Disability (PD)** In certain cases, a claimant may be found presumptively eligible for SSI benefits which can be paid for up to six months while evidence is being gathered for a full disability determination (Rosen, 2001). This can expedite Medicaid coverage and access to needed health services. SSA Field Offices have limited authority to approve presumptive disability from a list of specified impairments, including amputation at the hip, deafness, blindness, bed confinement, severe mental retardation, and opportunistic infections associated with HIV (20 CFR §§ 416.931–416.934; POMS DI 23535.000).

DDS staff may approve PD if they believe there is a high probability that the applicant will be found disabled after additional evidence is obtained. Impairments with “high PD potential” include mental deficiency, neoplasms, diseases of the central nervous system resulting in paralysis or motor dysfunction, and chronic renal disease. But DDS may not consider the presumptive disability option in every case where they could. Advocates should recommend to DDS that PD be approved if they think it is warranted. SSI outreach demonstration projects have confirmed the effectiveness of this approach, especially for mentally impaired adults who are homeless.⁷
4. **Disability Determination** Under an agreement with SSA, State disability determination services are given the responsibility of determining whether the applicant (claimant) meets Federal standards

⁷ SSA authorized an outreach demonstration project conducted by the University of Maryland, 1993–2002, to approve presumptive disability for homeless adults with severe and persistent mental illness. Virtually 100 percent of applications submitted presumptively received final approval from DDS (Perret, 2003). In FY 2004, SSA awarded a total of \$6.6 million to 34 community-based organizations to assist chronically homeless individuals apply for SSI and SSDI benefits. One of the optional project activities funded by these 3-year Homeless Outreach Projects and Evaluation (HOPE) grants is screening of claimants for presumptive disability. SSA policy on presumptive disability was still evolving at the time this manual was written.

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that are required to qualify for disability benefits. SSA forwards the application to the DDS, which usually sends questionnaires to the patient, family, and friends named by the patient, asking for information about the patient's daily functioning. The DDS will also send a request for medical records and a statement to the treating physician and any other treating sources (see "Who Can Document a Medical Impairment?" below). If the treating source does not respond, or if the records or response are inadequate, or if no treating source can be identified, DDS may re-contact the patient's treating source(s) and ask for supplemental information or arrange for a consultative examination with a medical or osteopathic physician, psychologist or other health professional on its list of medical examiners.

- a. **Initial determination** The disability determination is made by a medical or psychological consultant and a disability examiner. The average initial allowance rate for decisions on applications for SSI/SSDI benefits in FY 2003 was **37 percent** (GAO, 2004).⁸ Unfortunately, some providers ignore requests for evidence at the initial determination level because they mistakenly believe that there is no significant chance of an initial allowance. Lack of sufficient medical evidence is an important reason why applications filed by many homeless claimants are not approved at this stage. Allowance of disability claims at the initial determination should be the primary goal. It is also important to support patients in appeals of inappropriately denied disability claims.
- b. **Reconsideration** If benefits are not awarded, the claimant has 60 days to file a request for reconsideration (more if s/he can show good cause for not responding sooner). (At each stage of the adjudication process, the claimant has 60 days to submit a written request for review at the subsequent stage.) Claimants should be strongly urged to file a written request for reconsideration well before the 60-day deadline. New evidence may be presented at reconsideration, and a new analyst and physician reviewer will consider the case. On average, **15 percent** of disability claims were awarded to disability claimants at this phase in FY 2003 (Ibid.).
- c. **Hearing** If the claim is again denied, the applicant has 60 days to request a hearing before an administrative law judge (ALJ) who works for SSA. The ALJ reviews each claim anew and will accept new evidence. Health workers and social workers assist patients with their applications and benefits advocacy. If the application needs to proceed to the ALJ hearing level, the patient is often referred to a lawyer. Clinicians have consistently more credence from ALJs during appeals hearings when they can state that they have observed patients over a period of time, living in shelters, and can attest clearly to their marked loss of social functioning as a result of medical or psychiatric impairments. Too many applicants give up after one or two denials, unaware that ALJs allow **61 percent** of the claims they hear, despite the fact that each of those claims has been "carefully reviewed and regretfully denied" on two prior occasions (Ibid.).

⁸ Allowance rates specified in this section are national averages, which vary considerably from State to State, within individual States over time, and even among ALJs. For an analysis of the variation in allowance rates by State and among ALJs, 1980–2000, see Social Security Advisory Board, 2001 (Chartbook B): <http://www.ssab.gov/NEW/Publications/Disability/chartbookB.pdf>

- d. **Appeals** If the case is denied at the ALJ hearing level, the next step of appeal is to the SSA **Appeals Council** in Falls Church, Virginia. At this level, claimants can also initiate a new application. But cases at this step take months to years, and most cases don't make it that far. The FY 2003 allowance rate for medical decisions by the Appeals Council was only **2 percent** (Ibid.). If the claim is still not awarded, the case may go to Federal court. At present, the Social Security appeals process is extremely time-consuming; waits of up to two years for an administrative hearing and up to two more years for action by the Appeals Council are not uncommon. Thus, providing compelling evidence of disability at the earliest stages is to everyone's advantage, especially the patient's.
5. **Allowance** If SSI benefits are awarded, the application effective date (the point at which Social Security payments can begin) will usually be the first day of the month after the protective filing date (the date on which the patient notified SSA of the intention to file). SSI benefits are not retroactive beyond the protective filing date. For SSDI, it is more complicated: there is a waiting period of 5 calendar months from the time the person became disabled (*not* from the date of application) before benefits can begin. SSDI payments begin 1 month after the waiting period ends, and benefits are retroactive, covering up to 12 months before the month the application is filed.

There are two types of favorable disability determinations (allowances):

- **Medical allowances** are based upon a finding that the applicant meets or equals a listed impairment. The SSA's Listing of Impairments describes conditions so obviously inconsistent with work that benefits are awarded without considering the applicant's age, education or work experience.
- **Medical-vocational allowances** are based upon consideration of the applicant's age, education, work history, and residual functional capacity. In very simplified terms, unskilled applicants unable to perform past work are likely to receive medical-vocational allowances if they are:
 1. 50 to 54 and limited to sedentary work;
 2. 55 to 59 and limited to light work; or
 3. 60+ and limited to medium work.

The rules are somewhat more lenient for illiterate applicants.

(See Documenting Residual Capacity, below, for definitions of these work levels.)

In FY 2002, **49 percent** of allowances were based on meeting a Listing, **9 percent** of allowances were based on equaling a Listing, and **42 percent** of allowances were based on medical-vocational considerations (SSI Annual Statistical Report, 2003).

6. **Continuing Disability Review (CDR)** After a disability case has been awarded (approved), SSA is required to conduct a CDR at specified intervals, established at the time of approval. How often the case is reviewed depends on whether the beneficiary's condition is expected to improve. A CDR is scheduled 6–18 months after benefits start if medical improvement is expected, in 3 years if improvement is possible, or in 7 years if improvement is not expected.

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Patients sometimes come to caregivers in a panic, reporting that “Social Security is cutting me off.” This usually means that the DDS has been asked to review the case (i.e., conduct a CDR) to determine if the patient is still eligible for benefits. If the patient doesn’t respond to a CDR notice or doesn’t go for required medical examinations, the benefit may be cut off, and the patient could even end up owing money back.

The process of developing evidence in a CDR is the same as that used in the initial review of a disability claim, with one significant difference. For benefits to be terminated, there must be evidence that the individual’s condition has medically improved (decreased in severity), based on changes in the symptoms, signs and/or laboratory findings associated with conditions present at the last favorable medical review (CFR 404.1579). Although the claimant still has the responsibility to provide medical evidence of his or her impairment(s), it is ultimately SSA’s responsibility to determine from the medical evidence provided that there has been medical improvement.

Clinicians can support continued disability assistance for their patients by providing evidence that there has been no medical improvement related to ability to work since the last favorable disability determination.

The Sequential Evaluation Process

DDS uses a 5-step sequential evaluation process to determine disability for adults:

Step 1: Is the applicant engaging in Substantial Gainful Activity?

Step 1 addresses whether the claimant is currently working for pay or profit and how much income s/he is receiving from that work (i.e., full-time or part-time activities, including those that are legal or illegal).

- **What is Substantial Gainful Activity?** Substantial gainful activity (SGA) is the performance of significant physical or mental tasks that are “productive” in nature – that is, resulting in income that equals or exceeds an amount set annually by SSA.⁹ Individuals earning more than that amount are considered to be engaged in substantial gainful activity and are not eligible for disability benefits. SGA is intended to describe work on a full-time, reliable basis – 6–8 hours a day, 5 days a week. The fact that a claimant can do part-time work does not conclusively disprove that s/he is disabled, however, according to SSA’s definition. In most cases, clinicians rely on caseworkers or attorneys to address this area of the disability application. If a patient has substantial gainful activity, his or her disability claim will be denied.

If the answer to Question 1 is YES, the claim is denied at this step. If NO, proceed to Step 2.

Step 2: Does the applicant have a severe impairment?

Step 2 attempts to screen out groundless claims by assessing evidence of the severity of the applicant’s impairment.

- **What is a Severe Impairment?** An impairment is considered “severe” if it substantially interferes with an individual’s ability to perform basic work activities – such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions, using judgment, responding appropriately (to supervision, co-workers and usual work situations), and/or dealing with changes in a routine work setting. Evidence of the impairment’s severity may be provided by clinicians who have observed the applicant’s functioning or by others who have observed the applicant attempt to perform basic work activities in employment or social settings. A severe impairment is interpreted by SSA as the minimal level of impairment required for disability status. This is a threshold test used to screen out very weak

⁹ “Beginning January 1, 2005 a Social Security Disability beneficiary can earn \$830 a month as a result of ‘substantial gainful activity’ or SGA and remain eligible for benefits. For 2004, this amount was \$810. Under the new rule, monthly SGA earnings limits will be automatically adjusted annually based on increases in the national average wage index. This amount applies to people with disabilities other than blindness. For blind persons, effective January 2004, earnings averaging over \$1,350 a month generally demonstrate SGA. For January 2005, the blind SGA amount was increased to \$1,380” (Social Security Online, Answer ID 317: <http://ssa-custhelp.ssa.gov/>).

claims. In evaluating cases at this step of the sequential evaluation process, SSA is supposed to look at the functional effects of all impairments on the whole person, rather than assessing each impairment separately. The claims of patients whose impairments are not considered severe are denied.

If the answer to Question 2 is NO, the claim is denied at this step. If YES, proceed to Step 3.

Step 3: Does the applicant suffer from an impairment which meets or equals the severity of a listed impairment?

Step 3 utilizes the **Listing of Impairments**, a published list of specific physical or mental conditions that are so severe that SSA has determined that persons suffering from these are *automatically* considered disabled without further inquiry. Step 3 is often the critical step for physicians, psychologists and other acceptable medical sources who are responsible for completing medical evaluations of individuals seeking disability assistance.

- **What is a Listed Impairment?** The Social Security Administration publishes a book called *Disability Evaluation under Social Security*, also known as the Blue Book. In the Blue Book, SSA lists each body system, along with criteria for different disabling medical conditions. There are two sets of listings, one for children and one for adults. (When using the Blue Book, be sure you are in the right section.) The Blue Book is available at <http://www.socialsecurity.gov/disability/professionals/bluebook/> or may be obtained in hard copy from SSA (see p. 19 for information about how to order).

If the available medical evidence shows that the claimant has an impairment that meets the level of severity described in a listed impairment and has lasted or is expected to last at least 12 months or result in death, that person will be determined to be disabled based on the medical considerations alone and should be awarded benefits. Frequently, however, claimants are denied benefits for lack of adequate medical documentation supporting all required elements of the relevant Listing(s) and/or specifying the expected duration of their impairment(s). Thus, providing clear and precise information related to every element of the relevant Listing(s) can be critical.

Although most people who qualify for benefits at Step 3 do so by meeting a Listing, a person whose impairments are substantially equivalent in severity to a Listing can also qualify.

- **What is “Equivalent to a Listing?”** Patients whose impairments do not meet a Listing may nonetheless meet the disability standard by having impairments that are substantially equivalent to a Listing if the medical findings are at least equal in severity and duration to the listed findings (20 CFR 404.1526). Sometimes a patient’s impairments do not by themselves meet a Listing, but taken together have the same impact on a patient’s ability to work as a listed impairment. A patient may not satisfy every element of the Listing, yet in reality may have a more limiting set of problems.

For a condition to be determined “medically equivalent” to a Listing, the unique combination of medical impairments must result in functional limitations equivalent to those reasonably expected for a person actually meeting the Listing of Impairment. That is, the patient’s impairment(s) must be “medically equal” to the listed impairment(s). SSA compares the patient's impairment(s) to the relevant Listings and determines if a Listing is equaled.

Clinicians are not limited to describing the severity of a patient’s impairments in letters supporting disability claims, expecting that SSA will check for equivalence to a Listing. Advocates recommend that clinicians offer an opinion (for SSA to evaluate) on whether the evidence shows equivalence to a particular Listing.

While the latest reported percentage of allowances based on equivalence is rather low (6.1 percent in 2002 for those 18–64, according to the 2003 SSI Annual Statistical Report), well-prepared medical records and evaluations would increase the likelihood of an allowance at step 3 (or step 4). The critical lesson for providers is that **persons who meet or equal the criteria for a listed impairment are considered disabled by SSA and the sequential process is complete.** (The Listing of Impairments is discussed in more detail under “Using the SSA Listing of Impairments,” below.)

If the answer to Question 3 is YES, stop. Disability has been established. If NO, proceed to Step 4.

Step 4: Does the applicant have the residual functional capacity to perform his or her past relevant work, i.e., work performed in the last 15 years?

For an applicant who does not have a listed impairment or an equivalent condition, Step 4 involves a review of the applicant’s ability to do past relevant work by determining residual functional capacity.

- ***What is Residual Functional Capacity (RFC)?*** RFC is the most activities the individual is still able to perform despite functional limitations resulting from all of his/her impairments. Detailed information from physicians, psychologists and others who are responsible for completing medical evaluations of disability claimants is critical to assure accurate assessments.

Assessment of the RFC is particularly complicated for impairments that involve pain or fatigue, for mental impairments, and for combinations of mental and physical impairments. SSA compares the RFC with the functional requirements of the individual’s relevant work performed during the past 15 years. RFC is not what a person can do occasionally; it is what a person can do “on a regular and continuing basis ... 8 hours a day, for 5 days a week, or an equivalent work schedule” (SSR 96–8p, 7/02/96: http://www.ssa.gov/OP_Home/rulings/di/01/SSR96-08-di-01.html). If DDS determines that the individual has the functional capacity to perform past work, then the disability claim is denied.

If the answer to Question 4 is YES, the claim is denied at this step. If NO, proceed to Step 5.

Step 5: Does the applicant have the residual functional capacity to perform any other work which exists in significant numbers in the national economy?

Step 5 is the final step in the sequential analysis and involves the determination of whether the claimant can perform other work.

DDS looks at work available in the regional or national economy and considers whether the RFC of the individual and other vocational factors (age, education, literacy, and work history) allow the individual to perform such work. Disability benefits will be denied if other such jobs exist in significant numbers in the national economy – i.e., in the region where the claimant lives or in several regions of the country (68 FR 51166, 8/26/03; accessed 11/04 at: http://www.ssa.gov/OP_Home/cfr20/416/416-0960.htm).

If the answer to Question 5 is YES, disability is denied. If NO, disability is approved.

- ***What is the 12 month rule?*** To qualify as disabled, the claimant must have a severe impairment that has lasted or is expected to last for a continuous period of not less than 12 months or result in a patient's death. This 12 month ("duration") rule applies to all claims, at all steps of the sequential evaluation.

A claimant who has been impaired less than a year but is expected to be impaired for 12 months or longer may have benefits denied until it is clearer that s/he would actually meet the 12-month rule. For example, an individual who was seriously injured in car accident, hospitalized for 4 months and totally bedridden would still not qualify based on the actual duration of the impairment, unless the treating source certified that it would last more than 12 months. A forceful statement from the treating medical provider about the expected duration of the patient's impairment may be a helpful reminder to the analyst to consider this in determining disability.

In practice, the claims of patients who are expected to recover within a year are often denied at initial consideration and reconsideration. Claimants who have been impaired for nearly 12 months or slightly more but are expected to recover soon may be eligible for a closed period award or an award with a rapid medical continuing disability review.

DOCUMENTING DISABILITY

Who Can Document a Medical Impairment?

First, it is important to understand what SSA considers a medical impairment to be, who is authorized to document one for the purposes of disability determination, and what kinds of medical evidence are required to establish that an impairment exists.

- ***What is a Medically Determinable Impairment?*** SSA defines a medically determinable impairment as “an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques.” An impairment must be established by “medical evidence consisting of signs, symptoms, and laboratory findings – not only by the individual's statement of symptoms” (SSA Blue Book, January 2003, Part I: General Information).

Documentation of a medical impairment for the purpose of supporting a disability claim must come from “acceptable medical sources,” as defined by SSA regulations.

- ***Who is an Acceptable Medical Source?*** By acceptable medical sources, the government means medical professionals – licensed physicians, licensed or certified psychologists, licensed optometrists (for vision impairments only), licensed podiatrists (for foot and ankle impairments only), or qualified speech and language pathologists (20 CFR §§ 404.1513(a) and 416.913(a)).

The best medical evidence, according to SSA, comes from the “treating source.” By law, the statement of a treating source carries more weight than any other evidence, including the report of an outside examiner.

- ***Who is a Treating Source?*** A physician, psychologist, or other acceptable medical source that has (or did have) an “ongoing treatment relationship” with the claimant and provided medical treatment or evaluation (not just a report in support of a disability claim), is considered a treating source. The treating source may be a health care provider with a clinical doctoral degree – MD (Doctor of Medicine), DO (Doctor of Osteopathy), OD (Doctor of Optometry), or PhD (Doctor of Philosophy, e.g., a psychologist) – as long as the impairment addressed is within his or her licensed scope or practice. A doctor may report an assessment of impairment related to mental illness, even if he or she is not a psychiatrist, if it is part of the reasonable assessment the physician provides in his or her care of the patient. An optometrist can certify that a patient is blind, but would not be in a position to describe limitations related to heart disease, for example.
- A ***Nonexamining Source*** is a physician, psychologist, or other acceptable medical source who has not examined the claimant, but provides a medical or other opinion in the claimant's case.
- ***Other Medical Sources*** Medical practitioners who are not acceptable medical sources can prepare supporting letters and complete disability claims forms for their patients, but a licensed physician or other acceptable medical source (listed above) must also provide medical evidence to establish

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the impairment. According to the SSA definition, “other medical sources” include nurse practitioners, physician assistants, naturopaths, chiropractors, audiologists and therapists (SSA Office of Hearings and Appeals, HALLEX Volume I, Chapter I-2-5. Obtaining Evidence). These “other medical sources” can also provide evidence to establish the severity of impairment and its impact on a patient’s functioning, in letters supporting initial disability claims or as consultative examiners. If nurses or mid-level providers document impairments, they should be trained to use the specific language of the Listing of Impairments and discuss each case with a doctor.

- **Non-Medical Sources** SSA may also use evidence from non-medical sources – including social service providers, educational personnel, spouses, parents and other caregivers, siblings, other relatives, friends, neighbors and clergy – to assess the severity of an impairment (or combination of impairments) and how it affects the individual’s ability to work.

Responding to Records Requests

If you receive a request from the DDS, this means that a claimant has signed a release authorizing your program/clinic to release his or her medical records to SSA. You have some options about how to respond. The best option is to send a letter explaining your assessment of the patient’s impairment along with medical records. For some conditions (e.g., AIDS, mental illness), a questionnaire may be provided. If the questions allow you to answer in a way that illustrates your patient’s impairments fully, completing the form may be sufficient. But because questionnaires are rarely as thorough as letters, experienced advocates for persons with disabilities recommend writing a letter as well, whenever possible.

If you must triage these requests, it is reasonable to send relevant records without an accompanying letter for patients known to have a weak case or whom you don’t know well. Remember that you may not be in a position to judge whether a case is weak or strong, as the patient may have sought more care elsewhere of which you are unaware. A better option is to **build an ongoing relationship with your State DDS agency that evaluates disability claims.**¹⁰ Sometimes DDS workers will tell you the specific medical evidence they need to evaluate a claim positively. In most cases, not preparing a letter will almost certainly result in a referral to outside examiners.

If the evidence provided by the claimant’s own medical sources is inadequate to determine if s/he is disabled, additional information may be sought from the treating source, or SSA may purchase a **consultative examination** (an additional examination or diagnostic test) from a qualified medical source other than the patient’s treating source.

(See: <http://www.ssa.gov/disability/professionals/greenbook/ce-guidelines.htm>)

¹⁰ This strategy has worked well for HIV and homeless claimants in Boston. The Massachusetts Department of Disability Services’ Advisory Committee appointed a Homeless Subcommittee to investigate problems encountered by homeless claimants in applying for SSDI/SSI disability benefits and to develop strategies to resolve them. Its appointed members include DDS homeless disability claims specialists, consumers, and advocates. (Post, 2001, p.11).

Outside consultative examiners often fail to comprehend the full extent of the individual's impairments. What's more, they are often located far from areas in which homeless people reside and may have little experience and/or skill in interacting with this population. Many patients are intimidated by unfamiliar care providers – particularly individuals with significant mental illness, for whom denial of illness and paranoia are often symptoms of their impairment. Such patients sometimes fail to appear for a scheduled consultative examination (for lack of transportation or fear of the provider), or may show up but are too frightened or inhibited to respond candidly to the examiner's questions.

Therefore, **we strongly recommend that treating physicians and other qualified medical providers write letters of support for disability claims whenever possible.** We will discuss the specifics of how to write a letter below. In general, you will be asked to say what is wrong with the patient, discuss treatment, and tell what the patient can and can't do. Remember, your job is to describe *impairment*, not to make a judgment about disability.

Limitations of Medical Records

Medical records are notoriously unhelpful in documenting homeless patients' impairments. Most of the reasons are obvious and revolve around their poor access to healthcare (particularly diagnostic testing and specialty care), poor coordination of care (with documentation scattered over many hospitals, cities or States), and the fact that the immediacy of basic needs when surviving on the streets or in shelters renders health care a distant and often neglected priority.

A more subtle (and formidable) problem is health care professionals' lack of training in how to use the Social Security Administration's Listing of Impairments and our lack of understanding of the process and rationale for determining disability. We tend to document medical and psychiatric problems as we were trained to do during our medical education. Hence, we often do not address the particular criteria sought by SSA in making a disability determination, and SSA dismisses our medical records as unhelpful.

To remedy this situation, we offer the following recommendations:

- **Health centers and hospitals should train all medical professionals to highlight the important criteria under each relevant Listing for patients with disabling medical conditions**, in much the same way that they routinely record vital signs, screening tests, foot examinations, and A1C levels for diabetic patients.
- **To stimulate thinking about functional impairments, providers should expand the traditional occupational history** (with the help of social workers and vocational counselors) to include not only what jobs were done and when, but the duration of jobs held, reasons for leaving each job, current means of support, and reasons for unemployment and/or homelessness.
- **Whenever possible, document a longitudinal history of the patient's functional capacities.** The clinical team should document any work-related tasks the patient found difficult, any difficulties with activities of daily living (see page 28 for definition), and special barriers related to the patient's living situation, such as limited access to cooking facilities.

Augmenting medical records in this way will require a significant effort on the part of medical and social service providers, working collaboratively in multidisciplinary clinical teams. But, as noted above, there are very compelling reasons for doing so.

Patient Confidentiality

Two Federal laws protecting patient confidentiality are relevant to this discussion:

- **The Privacy Act of 1974**, as amended, permits an individual or his/her authorized representative to examine records held by a Federal agency that pertain to him or her. This means that disability claimants may request to see the medical or other evidence used to evaluate their application for disability benefits under SSDI or SSI. SSA screens all such requests to determine if release of the evidence directly to the disability claimant might have an adverse effect on that individual. If so, the report will be released only to an authorized representative designated by the claimant.
- **The Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996** (Privacy Rule, 45 CFR parts 160 and 164) require health-related organizations (including Federally Qualified Health Centers) that handle certain transactions electronically (such as medical claims) to protect the privacy and security of their clients' personally identifiable health information. HIPAA protects any patient information (in oral, written, or electronic form), created or received by health care providers or plans, which identifies or could be used to identify the individual.

In general, the Privacy Rule requires medical providers, including health centers to:

- provide information to patients about their privacy rights, as specified in the Rule, and explain when the provider may and may not disclose protected information;
- adopt clear privacy procedures;
- educate and train employees regarding the privacy procedures;
- designate an individual to be responsible for ensuring that the privacy procedures are adopted and followed; and
- secure patient records containing individually identifiable health information so that they are not readily available to those who do not need them. (Bureau of Primary Health Care, 2001)

The HIPAA Privacy regulations are applicable when SSA seeks information for SSDI/SSI claims. The standard form used to authorize provision of a claimant's personal health information to SSA (Form SSA-827, "Authorization to Disclose Information to the Social Security Administration") has been revised to meet HIPAA requirements. Health care providers are legally permitted to disclose an individual's medical records to SSA/DDS when SSA supplies an appropriate authorization, signed by the claimant (or a personal representative approved by that individual). The signed form, which is provided by SSA with each request for information, permits disclosure of the named individual's entire medical record (not including psychotherapy notes), unless it is noted on the form that the claimant desires to have less than the full medical record disclosed.¹¹

¹¹ Letter from the Social Security Commissioner to health care providers, health information managers, and medical records administrators, March 26, 2003. For a full explanation of SSA's obligations under HIPAA and the Privacy Act, see: How SSA-827 Meets Requirements for Authorization to Disclose Information: <http://www.ssa.gov/disability/professionals/827requirements.htm>

Some medical providers have erroneously claimed that even if such an authorization has been signed, confidentiality bars them from sending, either to Social Security or to a claimant’s representative, medical records from other providers contained in the patient’s file. There is no such legal distinction among medical records based on their origins, however. **No matter where an earlier record came from, if it is part of the patient’s current medical record, it may be released with the patient’s permission and in compliance with State and Federal disclosure laws, as part of the evidence to support a disability claim.** Many times, the originating source of earlier medical records cannot be located or these records have been destroyed, and the only source of the original records is in the more recent provider’s medical file. If such records are not provided to SSA – for example, to confirm the date of onset of a claimant’s disability – meritorious claims may be denied.

Using the SSA Listing of Impairments

Disability Evaluation Under Social Security (“The Blue Book”) contains medical criteria that the Social Security Administration uses to determine disability (SSA, January 2003). It is intended primarily for physicians and other health care professionals. The Blue Book is available online at: <http://www.socialsecurity.gov/disability/professionals/bluebook/>¹²

The Listing of Impairments Part A (88 pages) applies to adults age 18 and over. Part B provides additional medical criteria for children. (Guidance on documenting disabilities in children is beyond the scope of this manual.)

The list is divided into 14 body systems, numbered from 1.00 to 14.00 (adult listings) and from 100.00 to 114.00 (child listings). For each of these major body systems, criteria are specified for disabling impairments that are considered severe enough to prevent an adult from doing substantial gainful activity.

Most of the listed impairments are long-term or expected to result in death or of specified duration. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

All clinicians who provide medical evaluations or reports for patients seeking disability assistance should become familiar with the categories and the specific language of the Listing of

LISTING OF IMPAIRMENTS PART A: ADULTS

- 1.00 [Musculoskeletal System](#)
- 2.00 [Special Senses and Speech](#)
- 3.00 [Respiratory System](#)
- 4.00 [Cardiovascular System](#)
- 5.00 [Digestive System](#)
- 6.00 [Genito-urinary System](#)
- 7.00 [Hemic and Lymphatic System](#)
- 8.00 [Skin](#)
- 9.00 [Endocrine System and Obesity](#)
- 10.00 [Multiple Body Systems](#)
- 11.00 [Neurological](#)
- 12.00 [Mental Disorders](#)
- 13.00 [Neoplastic Diseases](#)
- 14.00 [Immune System](#)

SSA Publication No. 64–039, 1/03
 (“The Blue Book”)

¹² You can also order a hard copy online or by mail (SSA Pub. No. 64–039 ICN 468600, January 2003). This book can be obtained free of charge from the Social Security Administration’s Office of Supply and Warehouse Management (239 Supply Building, 6301 Security Blvd, Baltimore, MD 21235) or by contacting the SSA Public Information Distribution Center (phone: 410.965.2039; fax: 410.965.2037; e-mail: oplms.osm.rpt.orders@ssa.gov).

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Impairments. Disability assessments become easier and more focused when providers are familiar with SSA's language of disability, as well as with the criteria used by disability examiners.

Medical evaluations and reports should include specific Listings and numbers and address all criteria for relevant impairments. This practice will streamline disability assessments and minimize the number of denials. The Listing of Impairments is also an effective tool to share with patients seeking to understand whether they might be eligible for disability.

The most efficient approach to documenting disabilities of homeless patients (who are impoverished and typically have severely disrupted social networks) is to find a medical Listing, provide medical evidence of the impairment, and specify functional limitations that have resulted from it. If the patient meets the criteria for one or more of the Listings, the determination process is quick and unproblematic, especially if documentation has been provided by a treating source who has known the patient and observed his/her living situation over time.

The criteria in the Listing of Impairments apply to only one step of the multi-step sequential evaluation process. At that step, the presence of an impairment that meets criteria specified in the Listing of Impairments (or is of equal severity) is usually sufficient to establish that an individual who is not working is disabled.

The absence of a listing-level impairment or its equivalent does *not* mean that the individual is not disabled, however; it merely requires the adjudicator to move on to the next step(s) of the process and apply other rules in order to resolve the issue of disability. These steps (4 and 5) require more subjective judgment on the part of the adjudicator than is required at step 3.

SSA'S DESCRIPTION OF THE LISTING OF IMPAIRMENTS

Medical Considerations

§416.925 Listing of Impairments in appendix I of subpart P of part 404 of this chapter.

Purpose of the Listing of Impairments. The Listing of Impairments describes, for each of the major body systems, impairments that are considered severe enough to prevent an adult from doing any gainful activity or, for a child, that causes marked and severe functional limitations. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

Part A contains medical criteria that apply to adult persons age 18 and over. The medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons.

How to use the Listing of Impairments. Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some required in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. Following the introduction in each section, the required level of severity of impairment is shown under "Category of Impairments" by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

Diagnoses of impairments. We will not consider your impairment to be one listed in appendix I of subpart P of part 404 of this chapter solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing for that impairment.

Addiction to alcohol or drugs. If you have a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether you are, or are not, disabled. As with any other medical condition, we will decide whether you are disabled based on symptoms, signs, and laboratory findings.

Symptoms as criteria of listed impairment(s). Some listed impairment(s) include symptoms usually associated with those impairment(s) as criteria. Generally, when a symptom is one of the criteria in a listed impairment, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of the symptom as long as all other findings required by the specific listing are present.

(20CFR404, Subpart P, Appendix I, revised as of April 1, 2003: http://www.ssa.gov/OP_Home/cfr20/416/416-0925.htm)

Documenting Residual Functional Capacity

For patients whose impairments do not clearly meet criteria specified in one or more of the SSA Listings, medical professionals are encouraged to document (in collaboration with a multidisciplinary clinical team) functional limitations and activities the patient can or cannot perform despite those limitations. This information is necessary for SSA to determine a patient's **residual functional capacity (RFC)** – the most the individual is still able to do despite functional limitations resulting from all of his/her impairments. Once established, the RFC is compared to the functional requirements of relevant work s/he has performed during the past 15 years. If the applicant is physically and mentally capable of doing work s/he has done in the past, the claim will be denied.

For example, although the obese patient does not qualify automatically under the medical Listings on the basis of obesity alone, s/he may qualify for benefits based on the functional consequences of her obesity. If s/he has knees that hurt so much s/he can't stand for long, or dyspnea that keeps her from walking a block or two on level ground, she may qualify. But the disability examiner will want to know whether you sent her to physical therapy and whether she went, whether you have ordered pulmonary function tests and what they showed, and what therapies you have prescribed and what their effects were.

Past Relevant Work and Transferable Skills

If the applicant is not capable of doing work s/he has done in the past, DDS considers what other kinds of work s/he might be able to do. The individual's vocational factors (age, education, and work experience) and RFC are compared with criteria specified in the **Medical-Vocational Guidelines (Grids)** included in SSA rules (20 CFR 404.1599).

The "Grids" identify different **levels of exertional capacity** (sedentary, light, medium, heavy or very heavy) that are required for individuals of different ages, levels of education and past work experience to be determined disabled or not. Disability determinations depend on how well the "facts of the case" match criteria specified in the "Grids."

Thus, it is critically important for health care providers to indicate in letters supporting disability claims of patients with severe impairments that do not meet or equal a medical Listing:

SSA LEVELS OF EXERTIONAL CAPACITY

- **Sedentary work** generally requires sitting but may involve standing or walking for no more than 2 hours, with normal breaks, and in "most cases" good manual dexterity. It also requires lifting or carrying no more than 10 pounds and occasional lifting or carrying articles like docket files, ledgers, and small tools.
- **Light work** generally requires a good deal of standing and/or walking (approximately 6 hours a day), frequently lifting or carrying up to 10 pounds, and occasionally lifting or carrying no more than 20 pounds. Work may also fall into this category when it involves sitting most of the time with some pushing and pulling of arm or leg controls.
- **Medium work** involves frequent lifting or carrying up to 25 pounds, and occasionally lifting and carrying no more than 50 pounds.
- **Heavy work** (or very heavy work) represents substantial work capability for work in the national economy at all levels of skill and physical demand. In general, an individual who is able to do heavy work despite functional impairments will not meet the SSA disability standard.

SSA's Medical-Vocational Guidelines (POMS DI 25025.005:
<http://policy.ssa.gov/poms.nsf/lnx/0425025005>)

- How many hours during an eight-hour work day the individual can sit, stand, or walk (sedentary work requires the ability to sit for six hours and stand/walk for two; light and medium work require the ability to stand/walk for six hours); and
- How many pounds the individual can lift frequently (about 2/3 of the time) and occasionally (about 1/3 of the time).

This information should be provided even if it is not requested, and even if it is not called for in completing a DDS or SSA form.¹³ (Examples of physical and mental assessment forms are provided at the end of this document to simplify reporting of patients' functional status in support of disability claims.)

AGE CATEGORIES SPECIFIED BY GRID RULES:

- Younger individuals – under age 50
- Closely approaching advanced age – 50–54
- Advanced age – 55–59
- Closely approaching retirement age – 60–64
- Retirement age –over 65

SSA's Medical-Vocational Guidelines (POMS DI 25025.005:
<http://policy.ssa.gov/poms.nsf/lnx/042.502.5005>)

In most cases, individuals under age 50 are determined disabled only if they can't do sustained sedentary work (as defined above). Older individuals and those with less education may require evidence of an impairment that prevents light or medium work. In general, disability is easier to establish for claimants who are older and have less education, less vocationally relevant past work experience, and a lower residual functional capacity.

Most SSI applicants over age 65 qualify for age based benefits without regard to disability. Nevertheless, because even old age SSI has an asset test, if a claimant over age 65 has more than \$2,000 in the bank, s/he will be denied on financial grounds. A few non-citizen SSI applicants are not eligible for age-based SSI but can qualify based on disability, even beyond age 65. SSDI applicants are eligible for reduced early retirement benefits beginning at age 62, but receive a higher benefit if able to prove disability before full retirement age. (Full retirement age is currently 65 years and two months. It will gradually increase to age 67 in 2007.)

Persons who have only **nonexertional impairments** (impairments that do not limit the ability to lift, carry, stand, walk, sit, push or pull, including mental limitations) are evaluated under the criteria for heavy or very heavy work. For mental residual capacity, the evaluation turns on whether the individual can do simple, unskilled work on a sustained basis. The Grids are based on the availability of this kind of work. For persons with combinations of exertional and nonexertional limitations, the evaluation becomes more complex, but the Grids are still used as a framework to guide the disability determination.

¹³ Some disability determination services use a letter scale to rate functional impairments, requesting a statement from the treating source about the frequency that the claimant can perform certain exertional job requirements. For example, in Illinois, physicians are asked to rate patients' abilities in performing walking, standing, sitting, lifting, pushing, pulling, etc., on the following scale: A=100% able, B=up to 20% reduced ability, C=20–50% reduced ability, D= >50% reduced ability.

Special Considerations

Adverse Profiles

Adverse profiles are special circumstances with regard to past relevant work and transferable skills. According to SSA regulations, there are two medical-vocational profiles that show an inability to adjust to other work and warrant a finding of “disabled.” Disability claims of individuals with a 6th-grade education or less and 35 years of **arduous unskilled labor** who have a severe impairment that prevents past work will be approved. Claims of individuals aged 55 or older with a severe impairment and less than an 11th-grade education who have **no substantial work experience** will also be approved (POMS DI 25010.001B: <http://policy.ssa.gov/poms.nsf/lnx/0425010001>).

Substance Use Disorders

If an impaired person uses alcohol or drugs, documenting disability becomes more difficult. In 1996, Congress rescinded SSI eligibility for persons whose drug or alcohol use is “material” to the determination of their disability – that is, for those who would not meet SSA’s disability standard if they were clean and sober.¹⁴ When a person is disabled, considering all impairments, and there is evidence of drug or alcohol abuse, SSA must decide whether that person would still be disabled if drug or alcohol use stopped. The physician should provide evidence demonstrating that a patient’s impairment(s) would remain, were s/he to stop using drugs or alcohol. For example, if there is evidence of organic mental disease or other residual impairments from alcohol use, the patient may still be eligible for benefits.

Should clinicians support disability claims of patients with substance use disorders?

Some providers are reluctant to help functionally impaired patients with uncontrolled substance use disorders apply for disability assistance, for fear they will use SSI/SSDI payments to obtain drugs or alcohol. Scientific evidence of this risk is conflicting. One study found that homeless cocaine users with schizophrenia were more likely to be hospitalized following receipt of a disability benefit check (Shaner, et al., 1995). Another study found that homeless persons with alcoholism were more likely to obtain housing and report subjective well-being after receiving disability benefits, without increased incidence of complications secondary to alcohol use (Rosenheck, et al., 2000).

- **The authors of this manual recommend that clinicians advocate for impaired patients with substance use disorders seeking disability assistance if there is evidence that their impairments meet the criteria of a medical Listing or collectively result in a comparable functional limitation and are likely to remain if the patient were to stop using substances.** No matter how strong one’s belief in the importance of abstinence or sobriety, remember that SSI is an entitlement program that should be available to *all* persons meeting SSA disability criteria, and that SSDI is an insurance program that presupposes a history of work to which beneficiaries have already contributed in some measure through payroll taxes. Too many homeless people with disabilities do not get the assistance they urgently need.

¹⁴ Contract with America Advancement Act of 1996, Pub. L. No. 104-110 Stat. 847 (1996)

- **For patients at risk of spending disability benefits on alcohol or drugs, we recommend using the Social Security Representative Payee Program.** In letters supporting disabilities claims, the medical provider can recommend to SSA that a patient be required to receive disability benefits through a payee if the patient is believed to be incapable of managing his or her own benefits. Well-run charitable or public agencies may be preferable as payees for such patients, who are easily victimized. Providers should be alert to signs of misuse of funds by payees and report this to adult protective agencies and SSA. (For more information about this program, see <http://www.ssa.gov/payee/>; NLCHP, 2002; Rosen, 2001; Ries and Comtois, 1997.)

Should substance use be mentioned in letters supporting disability claims?

- **It is important to address any medical evidence of a substance use disorder explicitly in your letter.** Disability determination services and administrative law judges frequently focus on substance use as a disqualifying factor in disability claims. Substance use is commonly documented in homeless patients' medical records. It is not uncommon to find references to substance use in emergency room and specialist notes even for nonusers, due to the strong prevailing stereotype that all homeless people have drug and alcohol problems.
- **If a patient has a substance use disorder, state whether or not there is reason to conclude that the patient's impairment(s) would resolve if substance use ended, and report all irreversible adverse effects of this problem.** Chronic and irreversible medical illnesses and fixed functional deficits that result from the use of alcohol and other substances may qualify as eligible impairments. Examples include cirrhosis, organic brain syndrome from alcohol use, and loss of limb function from infections related to intravenous drug use.
- **If it is impossible to determine whether a patient's impairment(s) would be reversible with abstinence, it is appropriate to state this in the letter.** SSA acknowledges that it is often difficult or impossible to separate functional limitations resulting from drug or alcohol use from those resulting from other mental impairments and recognizes that an individual should be found disabled when it is not possible to separate limitations (DAA Q&A Teletype, <http://tinyurl.com/3nn4y> The date of this teletype will be extended beyond 1/30/05.).
- **For patients with chronic pain or mental health disorders, it is helpful to state that alcohol and drug use may represent attempts at self-medication to alleviate symptoms of the underlying illnesses.** Understanding the sequelae of trauma that many homeless people have experienced and continue to experience can provide a context for substance use that is important for DDS to understand. Since addiction is a brain disease marked by recurrent relapses,¹⁵ it is also helpful to document the patient's physical and mental status during periods of recovery. If the patient has relapsed at the time of assessment, commenting on any additional damage sustained during the current relapse is helpful.

¹⁵ A. I. Leshner, Addiction Is a Brain Disease, *The Addiction Recovery Guide*: <http://www.addictionrecoveryguide.org/articles/article151.html> (accessed 10/6/04)

- If an impairment appears to be primarily related to ongoing substance use, it is important to explain to the patient that although s/he may be unable to do work of any kind, the government does not give benefits for this type of disability. This may lead to a positive discussion about addiction as a treatable disease and possibilities for recovery.

Somatoform Disorders

Somatization is defined by the lack of objective findings upon examination. Patients may be markedly impaired by their overwhelming experience of illness, but their symptoms may or may not be consistent with expected symptoms from a named disease or syndrome. Nevertheless, it is important not to dismiss these patients as malingering. Malingerers are by definition aware of symptom generation; persons with somatoform disorders are not.

Somatization is very common in patients with behavioral health problems such as depression, anxiety disorders, posttraumatic stress disorder, personality disorders, alcoholism, or stimulant abuse. Somatoform disorders also co-exist with recognized medical conditions, but symptoms may be out of proportion to expected or normal responses. Symptoms can interfere with work and have been reported to persist over 12 months.

It is entirely appropriate for primary care providers to report to SSA manifestations of mental illness, which they have been trained to recognize. Documenting objective findings in support of patients' subjective complaints is essential in effective disability evaluation reports.

In providing evidence for disability claimants with a somatoform disorder, it is important to demonstrate impairments that result from the disorder. The required level of severity for these disorders is met when the requirements in both A and B of the medical listing for [Somatoform disorders](#) (12.07) are satisfied.

MEDICAL LISTING FOR SOMATOFORM DISORDERS

12.07 Somatoform disorders: Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or
2. Persistent nonorganic disturbance of one of the following:
 - a. Vision; or
 - b. Speech; or
 - c. Hearing; or
 - d. Use of a limb; or
 - e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
 - f. Sensation (e.g., diminished or heightened).
3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

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If both of these criteria are not met, focus on functional limitations and residual functional capacity:

- Document clearly and by example, if possible, the marked restriction of activities of daily living,¹⁶ marked difficulties in maintaining social functioning, and marked difficulties in maintaining concentration, persistence, or pace; and, if present, repeated episodes of decompensation.
- Document the presence of multiple physical complaints, quantify the number of medical visits, and document episodes of poor patient-physician relationship.
- When somatization accompanies another diagnosed mental health disorder, recognize and document it.
- In patients with a somatoform disorder, document poor or guarded prognosis for improvement.
- Evidence of a long pattern of illness and early onset supports a somatoform diagnosis. Use outside observed information if possible.

It is important not to confuse somatoform disorders with malingering. Although malingering is occasionally suspected in homeless patients, other explanations for their behavior must also be considered. For example, one patient complained of back pain so severe that he could barely stand up. He was later seen getting on and off a bus and walking down the street without difficulty, when he didn't know he was being watched. This was reported in the letter supporting his disability claim. His behavior was reported within the context of a severe personality disorder, which was, in the opinion of the treating physician, the primary source of his impairment. The patient was awarded a disability benefit.

In many places across the country, SSA has stepped up its investigations of fraud and abuse. Clinicians are advised to document any discrepancies in patient complaints and behaviors within the context of all medical and mental health conditions that impair functional capacity.

¹⁶ Activities of daily living (ADLs) include: bathing, dressing, eating, mobility, transferring, and toileting. Instrumental Activities of Daily Living (IADLs) include: meal preparation, medication management and administration, money management, telephone use, transportation, employment, shopping, and housework. (CDC. Current Trends Prevalence of Disabilities and Associated Health Conditions ~ United States, 1991-1992; MMWR October 14, 1994 / 43(40); 730-731,737-739: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00033002.htm>)

Groups Barred from Federal Disability Benefits

Clinicians should be aware that **undocumented immigrants, incarcerated persons, fugitive felons, and probation or parole violators are barred from receiving Federal disability benefits.**

Immigrants (non-citizens)

Welfare and immigration laws passed in 1996¹⁷ restrict access to SSI and SSDI based on a person's immigration status.

- **Undocumented immigrants** (who are not legally residing in the U.S.) are ineligible for SSI. In general, only legal immigrants who are exempt from bars on Federal assistance may qualify for SSI. Like other U.S. citizens, naturalized citizens and all children born in the U.S. (including those born to undocumented immigrants) may qualify for SSI and/or SSDI if they meet SSA's non-medical and medical disability standards (summarized above).
- Noncitizens who are **legal immigrants** (also called qualified or documented aliens) are people born in a foreign country who have been legally admitted to reside in the U.S. They may be eligible for SSI if they were blind or disabled or receiving SSI on 8/22/96, if they are permanent residents with a total of 40 credits of work in the U.S. (which may include a spouse's or parent's work), or if they are members of one of the following "exempt" groups:
 - Veterans or active duty members of the U.S. armed services who are qualified aliens and the spouses and children under 21 of these service members
 - American Indians born outside the U.S.
 - Certain noncitizens admitted as Amerasian immigrants
 - Cuban or Haitian entrants
 - Refugees and asylees¹⁸ during their first seven years after entering the U.S.
 - Those granted withholding of deportation during their first five years after entering the U.S.

Income and resources of all legal immigrants with a sponsor (someone who signed an affidavit of support when they entered the U.S.), must be deemed to include the income and resources of their sponsors and their sponsors' spouses. These "deeming" provisions make it extremely difficult for such immigrants to meet income eligibility requirements for SSI or Medicaid.

(Sources: National Alliance to End Homelessness: <http://www.endhomelessness.org/pub/immigration/imig3.htm>; SSA, SSI Benefits for Aliens: <http://www.ssa.gov/notices/supplementalsecurityincome/spotlights/spot-non-citizens.htm>)

¹⁷ The Personal Responsibility and Work Opportunity Reconciliation Act (Also known as PRWORA or the Welfare Reform Act) of 1996 (Public Law 104-193) and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (Public Law 104-208)

¹⁸ Refugees and asylees are people seeking protection from the U.S. on the grounds that they fear persecution in their homeland, based on their political opinion, national origin, or membership in a social group, religion or race. A *refugee* generally applies for protection from a place outside the U.S.; an *asylee* applies for protection after coming to the U.S.

Incarcerated persons

People who have qualified for SSI or SSDI usually cannot receive benefits while residing in a “public institution” (jail, prison, hospital, or mental health treatment center). The two disability programs have different requirements regarding whether and how benefits can resume following release.

- **Suspended versus Terminated Benefits**

Whether **SSI benefits** are suspended or terminated depends on the length of time a person is incarcerated. When incarceration lasts for a full calendar month but *less than 12 consecutive months*, benefits are suspended. Monthly payments can resume after SSA is informed of the person’s legal release and confirms that s/he still meets financial requirements only (disability does not have to be proved). When incarceration lasts *12 months or more*, benefits are terminated. A completely new application must be filed upon release, showing that the individual still meets all Federal disability standards.

SSDI benefits are suspended following felony conviction and incarceration for 30 days or longer, but are not terminated, no matter how long the individual is confined, so long as s/he continues to meet the Federal definition of disability (confirmed by continuing disability reviews performed at specified intervals which are established at the time of approval). Release from the correctional facility must be verified before payments can resume. If a worker's dependents qualify for SSDI, payments are not suspended or terminated while the worker is in jail.

- **Pre-release Agreements** Jails, prisons, and hospitals can enter into pre-release agreements with the local Social Security office to expedite applications and reapplications for SSI. When such an agreement exists, SSA processes claims more quickly, inmates have assistance in gathering information needed to support their application, and benefits are often payable immediately upon release or shortly thereafter.
- **Disability Applications during Incarceration** Inmates not receiving benefits when sent to jail can apply for SSI or SSDI while incarcerated, in anticipation of their release. An application is more likely to be successful if the prisoner is residing in an institution that has a pre-release agreement with SSA and has been identified by the institution as nearing release and likely to be disabled. Incarcerated persons usually need assistance to obtain the appropriate forms and gather the necessary evidence, and should apply as long as possible before their release date, so that payments can begin as soon as possible following release. Normally, review of an application takes about three months. If the application is approved before the inmate’s release, payments will begin on the first day of the calendar month following release. If the application is approved after the inmate is released, SSI (but not SSDI) benefits are backdated to the first day of the month following release.

(Source: Bazelon Center for Mental Health Law, 2001:

<http://www.bazelon.org/issues/criminalization/findingthekey.html>)

Fugitive Felons & Probation/Parole Violators

Fugitive felons and probation/parole violators are ineligible for SSI benefits. The Social Security Act states that an individual who has qualified for SSI will not receive payments in any month during which s/he is “fleeing to avoid prosecution, or custody or confinement after conviction ... for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees ... or violating a condition of probation or parole imposed under Federal or State law.” (U.S.C. § 1382(e)(4)(A) and (B)). The fugitive felon disqualification also applies to SSDI recipients.

The statute requires a **specific intent to flee**, however, and cannot be invoked just because an individual, for whatever reason, fails to appear for prosecution or for custody or confinement. There must also be a **warrant** issued on the basis of an appropriate finding that the individual is fleeing, or has fled to avoid prosecution, custody, or confinement (20 C.F.R. § 416.1339(b)(1)(i)).

SSA sometimes wrongly applies the disqualification to anyone with an outstanding felony warrant, even to those who are unaware of the warrant. Most such warrants are issued on the basis of a simple failure to appear and are unlikely to contain a finding as to the reason for the failure to appear. Among SSI recipients denied benefits under the “fleeing felon” statute, most are persons with severe mental illness or cognitive impairment, and it is likely that a disproportionate number are homeless people. (For information about how advocates can find relief for homeless clients who are neither fugitives nor felons, see McIntyre, 2003.) SSA will be issuing temporary instructions on this issue in January 2005, with permanent rulemaking to follow later in calendar year 2005.

(Sources: National Senior Citizens Law Center “Have You Seen a Fleeing Felon?” 12/27/01; McIntyre, 2003: http://www.nsclc.org/news/03/03/fleeingfelon_CRjanfeb2003.pdf)

LETTER-WRITING GUIDELINES

Requests for clinicians to write letters documenting medical impairments may come from patients, attorneys or case workers at the time of initial application, or may come from SSA or the State's disability determination services as it investigates an applicant's claim. The following guidelines for such letters are derived from an advocate's guide prepared by Peter H. D. McKee and from a curriculum for medical providers prepared by Paul Quick, M.D, Barry Zevin, MD, and Masa Rambo, FNP.¹⁹

1. **Review** the Listing of Impairments for each health problem that your patient has. Note the clinical findings and symptoms of each relevant impairment delineated in the Listing.
2. **Compare** the clinical findings and symptoms specified in the Listing with the findings recorded in your patient's medical record by you or any other medical provider.
3. **Write** a specific letter that
 - Gives your general past history of treatment and dealings with the patient; and specifies the length of your relationship and whether you are the treating physician;
 - Provides a candid observation of the severity and duration of the patient's impairments, documenting his/her relevant work history, age, height, weight, vital signs, relevant measurements, and physical examination results;
 - Gives objective evidence of the patient's impairments, one at a time, as defined by the Listing of Impairments, and compares exact findings or symptoms of the relevant listed impairment with the specific findings or symptoms of your patient;
 - Uses the recognized medical terms or measurements described in the age-appropriate Listing of Impairments;
 - If criteria for a listed impairment are not met, specifies the patient's functional limitations secondary to all specified disorders, how long they have lasted and are expected to last, the patient's ability to do basic work activities, and any special circumstances (whether the patient fits an adverse profile); and
 - Closes with a summary statement specifying what listing(s) is/are met or how the Listings are equaled, given all functional limitations taken together.
4. **Attach** all relevant chart notes and progress notes to the letter.

¹⁹ *An Advocate's In-Depth Guide to Social Security Disability and Medical Letter Guide*, prepared by Peter H. D. McKee, JD (Douglas, Drachler & McKee, LLP, 1904 3rd Ave., Ste 1030, Seattle, WA 98101; e-mail: PHDM@Qwest.net); PowerPoint presentation by Paul Quick, MD, Tom Waddell Health Center, San Francisco Department of Public Health (3/13/03). For examples of letters documenting impairments related to serious mental illness, readers are also referred to two forthcoming (2005) publications by the Substance Abuse and Mental Health Services Administration: *A Critical Role to Play: A Case Manager's Manual for Assisting People with Serious Mental Illnesses who are Homeless with Social Security Disability and Supplemental Security Income Applications* by Jeremy Rosen, JD, and Yvonne Perret, MSW; and *Stepping Stones to Recovery: A Training Curriculum for Case Managers Assisting People Who Are Homeless to Apply for SSI/SSDI Benefits* by Yvonne Perret.

EXAMPLES OF LETTERS SUPPORTING SUCCESSFUL DISABILITY CLAIMS

The following letters were written by medical providers working in Health Care for the Homeless projects in three different regions of the United States. The patients they describe were all awarded disability benefits based on the evidence provided by these clinicians. Each letter represents a slightly different strategy from the others.

- Letter #1 specifies a medical Listing met by the patient’s impairment and work-related functional limitations that resulted from it.
- Letter #2 focuses on two medical Listings as the primary basis for disability determination.
- Letter #3 documents multiple impairments which together are equivalent in severity to a Listing, and describes the patient’s residual functional capacity.
- Letter #4 focuses on functional limitations as the basis for disability determination, since the impairments described neither meet nor equal a medical Listing.

The physicians who composed and/or signed these letters made the following observations:

- **There is a significant amount of regional variation in how disability determination agencies work.** Some DDSs rely on treating sources more than others to identify medical Listings that are met or equaled by a claimant’s impairment(s). In Boston, for example, providing evidence that an impairment meets or is equal in severity to a Listing is sufficient for the DDS to determine the claimant disabled; no additional discussion of functional limitations is necessary. In San Francisco, some discussion of functional status is required in addition to presentation of evidence that a Listing has been met, particularly for patients with HIV or mental impairments.
- **Many medical providers do not feel competent to describe their patients’ functional impairments.** They are more comfortable specifying impairments that meet one or more medical Listings. Although this is the simplest way to document disability, not all patients have disabling conditions that meet or equal a medical Listing, yet many still qualify for SSI/SSDI based on medical-vocational considerations (42 percent of allowances in FY 2002).

“Physicians who work at the disability determination agencies or who testify as medical experts at Social Security hearings routinely rate the applicant’s ability to sit, stand, walk, lift, carry, and meet the functional requirements of work — based on a review of treatment records and without the advantage of ever having seen or spoken with the applicant. The law recognizes that any conflict between the functional assessment of a treating physician and the assessment of a non-examining physician should generally be resolved in favor of the treating physician. Therefore, treating physicians should be urged to describe their patients’ functional limitations to the extent possible.”

— David Ettinger, JD

Although this can be challenging in general, it is sometimes easier in the case of homeless applicants who must rely upon charitable organizations for all meals, shelter, and clothing. Some providers ask their clinical staff whether they would want to depend on the claimant for a job they counted on, and if not, why they would not want this person to work for them. This helps to stimulate thinking about what the patient’s functional incapacity is. (To facilitate this process, clinicians are encouraged to use the sample physical and mental assessment forms appended after the letter examples.)

Documenting Disability: Simple Strategies for Medical Providers

November 12, 2004

Re: L J

SS# xxx-xx-xxxx

To Whom It May Concern:

I am writing this letter on behalf of L J, a patient of mine at the Austin Cook County Health Center, in support of her claim for disability. She has been a patient at our health center since 5/99 and my patient since 11/00. She has been seen in the clinic an average of 5 times a year during that time period.

Ms. J had a central nervous system cerebro-vascular accident on July 6, 2004 which has left her with significant persistent deficits in right arm and right leg. Her impairments include the following:

Gait and Right lower extremity: She has an unsteady gait that has made her unable to walk safely at a constant rate on a treadmill with the physical therapists. Her therapy goal was to walk on a level treadmill at three miles per hour for 10 minutes. She could not keep herself centered on the treadmill and would have fallen repeatedly had she not been supported by the hand rails. She was unable to walk for more than two minutes at a time. Her right hip flexion strength is 3/5. She steps to the right when trying to walk with her feet in tandem.

Right upper extremity: Ms. J is right handed. She carries her right arm in a flexed posture when walking. Her right upper extremity strength is 3/5 in flexion and extension at the elbow, and 3/5 in shoulder abduction. She has mildly reduced rapid alternating movements with her right hand and severely reduced ability to write or sign her name. She also has subjective numbness throughout her right arm and moderately reduced ability to identify objects placed in her right hand. She can not carry anything of significant weight (over 2 pounds) in her right hand.

In my opinion, L J is permanently disabled as a result of her stroke. She meets Social Security listing **11.04** as described in the online Blue Book. She has significant and persistent (over 3 months) disorganization of motor function in 2 extremities (right arm and right leg) resulting in sustained disturbance of gross (inability to carry objects) and dexterous (inability to write) movements or gait and station (her gait is abnormal and unsteady).

L J also meets the functional requirements for a musculoskeletal listing described at section 1.00 of the listings. She requires a walker for distances as short as a single block and cannot sustain effective ambulation. Her use of the right arm is so restricted that she cannot prepare a simple meal or feed herself without assistance.

During an eight-hour work day, L J could stand or walk no more than one hour. She can sit without limitation. She is not limited in the ability to lift with her left arm, but she can lift no more than two pounds with her right arm.

L J has not had a mental evaluation since her stroke, but she has complained of memory loss and an inability to concentrate. If her disability claim cannot be favorably resolved based upon her physical limitations, I would recommend that a neuropsychological evaluation be obtained.

If you have any additional specific questions about her condition, please let me know. I am enclosing copies of my relevant treatment records.

Sincerely,

David Buchanan, MD
Attending Physician
John Stroger Hospital of Cook County
Board Certified in Internal Medicine
Assistant Professor, Rush University

11.04 Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

*Listing of Impairment cited in the preceding letter
Source: 2003 SSA Blue Book*

Documenting Disability: Simple Strategies for Medical Providers

January 4, 2000

RE: SS# / /
DOB: / /

To Whom It May Concern:

I have known Mr. S for the past 15 years, during which time I have cared for this gentleman frequently while working as the Boston Health Care for the Homeless Program's physician at Boston Medical Center, Massachusetts General Hospital, Pine Street Inn Nurses' Clinic, and as a member of the outreach teams serving individuals living on the streets of Boston. His medical and psychiatric issues are very complex, and shadowed in a relatively obscure history (most of his medical charts have either been lost or are unavailable to us).

In my professional opinion, this gentleman is totally disabled and unable to partake in substantial gainful activity. He meets the criteria noted in the Listing of Impairments under both Section 11.08 (Neurology, Spinal Cord and Nerve Root Lesions) and Section 12.02 (Mental, Organic Mental Disorders).

Mr. S's life has been decidedly tragic. He apparently left school in the 8th grade, although the circumstances are unclear. On July 19, 1968, at the age of 17, he sustained severe head trauma with facial fractures, loss of the left eye, and brachial plexus injuries with left arm paralysis and muscle contractions when he was struck by a train. Once again, we have few details about the circumstances surrounding this accident. He apparently was in coma for several weeks, and remained hospitalized for approximately six months. The injuries were substantial and devastating. He sustained severe blunt head trauma that left him with a permanent deformity. His left eye required enucleation, and has been a continual source of purulent drainage and intermittent infections since that time. His brachial plexus was severely compromised, and resulted in paralysis of his left biceps and triceps as well as contraction deformities of the left wrist, PIP, and DIP joints. This brachial plexus injury has also caused considerable vascular compromise, and he has well-documented episodes of recurrent frostbite as well as left hand and arm cellulitis. When last evaluated by the vascular surgeons at Boston Medical Center in December, 1998, the plan was to consider either surgical revision of the arm and vasculature or amputation.

Despite these debilitating injuries, Mr. S apparently attempted to work menial jobs from 1970-1974. He was unable to keep these jobs, although we do not know why. At some point during the rehabilitation from his accident, he began to use alcohol heavily. By 1974, at the age of 23, he became literally homeless and has essentially been living in the shelters or on the streets for the past 25 years.

I have thoroughly reviewed Mr. S's most recent chart at Boston Medical Center, which includes the past two years. He has been seen in the emergency department on at least 45 occasions, generally for grand mal seizures, pancreatitis, frostbite, or cellulitis. The ED visits have a tragic monotony, ending virtually always in his refusal to accept hospital or detox admission and an abrupt departure against medical advice. He rarely remains long enough for diagnostic studies, and I was unable to find documentation of a single EEG during this two-year period (although there are references to "abnormal EEGs in the past"). We have also facilitated multiple admissions to detoxification units for Mr. S through our outreach clinic sites, but he again has rarely been able to tolerate more than 2-3 days in any facility.

It is necessary to sort out his substance abuse issues from his underlying medical problems. While alcohol has been a relapsing and debilitating component of his life in the shelters and on the streets for the past 25 years, his head trauma and the brachial plexus injuries preceded his alcoholism and remain the major reason for his disability:

- (1) The severe nerve root and brachial plexus injury have left him with paralysis of the left upper arm and contractions of the musculature of his forearm and hands. The vascular compromise from this injury has resulted in repeated episodes of frostbite and cellulitis, even under conditions of mild exposure with ambient temperatures in the 40s. This significant and persistent disorganization of motor function in the left upper extremity in the setting of his brachial plexus injury meets the primary criteria for disability under Section 11.08 of the Listing of Impairments.
- (2) His primary disability is an organic mental disorder, and he meets the criteria listed in Section 12.02 of the Listing of Impairments. His massive head trauma resulted in multiple facial fractures (left orbit, zygoma, maxillary sinus), loss of the left eye, and increased intracranial pressure resulting in prolonged coma and requiring decompression with burr holes. This severe damage to the left frontal lobe is undoubtedly the focus of his seizures and most likely explains his disturbances of mood and his emotional lability with well-documented irritability and explosive outbursts. Alcohol clearly has lowered his seizure threshold, but cannot explain his entire history of seizures, many of which have come (by his report during several prolonged periods of incarceration) while sober and on Dilantin with adequate serum levels.

Most significantly, a head CT scan in September 1998 showed evidence of old burr holes as well as longstanding encephalomalacia in the left frontal lobe, cerebellar atrophy, and ventricular prominence resulting from volume loss. To be specific, Mr. S easily meets the required level of severity for an organic mental disorder. He demonstrates (A) marked affective changes since his head trauma that predate his use of alcohol and have resulted in mood disturbances and emotional lability that have resulted in (B) marked difficulties in maintaining social functioning (as evidenced by 25 years of homelessness and loss of family and social supports) and repeated episodes of deterioration (as evidenced by his inability to remain in hospital or detoxification facilities).

I hope that this letter has been helpful in assessing this most unfortunate gentleman whose life has been devastated by the head trauma and nerve root injuries he sustained at a young age. In my professional opinion, he is totally disabled. Please feel free to call me any-time with further questions.

Respectfully,

James J. O'Connell, M.D.
Boston Health Care for the Homeless Program
Departments of Medicine
Boston Medical Center and Massachusetts General Hospital

11.08 Spinal cord or nerve root lesions, due to any cause with disorganization of motor function as described in 11.04B.

11.04 Central nervous system vascular accident.

With one of the following more than 3 months post-vascular accident:

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.00 Neurological:

C. Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

*Listing of Impairment specified in the preceding letter
Source: 2003 SSA Blue Book*

12.02 Organic mental disorders: Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., Luria-Nebraska, Halstead-Reitan, etc;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic organic mental disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

*Listing of Impairment specified in the preceding letter
Source: 2003 SSA Blue Book*

Documenting Disability: Simple Strategies for Medical Providers

May __, 2004

Re: D. A.

SSN: ___ - ___ - ____

DOB: __/__/__

MRN: _____

To Whom It May Concern:

I am writing as the primary treating physician of D.A. (DOB __/__/__). I have been treating him since 5/3/02 and seeing him at intervals of 1 week due to the complexity of his medical and mental health conditions. His previous medical care has been received in correctional facilities and at San Francisco General Hospital where he is currently under a court mandated restraining order which prevents him from receiving care there. I have reviewed his extensive past medical records (1993-2002). The following are current active medical problems for this patient:

1) Chronic Abdominal Pain: The patient has had multiple abdominal surgeries since childhood. He suffers from chronic pain especially in the left flank and left lower quadrant areas. The pain is constant and unremitting with periodic increases in intensity several times a day. The pain has been attributed to intra-abdominal adhesions which are not amenable to surgical treatment. The pain is also likely related to recurrent kidney stones and extensive past instrumentation of his urinary tract. The patient has a history of left kidney vascular and ureteral malformations which have led to multiple episodes of nephrolithiasis, hydronephrosis, and required multiple surgeries. He has a history of recurrent uric acid kidney stones. He has required high doses of opiate analgesic medication for at least the last 10 years.

2) Bilateral Inguinal Hernia: The patient has bilateral inguinal hernias which are awaiting repair. These have been present and causing the patient pain for greater than 1 year. At this time surgical consultation is underway. The hernias are a source of pain and limitation in exertion.

3) Degenerative Joint Disease/neuropathic pain: The patient complains of chronic joint pains in his knees and other joints. He has had multiple traumas and accidents and likely has post traumatic arthritis. He also complains of burning/pins and needles type pain in both lower extremities left worse than right. He reports some improvement with gabapentin and indomethacin.

4) Asthma and frequent lower respiratory infections: Patient has had 2 episodes of pneumonia in the past 1 year and several episodes in the past and is frequently dyspneic with exertion. He reports some relief with bronchodilatory inhalers.

5) Personality Disorder/History of impulsive, violent, and threatening behavior: The patient has a history of multiple traumatic incidents. He has been incarcerated multiple times. His medical treatment has been compromised by the fact that he violently threatened his previous physician who could no longer treat him and obtained a restraining order keeping the patient away from the entire San Francisco General Hospital. The patient feels he has anxiety from traumas which occurred while he was in prison. Professionals who have interacted with him in the past have noted his anti-social behavior and threats of violence. The patient has poor insight into this and feels his behaviors have been misunderstood but it is clear from his history that he has anti-social personality disorder and poses a potential threat in any work or social environment. The patient also has an impulse control disorder and exhibits very poor judgment.

6) Substance Abuse: The patient reports previous use of stimulants as his primary problem. He reports previous loss of control of his use of opiate medications. At present he reports he is not using amphetamines, cocaine, heroin, or any other non-prescribed medications. He does not drink alcohol and reports that he is subject to random drug testing as a condition of his parole.

7) Hepatitis C Infection: The patient has positive hepatitis C antibody test. Further work up has not been done but his symptoms of fatigue and neuropathy may be attributable to this.

Physical Exam:

Patient appears stated age, somewhat disheveled with poor grooming

HEENT: EOMI, PERRLA, fundi nl. mouth and throat nl, poor dentition with multiple missing teeth and caries

Neck: - adenopathy, - thyromegaly, full ROM

Chest: Exp. wheezes and rhonchi, -rales, - dullness

COR: RRR, SIS2, - murmur, pulses nl.

Abd.: multiple healed surgical scars, diffuse tenderness, - rigidity, - point tenderness, + punch tenderness over left flank, bilat. inguinal hernia reducible with some difficulty and pain

Ext.: +crepitation L knee, full ROM at all joints, - edema

Neuro: alert, oriented x3, CNII-XII nl and symmetrical, strength and sensory nl. and symmetrical

Psych: Patient appears anxious and at times impatient, thought content is predominated by his chronic pain, complex medical history, and anger and frustration that he cannot physically perform his previously normal activities. He is homeless and has minimal social supports, no family support network, no social network. He has not appeared intoxicated or impaired in any encounter. -SI, - HI

Current medical plan: refer patient for surgical repair of bilat hernia, refer patient to comprehensive pain management center (requires Medi-Cal or other medical insurance)

Continue current meds - oxycodone with tylenol 5/325 6/d, indomethacin 25mg 3 bid, gabapentin 300mg 3tid, albuterol inhaler, hydroxyzine 25mg q8hr prn

In Summary:

This unfortunate 40 year old man is currently homeless and socially isolated. His past records and current exam demonstrate long term chronic severe pain. He also has a personality disorder which has caused him to be involved in many violent situations and extensive conflict. In particular this has caused him to be prevented from receiving medical care at the only public hospital in San Francisco. He has a long history of substance abuse but is currently not using drugs. He appears to have some insight into this problem. His ability to respond appropriately to supervisors or co-workers is highly doubtful due to his personality disorder and the poor prognosis for improvement of these types of conditions. It has been felt that his potential to actually commit violent acts is high. Due to chronic pain his concentration and persistence in tasks are very poor. Mr. A's arthritis and lung disease would prevent him from performing a job which required the ability to stand or walk more than two hour in a work day or to lift more than 15 pounds occasionally. If Mr. A follows through with all medical plans he may achieve some general improvement in his functional level but I do not anticipate that even with the maximum expected improvement and continuing abstinence from drugs that he will ever be able to work again. I have attached copies of my relevant treatment records.

Barry Zevin MD
Internal Medicine
Medical Director, Homeless and Community Services
Tom Waddell Health Center

Documenting Disability: Simple Strategies for Medical Providers

May 12, 2004

Re: E. A.

SSN: ___ - ___ - ___

DOB: ___/___/___

MRN: _____

Social Security Analyst:

Mr. _____ of the Disability Evaluation Assistance Program referred Mr. E. A. for a medical consultative examination. He was evaluated today in collaboration with Dr. Barry Zevin. Medical records from San Francisco General Hospital and South East Health Center were also used for this report.

Mr. A. was raised in San Francisco. He was a junior high and high school athlete, primarily running track, and playing football and basketball. He left high school in the 12th grade to join the job corps and never finished his GED. He states he is quite illiterate. He can read some words and a few sentences in the newspaper, and has trouble spelling. He does not write very well.

After high school he worked in a car wash for approximately 10 years and later became a security guard. He only did security for about 6 months when he was forced to quit due to severe knee pain. He worked off and on, the last job was sweeping the streets for SLUG, which he enjoyed but was only able to do for 6 months, again leaving due to too much missed work from the knee pain and progressive hip pain. His last day of work was 9/11/01.

He now complains of bilateral knee pain, bilateral hip avascular necrosis, benign prostatic hypertrophy and some recurrent "distress", with some depression in the last year. His wife of 23 years passed away 1 year ago and he is having great difficulty adjusting. He has 3 grown children whom he sees only occasionally. He is currently on GA and is living with his grandmother. He states his greatest problem is the constant, throbbing and shooting pain he experiences. He complains of great difficulty using public transportation. He can not get on the "kneeling bus" without using both hands and arms to pull him up the stairs. He states he is unable to carry groceries and cannot sweep or vacuum. He is able to stand for short periods of time to do dishes.

Medical Problems:

Bilateral hip pain

He describes severe aching and shooting pain in his left hip for the last 3-4 years. He was sent to the orthopedic clinic at SFGH. They performed a left hip core decompression for avascular necrosis on 7/25/03. He continues to have constant pain, 8/10 on a pain scale of 1-10, 10 being the worst possible pain. He is being treated with Tylenol with Codiene #3, two every 4-6 hours without relief. He describes the pain as shooting down the side of his leg, sometimes accompanied by a warm sensation of hot oil going down the front. MRI dated 4/22, 2004 shows core decompression of the left hip with granulation and continued avascular necrosis (AVN). The right is without AVN of the trochanteric head but does show inter-trochanteric necrosis. These conditions are consistent with the amount of pain he is experiencing. Due to a GI bleed he is unable to take NSAID's.

Knees

He complains of recurrent, worsening bilateral knee pain. He remembers being told that he needed "knee cap replacement" with a plastic patella. He was afraid of the surgery and did not pursue it. He was diagnosed with patellofemoral syndrome on the left, after the core decompression of his hip. Plain films from January 8, 2004 show bilateral infarcts of the distal diaphysis of the right and left femur and a bony infarct involving the posteromedial left tibia.

Left arm radiculopathy

He has left arm numbness and a deep ache. The pain is intermittent and often disturbs his sleep. An MRI is scheduled for July 12, 2004 to further evaluate the cause of the radiculopathy.

Low Back Pain

MRI of the lumbar spine dated 4/22/04 showed broad based disk bulges of L3-4, L4-5 and L5-S1. There appears to be mild canal stenosis and the bulges may be touching the L5 and S1 nerve routes.

Substance Use

He describes using drugs and alcohol since the age of 13. He became clean and sober 5 years ago and remains so today. He describes the last year being difficult since his wife's death but he is proud of himself for not using drugs.

Benign Prostatic Hypertrophy

He has a history of urinary dripping and frequency, which is being followed by a Urologist. He is taking Terazosin 10 mg daily with moderate relief.

Findings:

General: Mr. A arrived on time for his appointment. He was clean and well dressed and walked with a cane and a significant broad based limp. He was unable to do the heel to toe walk or walk on his heels and toes without holding on to the walls. He was pleasant and articulate however he had a depressed affect. He seemed somewhat distressed in his speech. He squirmed frequently in his chair and had very frequent spasmodic jerking. He attempted all requested maneuvers with moderate difficulty in carrying them out.

Height: 70", Weight: 164 lbs., B/P sitting (R): 140/82, Pulse: 72

HEENT: Unremarkable

Spine: Tender midline at the lumbosacral area. Decreased range of motion with lateral bending bilaterally, limited by pain and loss of flexibility. He did have positive straight leg raises on the right while supine.

Upper Extremities: Full ROM and strength equal bilaterally.

Cor: Bounding without murmur. Skin is warm and dry.

Pulm: Clear to auscultation, all lobes.

Abd: Liver tender, not enlarged

Lower Extremities: Both knees were painful with flexion. Able to perform a ~ 30° deep knee bend. Crepitus present bilaterally on passive and active range of motion. He had significant hip pain with flexion limited to ~80° / 110° on the left. There was significant loss of internal and external rotation of the left hip. The right hip was painful with all maneuvers, with moderate generalized limited range of motion.

Neuro:

DTR's	Biceps	Triceps	Patellar	Achilles
Right	1+	1+	1+	0
Left	1+	1+	1+	0

Summary

Mr. A is a pleasant 52 year old man. He suffers from significant deep-seated pain in both of his hips and knees as a result of many different disease processes. The progressive nature of the avascular necrosis, intertrochanteric necrosis and bony infarcts in all weight bearing joints, has become almost totally debilitating. Given his long and active athletic and work history, it is evident that he would work if he possibly could. He has made many attempts to maintain work only to have to quit due to the pain and lack of physical endurance. He is still in the process of a workup for his upper extremity radiculopathy.

Observation of him and his physical state during the interview and exam showed him to be in severe discomfort with sitting for even a short period of time. His grimacing and spasmodic jerking from pain were very distracting and obviously debilitating. His broad based gait and limp, assisted by a cane was slow and labored. His depressed / distressed affect could certainly be from the severity of his chronic pain.

I do not believe that Mr. A can sit or stand for more than 15 minutes without the opportunity to alternate position. He cannot walk without the use of a cane. While he holds his cane in his dominant right hand, his use of the left arm/hand is severely restricted by radiculopathy. Although he can use his right hand to lift when in the seated position, he cannot carry even 10 pound weights. He has chronic pain while on a high dose of narcotic medication. His ability to concentrate is severely impaired. His past history of substance use is not material to his case.

If he were to be awarded disability benefits, I believe he would be able to manage his own funds without difficulty. I have enclosed copies of my relevant treatment records.

Sincerely yours,

Masa Rambo, RN, MS, FNP
 Barry Zevin, MD
 Diplomate, American Board of Internal Medicine

PHYSICAL ASSESSMENT

NAME OF PATIENT _____ SSN _____

In addition to your examination/treatment records for this patient, please provide a medical assessment of your patient's physical capacities/limitations as of the earlier of the following two dates:

- Date of last visit _____, or
- _____, end of period being evaluated

A. The patient has no impairment-related physical limitations; or

B. In relation to the impairment(s), the patient retains the capacity to:

1. Occasionally lift and/or carry (including upward pulling) for up to 1/3rd of an 8-hour workday a maximum of: What are the medical findings that support this assessment?
 - less than 10 pounds
 - 10 pounds
 - 20 pounds
 - 50 pounds
 - 100 pounds
 - cannot assess

2. Frequently lift and/or carry from 1/3rd to 2/3rds of an 8-hour workday a maximum of: What are the medical findings that support this assessment?
 - 10 pounds
 - 25 pounds
 - 50 pounds
 - cannot assess

3. Stand and/or walk (with normal breaks) for a total of: What are the medical findings that support this assessment?
 - less than 2 hours in an 8-hour workday
 - at least 2 hours in an 8-hour workday
 - about 6 hours in an 8-hour workday
 - cannot assess

4. Sit (with normal breaks) for a total of: What are the medical findings that support this assessment?
 - less than about 6 hours in an 8-hour workday
 - about 6 hours in an 8-hour workday
 - cannot assess

PHYSICAL ASSESSMENT (Continued)

C. The patient has other impairment-related physical limitations.

Please describe any other significant physical limitations such as postural, manipulative, environmental, visual, aural, speech, etc.

What are the medical findings that support this assessment?

SIGNATURE: _____
PHYSICIAN

DATE: _____

adapted from DDS-113P HS-2065 (12-88)

MENTAL ASSESSMENT

NAME OF PATIENT _____ **SSN** _____

Please evaluate this patient's mental abilities in terms of the individual's capacity to sustain the ability over a normal workday and workweek on an ongoing basis.

	Unable To Determine	Not Significantly Limited	Moderately Limited	Markedly Limited*
A. <u>UNDERSTANDING AND MEMORY</u>				
1. The ability to remember work-like procedures.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. The ability to understand and remember very short and simple instructions.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
B. <u>SUSTAINED CONCENTRATION AND PERSISTENCE</u>				
3. The ability to carry out very short and simple instructions.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. The ability to maintain attention for extended periods of two hour segments.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. The ability to maintain regular attendance, and be punctual within customary tolerances. (These tolerances are usually strict.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. The ability to sustain an ordinary routine without special supervision.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. The ability to work in coordination with or proximity to others without being unduly distracted by them.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8. The ability to make simple work-related decisions.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. The ability to complete a normal workday and work-week without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

MENTAL ASSESSMENT (Continued)

	Unable To De- termine	Not Sig- nificantly Limited	Moder- ately Limited	Mark- edly Limited*
C. SOCIAL INTERACTION				
10. The ability to ask simple questions or request assistance.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11. The ability to accept instructions and respond appropriately to criticism from supervisors.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12. The ability to get along with coworkers and peers without unduly distracting them or exhibiting behavioral extremes.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
D. ADAPTATION				
13. The ability to respond appropriately to changes in a routine work setting.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
14. The ability to be aware of normal hazards and take appropriate precautions.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

* A marked limitation is more than moderate, but less than extreme. An individual need not be totally precluded from performing an activity to have a marked limitation as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

Please describe the mental impairments which are the source of any limitations noted above:

SIGNATURE: _____
PHYSICIAN OR PSYCHOLOGIST

DATE: _____

*form created by David Ettinger, JD
 Legal Aid Society, Nashville, TN*

RESOURCES

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WEBSITES:

Centers for Disease Control and Prevention:
How to obtain vital records to verify eligibility
for SSI or other benefits in all 50 States

<http://www.cdc.gov/nchs/>

Centers for Medicare and Medicaid Services
First Step, Income Assistance:

<http://www.cms.hhs.gov/medicaid/homeless/>

HCH Clinicians’ Network, National
Health Care for the Homeless Council:

<http://www.nhchc.org/>

Health and Disability Advocates:

<http://www.hdadvocates.org/index.htm>

Health Resources and Services Administration
HIPAA website:

<http://www.hrsa.gov/website.htm>

National Law Center on Homelessness
and Poverty:

<http://www.nlchp.org/>

National Organization of Social Security
Claimants’ Representatives:

<http://www.nosscr.org>

Social Security Online:
Service to the Homeless:
Blue Book:

<http://www.ssa.gov/>

<http://www.ssa.gov/homelessness/>

<http://www.ssa.gov/disability/professionals/bluebook>

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership association that unites care providers from many disciplines who are committed to improving the health and quality of life of homeless people. The Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is operated by the National Health Care for the Homeless Council, and our efforts are supported by the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and member dues. The Network is governed by a Steering Committee representing diverse community and professional interests. To become a member or order Network materials, call 615 226-2292 or write to network@nhchc.org.

ABOUT THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

The National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to homeless people, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness. Please visit our Web site at <http://www.nhchc.org>.