Evidence is the Key to Winning!

The quality of medical evidence and your effectiveness in extracting information from it will largely determine whether or not you win the case. In this module, we will show you how to evaluate medical evidence.

Regardless of your background, this lesson is critical to your understanding of Social Security case evaluation. Learning to evaluate medical evidence is an important skill that must be mastered to function successfully in this field.

Common Sense Evidence Evaluation

You should always evaluate medical evidence from a functional standpoint. Note how the claimant's symptoms affects his/her ability to function within a normal home and working environment. Most disability decisions are based on how the claimant's symptoms affect his/her ability to perform work. The stronger the medical evidence supporting a given limitation, the more likely SSA will accept it. When reviewing evidence, focus on how the claimant's alleged limitations restrict his/her ability to work.

Quality of Evidence

The quality of the supporting medical evidence is very important. Good quality evidence addresses all alleged issues suffered by the claimant. You should evaluate both primary and secondary impairments, combine the limitations and determine their effect on the claimant's ability to perform work.

Supporting medical evidence should be no older than six months prior to the onset date. The evidence should show the progression and treatment of the claimant's disorder leading to the most current date. Good quality evidence should be:

- Legible
- Timely

- Pertinent
- Meet SSA Standards
- Release is properly endorsed by client.
- Signed by the appropriate health professional.

Purpose for Evaluating Medical Evidence

Medical evidence is used in a disability claim to prove that a claimant is suffering from a severe limiting disorder that prevents work. An argument for disability must hold up under close scrutiny by SSA. Any medical finding that shows the claimant to be functionally impaired is a critical piece of evidence.

Medical Evidence of Record_

Any evidence used in the evaluation of a Social Security disability claim is referred to as Evidence of Record. Each claimant allegation must be accompanied by medical evidence. SSA will request and purchase records if needed. SSA is required to make sure that all of the claimant's alleged impairments are addressed by the evidence before making a decision.

On appeal levels, the majority of evidence will already have been collected by you, the claimant or the DDS examiner. It's always a good idea to encourage the claimant to get copies of his/her own evidence regardless of source or claim level. Both the claimant and the Advocate will have greater flexibility if the evidence is readily available to them.

Having the evidence on hand also allows for faster case processing. When you accept a case, you'll have legal access to all accumulated evidence in the case. You can use the claimant's medical evidence at any level to formulate your argument.

Sources of Medical Evidence

The claimant may allege disability due to a physical or mental impairment or both. There]s no limit to the number of impairments a claimant can allege, so it's common to have medical evidence from many different professional sources. A typical disability case may contain medical data from attending physicians, outpatient clinics, specialists, psychologists, hospital records, surgical summaries, outpatient records, nurse's notes, etc. Only request

records that directly address the claimant's primary or secondary diagnosis. Your record request should cover the entire period of disability.

Period of Disability

The Period of Disability is the time period from the date the disability stopped the claimant from working to the most current date. You should seek medical evidence covering this period of time.

Types of Medical Evidence

A typical disability case will contain some or all of the following types of medical evidence of record:

1. Narrative Reports from Medical Doctors

This is a common type of medical evidence and can come from many different types of physicians. This form of evidence usually provides specific information about the claimant's condition. The physician may also offer his/her opinion as to the extent of the claimant's disability and he may even elaborate on client limitations. If this data is not present, you can request a doctors opinion as to the claimant's remaining functionality.

2. SSA Questionnaires

A questionnaire is a pre-developed form sent to the claimant or his/her physician in order to extract specific information about a given medical or mental disorder. SSA often sends a questionnaire to the claimant regarding his/her daily activities. Questionnaires are also used to address specific issues to determine the characteristics of a symptom like chest pain or shortness of breath.

If your client receives an SSA questionnaire, it's a good idea to assist_the claimant in filling out the form. SSA_uses questionnaires in various ways. SSA will send these forms to the claimant or a family member asking them to describe the claimant's daily activities. This is in fact a common ploy used by SSA to get the client to deny himself.

For example, the claimant states in his application that he is unable to stand and walk for more than ten minutes. In a questionnaire sent to his wife, she

mentions that he lifts weights three times weekly. There is clearly a conflict in the claimant's description of limitation compared to that of the wife. SSA may accept the wife's description and deny the case. If the claimant indicates a higher level of activity than is alleged in his/her application, SSA will use this information to justify a denial of benefits.

3. Hospital Records: Inpatient

Inpatient hospital records are another common type of medical evidence. Most inpatient hospital records contain an admission and discharge summary which describes the claimant's hospital stay in a couple of pages. Requesting the discharge summary can significantly reduce the number of pages in your client's folder! You really don't need to send for every page of a hospital report. All you need are the records that directly address the impairment and it's effect on the claimant's ability to work.

Inpatient hospital records may also contain medical data such as laboratory tests, pathology reports, surgical reports, x-rays and more that may have occurred during the hospital stay. Always request this hard data. Inpatient hospital records can be one of your best sources of specific medical documentation.

4. Hospital Reports: Outpatient

Hospital outpatient records can also be valuable to a disability case. If a claimant is treated at a hospital outpatient clinic, there may be one or more clinic notes on file. You should treat these clinic notes the same as any other doctor's report.

Note: Never request medical records that have nothing to do with the claimant's alleged impairment!

5. Consultative Examinations

A medical examination, lab test or any other procedure ordered and paid for by SSA is referred to as a Consultative Examination. SSA will only order this

examination when the medical evidence of record is insufficient or too old to establish the claimant's current medical status.

You have the option to use SSA's medical source or the claimant's family doctor for a consultative examination. We suggest you use the claimant's family physician if he/she is a supporter of the claimant's inability to work.

If you feel that the examination isn't necessary for a favorable decision, point this out to SSA. However, if SSA orders the claimant to attend a consultative examination, make sure the claimant attends. Otherwise, SSA will deny the case based on the claimant's failure to cooperate.

6. Special Procedure Reports

This type of documentation is usually found in hospital records. Special Procedure reports include tests like angiography, CAT scans, biopsies, etc. These types of reports can be invaluable because some are capable of pinpointing very strong evidence supporting the claimant's allegations. Incorporate these abnormal findings into your argument.

7. Military or VA Hospital Reports

Treat information from military facilities the same as any other evidence of record. Look for the same findings in these reports as you would in any other hospital report.

8. Activities of Daily Living Reports

A DDS Examiner may send the claimant or his family member an Activities of Daily Living (ADL) questionnaire. This form asks the recipient to describe the claimant's daily activities. The purpose of this communication is to see if the claimant is as restricted as claimed. If the third party report is inconsistent with the claimant's allegations, SSA might deny the case. SSA accepts third party reports as a means of determining consistency in limitation. Thus, ADL reports are extremely important to a disability claim. If the claimant's ADLs are consistent with his alleged limitations, this will help you to win the case.

9._ Chiropractic Reports

SSA does not consider chiropractic reports to be an acceptable form of medical evidence in making a final disability decision. However, you shouldn't ignore this source. Although chiropractic reports aren't allowable in establishing a disabling condition under SSA regulations, they can be used as supportive evidence if the condition has been previously diagnosed by a medical doctor.

We recommend using chiropractic reports to support orthopedic impairments previously diagnosed by an MD - especially when there's little other supporting evidence in file. Chiropractic reports also show that the claimant has made an effort to acquire treatment and relief, which suggests a chronic disorder with long term disabling symptoms.

Medical Record Confidentiality

As the claimant's authorized representative, you have as much right to access case information as the claimant himself. Federal law clearly states that all case information is to be kept strictly confidential and should not be available to anyone except those with authorized access to these materials.

Even if you break the confidentiality rule unintentionally, SSA could bar you from performing as a representative. So be careful! Do not share information about a claimant or his/her case with anyone outside of your firm. Also make sure that your staff understands and abides by SSA's confidentiality rules.

Common Sense Medical Review

Evaluating a claimant's medical evidence is an extremely important part of the Social Security disability process. It's a common assumption that only medical professionals can be effective advocates because they can read the medical evidence. To make it possible for individuals without medical training to be effective advocates, we have developed a unique method of reviewing medical documentation called Key-Point Extraction. See Module Two.

The Invisible Relationship

There is a subtle but extremely important relationship that flows from Diagnosis to Signs, Symptoms and Limitations. If you understand this relationship,

winning disability claims will be a breeze.

Every medical disorder has characteristic medical signs and symptoms. Once you identify a disease's symptoms, you can infer reasonable physical or mental limitations. Identifying the relationship between the alleged disease, its medical signs and symptoms and the limitations it causes, enables you to create an argument for a reduced RFC.

Example: Your client suffers from multi-level degenerative disc disease. He complains of severe back pain on walking, bending and sitting.

You acquire a copy of the claimant's medical records that verify both the diagnosis and the alleged physical limitations. You're a careful Disability Advocate, so you look up the claimant's specific diagnosis online or in a medical text. You discover that a person with this diagnosis may also suffer from numbness and weakness in the lower extremities.

You call the claimant and ask him, Do you ever experience numbness and/or weakness in the legs? He replies, I suffer from both. In fact, I fell down a flight of stairs because of my leg weakness.

In the above example, a little research and one question provided the starting point for your strategy to reduce the claimant's RFC. All genuine medical conditions will have associated signs and symptoms. A medical sign is much more important because it represents hard evidence. A Sign is a hard piece of evidence like a laboratory test or examination that shows proof the condition exists. If the condition is severe, you can expect the symptoms to be severe.

The more severe a claimant's symptoms, the more restrictive the limitations it causes.

Symptoms cause limitations that can reduce a person's ability to perform work. With many medical conditions, a little common sense and research will help you to determine how the condition limits the claimant.

Medical signs support your argument. A pathology report for example will verify the existence of a cancer and indicate the degree of severity. An X-ray can show the existence of a severe injury or chronic disorder like degenerative disc disease. Remember, a sign is a hard piece of evidence that proves the existence of an impairment.

The Medical Evaluation

The steps a Disability Advocate takes in processing a disability case are:

1. Client Interview - Collecting of client data.
2. Case Assessment - Determine case viability.
3. Case Acceptance or Intake - Process case and become the authorized representative.
4. Case Development - Request copies of all relevant medical evidence.
5. Case Evaluation - Review evidence and formulate a strategy.
6. Argument Creation - Create an argument based on your strategy.

Discussion of Specific Medical Conditions

The Case Evaluation or the review of medical evidence is an important part of any disability claim. The evidence enables you to identify evidence that supports claimant's alleged limitations. You can find a discussion of specific disease states in the SSDG. In part 2 of Medical Evidence segment, we'll delve deeper into the process of evaluating medical evidence.