Key Point Extraction is the act of reviewing medical documentation for the purpose of identifying signs and symptoms. These signs and symptoms are used to identify physical limitations that support a reduced Residual Functional Capacity (RFC).

No Medical Background

A successful advocate does not need to be a medical professional. However, if you have no medical background, how are you going to effectively evaluate your client's medical evidence? The answer is Key-Point-Extraction (KPE).

Part of my formal education was as a primary health-care Physician Assistant. This medical background gave me a tremendous advantage when I entered Social Security. It was effortless for me to evaluate a claimant's medical data and extract those elements needed to prove the case.

As an advocate trainer, I faced a new problem. How do I teach a non-medical professional to properly review medical evidence? While I can teach you to be a disability advocate, I'm not qualified to make you a medical professional.

To address this issue, I invented the Key-Point-Extraction (KPE) process. This process is a common sense approach to the evaluation of medical evidence. KPE will enable you to recognize that all important relationship between the medical evidence and the RFC. KPE does require a little research, but the effect on your ability to win cases can be spectacular.

The Foundation of Medical Evidence

Medical evidence is incredibly well structured. Medical science has its own language and internal processes. With experience, I discovered that like all complex processes, medical evidence has a subtle built-in pattern that can be used to simplify the process. All physicians are taught to document a disease in a specific manner. These rules are referred to as SOAP. SOAP indicates the kind of information a medical professional should provide that would enable

other physicians to quickly determine treatment status.

SOAP stands for Subjective, Objective, Treatment and Plan. Subjective evidence is a symptom that cannot be directly observed. An example of a subjective symptom is pain. "Doc, I have pain in my right knee". The Doc can't prove or disprove that the pain exists or its intensity without more evidence.

An objective symptom is one that can be observed. A black eye is an example of an observable symptom. Symptoms are one of the tools used by physicians to establish a **diagnosis**. Now you've got symptoms and a potential diagnosis.

You can't make a final assessment on the diagnosis without hard evidence. Hard evidence (x-rays, lab test, etc.) are also known as **signs**. So now you've got a piece of evidence that contains the claimant's diagnosis, signs and **symptoms**. You've also made an assessment of the diagnosis based on hard evidence. The final piece of evidence is the **Plan**. The Plan is the patient's treatment plan created by his doctor. If the treatment plan fails to improve or relieve the client's symptoms, you have a stronger case.

Data Structures in Medical Documents

Medical documents can contain various types of data but they all use the SOAP rule to document patient condition. For example, your average hospital report will contain an intake report and discharge summery. A hospital report will also include the results of any and all actions performed on or for the patient. A hospital report will also contain all of the document types used to evaluate a case.

Point: No matter what kind of medical report you are dealing with, the data can be explained and categorized using the documentation SOAP.

Examples of medical data types are:

Hospital Intake Reports
Physician Notes
Physical Examination reports
Nursing Notes
Laboratory Test Results
Radiological Test Results

Surgical Reports
Treatment Regiments

No matter what type of medical report you are reviewing, most contain a summation written in semi-medical terms. These summations can be used to speed up the document evaluation process. A summation is abbreviated and only contains the exact finding or test result. If the test result favors your client's alleged impairment or limitation, it can be used to lower his/her RFC.

Medical evidence also has another common treat. All medical evidence provides similar information. No, an x-ray report is not a physical examination, but it can support the findings of the examination.

As advocates, we are interested in knowing the primary **diagnosis**. A primary diagnosis from an advocate perspective is the impairment causing the greatest amount of physical or mental limitation.

The next common element within medical evidence is called the **Sign**. A sign is any hard (factual) medical finding like an MRI or blood work results. Signs are important because they are extremely difficult to fake. If an x-ray shows a fractured femur, the patient probably has a fractured femur. Rarely will SSA argue against a sign, making it the most powerful type of medical evidence.

The next important item within a medical record is the client's **symptom**.

Symptoms fall into two categories, those that can be directly observed and those that cannot. Please note that an observable symptom can also be a sign. Example, a black eye from a punch in the face. While there is no lab test for a punch in the face, an observable symptom like a black eye is pretty convincing and is almost as good as a sign.

A non-observable symptom like pain is less credible than an observable one like a black eye. However, the non-observable symptom is still an important weapon in an advocate's arsenal. I'll teach you to use pain and other subjective symptoms to reduce RFC later in the course.

Limitations are physical or mental restrictions caused by the claimant's impairment. Physical limitations are more credible when supported by **diagnosis**, **signs** and **symptoms** that are appropriate for the impairment.

Summation

You've just been introduced to key-point extraction. In Module 2 - Key-Point Extraction, we will show you how to actually implement key-point extraction on a piece of medical evidence. For now, it is most important to remember that key-point extraction is the act of reviewing medical documentation for the purpose of identifying **diagnosis**, **signs** and **symptoms** that can be used to reduce a claimant's Residual Functional Capacity.