Evidence Foundation

Medical science has its own language and internal processes. My professional medical experience enabled me to discover that like all complex processes, medical evidence has a subtle built-in pattern that simplifies the process.

All physicians are taught to document a disease in a specific manner. This rule is referred to as the SOAP. SOAP indicates the kind of information a medical professional should provide that would enable other medical professionals to quickly determine a patient's treatment status.

SOAP stands for Subjective, Objective, Treatment and Plan. Subjective is used to describe symptoms that cannot be directly observed. An example of a subjective symptom is pain. "Doc, I have pain in my right knee. The doctor cannot determine if the claimant truly has pain or its intensity because pain is a subjective symptom. Again, a symptom that is subjective cannot be directly observed.

Subjective symptoms are still extremely important. Symptoms enable a physician to determine cause. That is, a physician can use subjective symptoms as part of his arsenal to determine the patient's true **diagnosis**.

You cannot make a final assessment of a diagnosis without hard evidence. Hard evidence, x-rays, lab rest, etc. are known as a **signs**. Signs are used in conjunction with symptoms to determine diagnosis. So now you've got a piece of evidence that contains the claimant's signs and symptoms. You've also made an assessment of the diagnosis based these signs and symptoms.

The next most important piece of evidence within the SOAP is the assessment of diagnosis. The assessment of diagnosis is determined by the patient's signs and symptoms. The final factor in the SOAP is the Plan. A Plan is the treatment regiment provided by the physician. The treatment regiment should be appropriate for the patient's diagnosis.

Data Structure in Medical Documents

Medical documents can contain various types of data but they all use the SOAP rule to document a patient's signs and symptoms assessment and the plan. 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 behalf of the patient. A hospital report will also contain all of the document types used to evaluate a disability case.

Note: No matter what kind of medical report you are reviewing, the data can be explained using the SOAP protocol.

Examples of medical data types are:

Hospital Intake Reports
Physician Notes
Physical Examination Reports
Nursing Notes
Laboratory Test Results
Radiological Test Results
Pathology Reports
Surgical Reports
Treatment Regiments

No matter what type of medical report you are reviewing, most will be formulated using SOAP. Many reports also contain a summation written in semi-medical terms. These summations can be used to speed up the document evaluation process. A summation is an abbreviated version of a full medical report. It can quickly provide you with the information you need to support a client's allegations of an impairment.

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.

Diagnosis, Signs and Symptoms

For an advocate, the primary diagnosis is the impairment causing the greatest amount of physical or mental limitation. A diagnosis is proven using subjective symptoms and objective signs. A sign is any hard (factual) medical finding like an MRI or blood test. Signs are important because they are extremely difficult to fake. If for instance 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.

Symptoms are subjective and therefore cannot be directly observed. However, symptoms must be appropriate for the disease state claimed by the applicant. If for example a claimant alleges a severe back condition but has no symptoms. If he has no symptoms of a back condition then he cannot be considered impaired.

Symptoms fall into two categories. Those that can be directly observed and those that cannot. Most symptoms cannot be directly observed but there are many exceptions. An example of an observable symptom would be a black eye. The color change around the eye proves that the patient has sustained an eye injury. While there is no lab test for a punch in the face, an observable symptom like a black eye is pretty convincing and is as credible 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 because it can be used to lower a claimant's RFC.

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

Using medical data types:

Diagnosis, signs, symptoms and limitations in this order are all the ammunition you need to win a Social Security disability claim. No matter what medical condition you are evaluating, it must have a diagnosis. If it has a diagnosis, it must have signs (tests) that prove the diagnosis exist. If there are tests showing that the diagnosis exists, then the disorder must cause symptoms. If the disorder causes symptoms, are the symptoms severely limiting? If the symptoms are severely limiting, you can argue for a reduced RFC.

Key-point-extractions ties in perfectly with the five steps of sequential analysis:

Is there a diagnosis that prevents work? = SA Step 1

Will the impairment last 12 months? = SA Step 2

Does the impairment meet or equal the listing? = SA Step 3

Does the diagnosis cause limitations that prevent past work? = SA Step 4

Does the diagnosis cause limitations that prevent all work? = SA Step 5

The above correlation between the sequential analysis process and how medical evidence is presented, gives you an incredibly powerful weapon. With this knowledge, there is no condition you will encounter that cannot be argued. The strength of the argument will be directly based on the severity of the diagnosis, signs, symptoms and resulting limitations.

Evidence and the RFC

A Residual Functional Capacity is your opinion of a claimant's remaining functional capabilities caused by the primary and secondary impairments. The medical evidence is used to argue the severity of the limitation. The more severe the diagnosis, signs and symptoms, the more severe will be the limitations. The more severe the limitations, the greater the reduction in RFC.

Examples of restrictive symptoms:

- Pain
- Fatigue
- Dizziness and Vertigo
- Loss of physical coordination

Loss of Strength

- Inability to ambulate

Blurred vision

Muscular weakness

Memory loss

- Lack of concentration

- Inability to interact with others
- Extreme hostility

Individually or collectively the above symptoms can support a more restricted RFC, improving your chances of winning the case.

Evidence Use and Considerations

How you use a claimant's medical evidence is extremely important to a disability case. For example, use a doctor's written statements that support your case conclusions.

Example: Dr. Good states within several of his office notes that the claimant should not be on his feet for more than an hour or so a day because of his impairment. Statements like this are powerful tools for restricting a claimant's RFC.

Be Mindful of the Dates

It is good idea to review all available evidence for the time period that the claimant alleges for disability. Unless there's a DLI in the past, you should acquire medical reports from the onset date to the present. The word present refers to evidence dated within a month or two of the current disability decision.

If the claimant has a DLI in the past, you should request evidence from the alleged onset date to the DLI date. A person with a DLI in the past must be found disabled on or before the DLI date in order to receive benefits.

Steps for Extracting Evidence

Efficiently extracting key findings from the medical evidence is a step-by-step procedure that starts with the analysis of the evidence. You identify and summarize the key medical facts as you proceed through the evidence.

Once you have a list of key findings, you can use this evidence to formulate an RFC and create an argument on behalf of the claimant. To make this process easier to understand, let's create a hypothetical case on behalf of a fictitious Mr.

Katz.

As we go through our general discussion, we will use Mr. Katz's evidence as an example of how to extract the key medical findings.

Step One: Client Telephone Interview

Interview the claimant to acquire specific case information like date impairment began, medical treatment sources and alleged symptoms. Don't forget to consider case viability as you proceed through the client interview. If there are no red flags that would cause you to drop the case immediately, then you can move forward. Our Olivia software contains an automated case assessment tool. If results of the assessment are positive, you can formally accept the case.

After determining that the case is worth accepting, you move to the next step in Case Development. Recall that case development has several objectives.

A. Interview the Claimant

B. Identify relevant evidence.

C. Request copies of the evidence.

D. Evidence addresses the primary and secondary diagnosis.

Step A: Interview the Claimant

The claimant can be your best source of information. Use the interview to identify what evidence is needed in the case.

Step B: Identifying Relevant Medical Evidence

It's relatively easy to identify relevant evidence in a disability claim if you keep these criteria in mind.

a) Evidence should address primary diagnosis.

b) Evidence should cover the period of disability. Onset date to most current date.

c) Evidence must be from an SSA accepted source.

d) Evidence should be reviewed in chronological order.

Another way to identify relevant evidence is to only request evidence that is dated within the disability time frame.

Step C: Request Evidence

One of the primary duties of a disability advocate is to request copies of all relevant medical evidence. The procedure for requesting evidence is covered in Module One.

Step D: Addresses Primary Diagnosis

Believe it or not, many new advocates do not understand what relevant evidence means. The evidence is only relevant if it discusses the primary and secondary diagnosis.

The Case Evaluation Process

Once you have acquired all of the relevant medical evidence in a case, you're ready to move on to case evaluation. During this phase, you will actually review the evidence. You are reviewing the evidence to extract key-points that can be used to support your client's reduced RFC.

In the following example we will use using Mr. Katz to highlight the important information useful in the evaluation of his case.

Example Client Interview

In a phone conversation with Mr. Katz, we learned that he suffered a heart attack on 10/01/13 and has not been able to work since. He applied for benefits on 2/01/14 and was denied four months later on 6/1/14. A total of eight months has passed since the onset date of his impairment 10/01/13. He asked you to represent him on appeal on 7/15/14 that is still within his sixty-day limit for applying for an appeal.

The claimant states that he continues to suffer from chest pain on exertion and an inability to walk for more than thirty minutes without chest pain requiring rest. He feels physically

weak and has a high level of anxiety caused by his financial circumstance.

Since his heart attack on 10/1/13 he has been seen by two dpctors; Dr. Jones and Dr. Smith. He has been hospitalized twice. Once at the time of his initial heart attack and again six months later on 4/15/14 for unstable angina. Both hospitalizations were at St. John's Hospital. The claimant also states that he is fifty-one years old, has twelve years of education and has worked for fifteen years as a carpenter.

Analysis of Mr. Claimant's Data

In the phone interview you learned that Mr. Katz's primary diagnosis is heart disease. The onset date is 10/01/13 - the date of his original heart attack. You also found out when he applied for benefits on 01/1/14, the outcome was a denial issued on 6/1/14. You discovered that the claimant is now applying for an appeal and that he's still within the sixty-day appeal limit.

You've also learned that the claimant has a new allegation that if medically documented, could be used as additional ammunition. This additional ammunition is used to further reduce the claimant's perceived RFC at the appeal level. The claimant is asked to provide the name of the doctor treating his new allegation. If there is no new doctor, look for supporting evidence within the existing client records.

Since the case is at the Reconsideration or first appeal level, you can petition SSA to get any new evidence you deem necessary at SSA's expense. You can also request evidence directly from the claimant's medical source.

Extracting Information from the PDN

Assuming that you accept the case at an appeal level, the claimant will normally have received a Personalized Denial Notice (PDN). The PDN is a letter from SSA that indicates the reason for the denial decision. Get a copy of the PDN from the claimant or SSA to quickly determine why and at what level within Sequential Analysis the case was denied.

Mr. Katz;s PDN reads as follows (key-points are highlighted in blue):

Mr. Katz is a 51 y/o individual who has alleged disability due to an acute myocardial infarction on 10/01/13. The evidence shows a significant impairment that does not meet or equal the listings. The evidence also shows that despite his impairment, he is still capable of performing work of a light RFC. It appears that the claimant is capable of returning to the duties of his past work as a finishing carpenter.

We (SSA) have considered Mr. Katz's age of 51, education12th grade and his remaining ability to perform work in determining that he is capable of performing his past work. The cited Voc Rule in this case is 202.12, which directs a decision of not disabled. It has been determined that Mr. Katz is capable of performing past work and accordingly he is found not disabled as defined by law.

Analysis of Mr. Katz's PDN

The Personalized Denial Notice or PDN (also known as the Form 4268) has given us a lot of useful information. It tells us the primary diagnosis is a myocardial infarction. The PDN also takes us through to step four of the Sequential Analysis (SA) process, which indicates that he is capable of performing his past work.

The DDS Examiner who performed the initial case review has given Mr. Katz an RFC for light work. Apparently, Mr. Katz's past work as a finishing carpenter must carry an exertion level of light, resulting in the claimant's denial to past work.

The PDN has told us that the case was denied at Step Four of the SA process. Our job as Mr. Katz's representative is to argue that Mr. Katz has a lower RFC than that given by the SSA. We would also argue that given our RFC, he is not

capable of performing his past work. If we want to win the case, we must also argue that he is not capable of performing other less demanding work.

This sample PDN has also mentioned the Vocational Rule. We cover Vocational Rules in Module 4 of this training program.

Evaluating the Medical Evidence

The process of evaluating medical evidence is called a case evaluation. As discussed in Module Four, the Whole Body Principle is critical to your case evaluation. The whole-body principle demands that you consider the effects of all impairments suffered by the claimant.

Common Sources of Evidence:

- Doctor's Notes
- Hospital Intake and Discharge Summary
- MD Narrative Reports
- SSA questionnaires
- Physical Therapy Reports
- Occupational Therapy Reports
- Inpatient and Outpatient Medical Records
- Consultative Examinations
- Surgical Reports
- Military or VA Hospital Reports
- ADLs from claimant, family or physician
- Psychiatric Evaluations
- Treatment Center Reports
- School Reports - Child cases.

Be sure to review all information carefully

You've just received Mr. Katz's medical information from the DO. It includes a number of reports from Dr. Smith and Dr. Jones, as well as records from St. John's Hospital. The St. John's Hospital records tell us what occurred during Mr. Katz's hospitalization for the acute heart attack. Mr. Katz's records also include results of a physical exam, EKG and other cardiac-related tests.

The tests are indicative of a fifty-one-year-old man in acute cardiac distress. He was treated appropriately and recovered without complication. There were no surgical procedures. A cardiac test that showed partial blockage of a major coronary artery. Mr. Katz was placed on nitroglycerin for chest pain and was discharged three days later in stable condition.

Mr. Katz was hospitalized at St. John's six months after his heart attack for unstable angina (chest pain). He was sent home two days later with nitroglycerin and instructions to rest.

Dr. Smith is Mr. Katz's cardiologist. He has supplied a narrative report on the claimant's cardiac condition since his hospitalization in 2013. Dr. Smith states:

Mr. Katz's suffered an acute MI and since that time has been experiencing chest pain upon exertion. Mr. Katz's has complained of chest pain on exertion that is relieved by nitroglycerin and rest.

Although it has been months since his original heart attack, Mr. Katz is not as yet able to return to any type of work activity. The patient continues to suffer from exertion-related chest pain that is giving us some concern. We are slowly increasing his exercise tolerance, but we do not want to push him too hard due to his poor physical conditioning. Mr. Katz has also shown signs of situational depression that may be associated with his current financial problems."

Dr. Jones has taken care of Mr. Katz for years as his family doctor. Dr. Jones' report gives essentially the same information as Dr. Smith's concerning Mr. Katz's heart condition. However, Dr. Jones' report also alerts us to a medical problem that we previously knew nothing about. According to Dr. Jones, Mr. Katz as a history of type II diabetes. Mr. Katz's diabetes is insulin-dependent and has caused poor circulation and pain in his both lower extremities. Dr. Jones also confirms the claimant's continuing problem with chest pain.

Analysis of Mr. Katz's Medical Evidence

The St. John's Hospital records are important because they establish Mr. Katz's onset and diagnosis. The heart catheterization report showed a significant blockage of a coronary artery, which Mr. Katz's primary diagnosis of coronary artery disease. Evidence supports Mr. Katz's diagnosis, symptoms and alleged physical limitations.

Dr. Smith's report yields facts we were not previously aware of by adding the

allegation of diabetes. Dr. Smith has verified Mr. Katz's continuing problem with chest pain and poor exercise tolerance. He has also given a written opinion concerning the patient's inability to work and has added a third diagnosis of situational depression. This additional diagnosis supports Mr. Katz's allegation of anxiety and depression associated with his concerns about the future.

Note: Anxiety and depression are mental states that if severe, may result in a further lowering of the claimant's RFC. This type of finding can further reduce the RFC.

Case Evaluation: List and Summarize the Evidence

Summarize the medical findings in preparation for creating your final argument. This is a good habit to get into when reviewing any disability case because it makes it easier to recall the key facts as you write your argument.

Our Olivia software makes this process easier by providing a method of transferring key evidence from the records to the claimant's argument. See MW Composer tool inside of your Olivia account.

Here's a summation of key evidence found in Mr. Katz's evidence:

- Mr. Katz's suffered an acute myocardial infarction (heart attack),
- EKG, lab and cardiac cath reports verify the condition
- Onset date: 10/01/13, which is the day of the heart attack
- Mr. Katz's also suffers from diabetes, poor circulation and pain in both legs
- Mr. Katz's has proven symptom of chest pain on exertion
- Mr. Katz has a secondary diagnosis of type 2 diabetes with symptoms.
- Mr. Katz has a third diagnosis of anxiety and depression.
- Dr. Smith, Mr. Katz's cardiologist states that Mr. Katz' is unable to work due to fatigue and unstable chest pain.
- Mr. Katz's alleges that he cannot walk for extended periods of time due his chest pain, weakness and pain in his legs.
- Mr. Katz's also alleges that anxiety makes it difficult to concentrate.
- The case is at the Reconsideration or First Appeal Level

- SSA has determined that Mr. Katz's can do his past work

This is not an exhaustive list for Mr. Katz's evidence, but it gives you an idea of how to summarize your key-points within the evidence.

Case Evaluation: Identify All Physical & Mental Limitations

To accomplish claimant limitations, you must take the time to learn about the disease state(s) you're dealing with in each case. You don't have to understand every aspect of every disease you encounter. But you should become familiar with the normal signs and symptoms that coincide with the claimant's diagnosis.

We recommend that you read a little about each disease state you encounter. This action will help you to evaluate the case and shorten the time it takes to create an effective argument.

You can access several sources of information within your Module One program Syllabus. Other helpful resources for learning about a disease are:

· Merck Manual Online

· Social Security Disability Guide

· Any medical text that discusses disease states in layman's terms

The above medical reference sources will help you to identify physical or mental limitations that are normal and appropriate for a particular disorder. It's more important that you understand how a disease can physically or mentally restrict a person's functioning than it is to understand the disease itself. If you understand how a disease can physically or mentally limit an individual, you can create better quality arguments. As an advocate, you would seek to prove that the claimant's restrictions are appropriate for a given disease state at a particular severity level.

How to Use the Merck Manual

The Merck Manual is a diagnostic reference book widely used by consultants, medical professionals and many Social Security-related agencies. The text is broken into segments, each covering a category of disease. To use the

manual, take the name of the primary disease, such as “myocardial infarction, lay-term heart attack”, and turn to the index in the back of the book.

Look up the diagnosis (they are listed in alphabetical order). The number that appears by the name of the disorder is the page number where you will find information. The Merck Manual provides a wealth of data about almost any disease state. It also provides information on common signs and symptoms associated with a disease state.

Steps to Building Your Case

In your case interview with the claimant, you've allowed the claimant to tell you what his most severe limitations are. In the Case Evaluation, you review the claimant's data to prove that the alleged restrictions are reasonable and consistent. Finally, in the case argument, you described the claimant's limitations and how they restrict work.

Note: If a claimant has several severe impairments, each of which cause restrictions. Combine the effects of all limitations and compare them to the claimant's past and other less demanding work.

Mr. Katz's suffering from a number of diseases, each of which can potentially cause a number of physical and mental limitations. It is these limitations, not the disease itself that we use to argue for a reduced RFC. We have found that Mr. Katz's alleged restrictions are indeed reasonable and supported by medical evidence.

In order to win this case, all we need do is compile the evidence into a convincing argument for a significantly reduced RFC. If we successfully reduce Mr. Claimant's RFC to less than sedentary, the case will be allowed as long as SSA agrees with our findings. SSA will only agree to our RFC if we can back it up by the medical evidence.

Now your ready to review the actual Key-Point Extraction process.