The ability to write a complete and technically correct report, assessing the patient’s disability for the Social Security Administration, seems to be a lacking skill set for most of the chiropractic profession.

Sick or injured persons who cannot work are cut off from the primary method of access to the health care system because the employer provided their health care insurance coverage. One congressional study after another has documented what every health care professional already knows: that people without health insurance often defer medical treatment until their condition has considerably worsened. Preventative treatment or earlier intervention is unheard of. This, in turn, frequently necessitates more expensive treatment—often with less success. In addition, because of the severity of the conditions, death rates tend to be higher.

The implications for the chiropractor are obvious. In an age of spiraling costs for medical care, the patient’s need for health insurance coverage is a necessary component of proper health care. The chiropractor who is better able to assist the patient in obtaining such coverage provides better and vitally necessary treatment.

The Social Security Disability Insurance (DI) and the Supplemental Security Income (SSI) programs are the nation’s two largest federal programs providing cash benefits to people with severe, long-term disabilities. One of the most significant elements of Social Security benefits for disabled people is Medicare coverage, for which an individual qualifies after having been found disabled by the Social Security Administration (SSA). The chiropractor who treats the disabled person can be of invaluable assistance to the patient in obtaining this coverage, if his or her skills are up to the task. Since the chiropractor can provide this vital skill after an initial rejection, the chiropractor who treats the disabled should be prepared to do so.

**Deck Stacked against Claimant**

People applying for Social Security disability benefits (referred to as “claimants”) have a more difficult time achieving disability benefits than ever before. The reasons go well beyond the simple explanations of government cutbacks and bureaucratic prejudice against the poor, and are indicative of yet another facet of the nation’s growing health care crisis.

The reaction of the Social Security Administration has been to scrutinize disability claims to a greater extent than ever before. This greater level of scrutiny has resulted in a clear trend toward fewer awards.

There can be no question that the denial rate is growing far more rapidly than the number of claimants. Furthermore, the number of claimants awarded benefits at the hearing level is steadily increasing, giving rise to the suspicion that the lower award rates at the first two levels are the result of an administrative bias in favor of denial, rather than legally defensible determination practices.

Not only are applications more closely scrutinized, but they are also processed over a considerably greater peri-
od of time. In 1986, the time frame for a claimant’s initial request for a hearing to the time a disposition was made was approximately six months. By 1991, that statistic had increased to greater than eight months. This represents an increase in SSA processing time, for that stage of the process alone, by over 33 percent.

These figures may seem pallid on the page, but there is a terrible human cost associated with them. Disability claimants, and most particularly SSI claimants, are people in poor health who are unable to work and who have typically expended most—if not all—of their financial resources by the time their claim is filed. They face a determination process that is growing ever longer, and now approaching two years. The financial pressures on these people are extreme, but so also are the stresses that affect nearly every aspect of life. Everyone in the system is affected. People get sick more often, stay sicker longer, suffer poorer health outcomes from the treatment they do receive, and die more often.

What You Can Do
A chiropractor committed to assisting a patient in obtaining disability benefits needs to do five things:

1. Obtain postdoctoral education in federal disability programs. To get information on CCE-sponsored programs, e-mail Dr. Warren Jahn, DC, at the American Board of Forensic Professionals (ABFP) at drwjahn@ix.netcom.com, or fax 770/619-3203.

2. Become familiar with the decision-making process that leads to a determination of “disabled.”

3. Be prepared to write a prompt, complete report that meets the expectations of the Social Security Administration. The importance of a well-written medical report cannot be overestimated. Evidence of a claimant’s impairment(s) is the most important information the claimant will put forward in support of a claim. Furthermore, the law (Title II of the Social Security Act) requires that the opinions of treating professionals (chiropractors) must be given greater weight than those of consultative physicians hired by the SSA because treating chiropractors are employed to cure, and have had a greater opportunity to observe the applicant.

4. Become proactive. If you are treating an unemployed patient whose unemployment status may be related to illness or injury, and “meets the SSA definition of disabled”, suggest that he or she file a claim for disability benefits with a local Social Security Administration office. Inform the patient that you should be identified as a treating chiropractor on the patient’s application for benefits, and be prepared to write an appropriate medical report if and when you are requested to do so by the SSA.

5. If the patient has a lawyer, be willing to talk to him. Most lawyers who represent Social Security claimants are people dedicated to helping the claimants. Both you and the attorney have the patient’s interests in mind. Discuss the patient’s legal and medical situation with the attorney, and if asked to write a medical report, do so.

6. If the patient does not have legal counsel, suggest that he/she see a lawyer or advocate who specializes in Social Security claims. Although representation is not required, claimants have a significantly greater chance of obtaining benefits if they are represented. The reason is obvious: the “system” through which disability determinations are made is increasingly demanding of specific kinds of proof of disability, increasingly complex in its judgment-making process, and increasingly unforgiving of technical mistakes. Since most claimants have little or no financial
resources, the attorney or advocate may represent a claimant on a contingency basis. Additionally, the SSA requires that any fees charged by an attorney to a successful claimant be submitted to the SSA for approval, along with information detailing the amount of time spent working on the case. This system of review assures that fees will truly reflect the work performed and the level of difficulty of the representation.

The Determination Process and the Treating Chiropractor’s Role
For purposes of both DI and SSI programs, Congress has defined the term “disabled” as an “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, or impairments, 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.”

Furthermore, an individual “shall be determined to be under a disability only if his/her physical or mental impairment or impairments are of such severity that he/she is not only unable to do his/her previous work but cannot, considering his/her age, education and work experience, engage in any other kind of substantial gainful work that exists in the national economy…in significant numbers…”

As the treating chiropractor (chiropractors are listed as non-acceptable sources for performing evaluations under SSI since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996), one should keep in mind that the disability determination will be made by the SSA, not the treating chiropractor. The SSA will base its decision on a variety of legally relevant evidence, including the treating chiropractor’s report, but the treating chiropractor is by no means the final arbiter of the meaning of the term “disability.” Indeed, many factors to which the SSA is extremely sensitive (such as the impact of age, education, and work experience on an individual’s ability to work) are factors upon which the treating chiropractor is usually not able to comment.

How are disability determinations made? At each level of administrative review, the law requires a five-step evaluation process (sequential evaluation process) to be performed:

1. Determine whether the claimant is engaged in “substantial gainful activity.” In practical terms, this means, “Is the claimant currently working?” If so, the claim is denied.
2. Determine, solely on the basis of medical evidence, whether the claimed impairment (or combination of impairments) is “severe.” Is the nature of the claimant’s ability to do basic work activities noticeably limited? If not, the claim is denied.
3. Determine, again based only on the medical evidence, if the impairment equals or exceeds in severity certain impairments described in the Social Security regulations. If so, the claimant is automatically awarded benefits.
4. Determine whether the applicant has sufficient “residual functional capacity” (meaning “what he or she can still do despite limitations”) to perform the work the claimant has done in the past. If so, the claim is denied.
5. Determine, on the basis of the claimant’s age, education, past work experience, and residual functional capacity, whether the claimant can perform any other gainful work that exists within the economy.

Role of State Agencies
The process of obtaining benefits begins by filing a claim at a local office of the Social Security Administration. If there is a non-medical reason for granting or denying benefits, the SSA office at which the application was filed will make the disability determination.

Most cases turn on the existence of a medically determinable condition. In these situations, the SSA forwards the claim to a state agency, the Disability Determination Services (DDS). The DDS, in turn, will forward all available medical evidence to a physician (no chiropractor is eligible for this position under current law) for a consultative opinion as to whether the claimant’s impairment “meets or equals” one of those listed in the Social Security regulations (in which case the claimant is automatically granted benefits), or, in the alternative, for an opinion concerning the claimant’s capacity in light of one’s impairment(s) to perform work. Frequently, this requires that the claimant be examined.

Outside medical opinions are also sought by administrative law judges (ALJs) in the course of their review of a claimant’s application. Often, the ALJ will order additional medical examinations and reports by medical advisors (MDs, DOs, psychologists, and optometrists [DCs are not eligible to perform these exams under current law]).

The DDS has a constant need for impartial, qualified evaluations and opinions. Our profession needs to
change the current law (Personal Responsibility and Work Opportunity Reconciliation Act of 1996) to allow DCs to qualify for these positions.

The Report

The sequential evaluation process suggests that medical evidence is crucially relevant in two areas:

1. Determining whether the claimant’s impairments are severe enough to comply with (“meet or equal”) one of the various impairments described in the Social Security regulations, and

2. Determining the claimant’s “residual functional capacity” (RFC). Ideally the medical report should contain an assessment of your patient’s condition relative to both areas.

Since the treating chiropractor’s report will be granted more weight than evidence from any other physician, your report will certainly be more important than any other single piece of evidence put forward by the claimant.

Ideally, your medical report will be a well-written narrative containing the following information:

1. A comprehensive medical history
2. The patient’s symptoms and subjective complaints
3. Medications
4. A description of any physical or mental examinations, along with clinical findings and results of such examinations
5. Laboratory findings
6. Diagnosis
7. Your treatment and treatment plan
8. Prognosis
9. An assessment concerning the extent to which a patient's impairments “meet or equal” applicable impairments described in the SSA regulations
10. A Residual Functional Capacity assessment*

Assessing whether impairments “meet or equal” those in the Social Security regulations:

A portion of the Social Security regulations, known as the “Listing of Impairments,” (complete list can be found in SSA Publication No. 64-039 January 1998 or on the web at www.ohsu.edu/clinweb/disability/adult.html#524.001.010) contains over 100 descriptions of medical conditions that the SSA has determined to be severe enough to prevent a person from working.

A claimant’s particular impairment, or combination of impairments, may either correspond exactly to one of those listed impairments (known as “meeting the listing”), or, in the alternative, may be as severe (meaning “equally limiting to work capability”) as one of those listed impairments (known as “equaling the listing”).

To “meet a listing,” the medical evidence must substantiate all of the signs, symptoms and findings called for in the Listing. Listing 1.05C serves as a good example:

1.05C. Other vertebrogenic disorders (e.g., herniated nucleus pulposus spinal stenosis) with the following persisting for at least three months despite prescribed therapy and expected to last 12 months.

With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

Most people suffering from chronic low-back pain will not meet this listing. The listing requires that the patient suffer muscle spasms for three months despite therapy;
and be expected to suffer them for 12 months. Only the very rare case would present such findings.

Some people do suffer from severe back pain that prevents them from working on a sustained basis. Where some, but not all, manifestations of a condition exist, the patient must “equal” the listing to be declared disabled.

Social Security regulations outline three ways in which an impairment may equal a listing:

1. The claimant has a listed impairment, but one or more of the required medical findings is not present. There are other medically determinable findings which are of equal or greater clinical significance; or

2. The claimant’s impairment is not listed, but is clearly analogous to one that is listed, and for which the criteria are comparable; or

3. The claimant has a combination of impairments that are closely related and nearly equivalent, medically, to a listed impairment.

A claimant whose medical findings are not sufficient to establish all elements of a listing may equal the listings by showing the existence of other impairments that affect the ability to perform work. For example, the claimant who suffers from chronic lower-back pain, but who is unable to exhibit the findings required by 1.05C, may also suffer an impairment of the respiratory system in such a way that, under appropriate circumstances, breathing becomes difficult. The pulmonary impairment may represent a finding of equal or greater clinical significance than the missing elements of Listing 1.05C. Alternatively, the two impairments, taken together, may be medically equivalent to the impairment described in 1.05C with respect to the patient’s ability to work.

Practically, the listings contained in the SSA’s “Listing of Impairments” describe conditions that are so severe that few persons meet them. The issue will most often be whether an impairment, or combination of impairments, so severely impacts a claimant’s ability to perform work that the impairment(s) leads to a finding of equivalency to one of those listed. This is inevitably a judgment call. It is this judgment that is called for in the treating chiropractor’s medical report.

What does this suggest? First, it suggests that the word disability is a term that involves many concepts, some of them medical, some of them legal, and some of them social. Second, it suggests that disability is not a term which can be easily fixed by a rule-oriented set of words, but rather is a flexible notion, the application of which may shift from one patient to another.

Primarily, it suggests that a quality assessment of whether your patient’s impairments comply with those found in Social Security regulations require intelligent, knowledgeable and creative application of your chiropractic abilities. The better-prepared chiropractor will become familiar with the applicable listing and, using it as a tool, find the means by which to articulate the reality of the patient’s condition.

**Residual Function Capacity Assessment**

A report that contains an assessment of whether the claimant’s condition meets or equals a listing is helpful and useful. A report that contains a Residual Functional Capacity assessment by the treating chiropractor is indispensable.

Residual Functional Capacity (RFC) is the capacity of a person to perform basic work activities (such as walking, standing, pushing, pulling, balancing, reaching, carrying, seeing, hearing, speaking, remembering, using judgment, following instructions, dealing with supervisors, dealing with coworkers) despite the existence of physical or mental impairments.

The SSA has a standard form which can be used to communicate your evaluation of the patient’s RFC. Avoid using this form in favor of a written narrative.

To write a good assessment of RFC, do the following:

1. **Avoid stating only your conclusions.** Your report will be enormously more helpful if it is persuasive. It should therefore contain not only your conclusions, but the facts you have observed and the reasoning that leads to your conclusions. For example, it is not enough to state that “the patient should not carry more than 10 lbs.” Rather, put it this way: “The patient has constant pain in his fingers, which prevents him from using them with any dexterity, or to handle objects of over 10 lbs. Recent x-rays (copies of which are enclosed with this report) disclose significant arthritis in the fingers. I have observed the patient having difficulty buttoning a shirt. He would be unable to lift even a small bag of groceries, and would often drop objects of that weight.”
2. Assess factors that may affect the patient’s ability for sustained effort. SSA regulations provide that a person must be able to work on a “regular and continuing basis.” If an impairment causes a person to lose a significant amount of productivity over a period of time (documented by digital camera) because that person is incapable of sustaining his or her work efforts, then that person is disabled. A good RFC report will assess the patient’s ability to maintain concentration and accomplish tasks over a period of time, specifically pointing out factors that may make sustained performance difficult, and describing the effects of those factors.

What happens, for example, if the patient sits for a prolonged period of time? Does the consequential pain cause the patient to lose the ability to concentrate or become irritable (and therefore have difficulty getting along with coworkers and supervisors)?

3. Stay within the language of the system.
Remember that in a disability determination, words are being used in a legal sense, not a medical sense. Every profession has its “terms of art.” As an example, a glance at the sequential evaluation process described above should indicate the importance of words such as “significant” and “severe.” To a chiropractor, “severe” scoliosis may describe a condition so advanced that the patient cannot stand upright. In a disability determination, however, “severe” scoliosis need only be such that, to some extent, it affects the person’s ability to perform work (e.g., to sit comfortably, in the case of a typist). The SSA will jump on the opportunity to dismiss an impairment as “non-severe” if you give them the ammunition by using a term such as “moderate,” even though that may be an appropriate chiropractic description.

4. Consider work-related side effects of treatment, medication, or special equipment made necessary by the nature of the impairment. Varicose veins may require constant elevation of a limb, creating a need for special conditions in the workplace. Medications may create work-related problems, which the impairment itself does not, such as irritability, or loss of ability to concentrate or follow instructions.

5. Wherever possible, evaluate (or at least mention the possibility of) the effect of “non-exceptional” limitations. An alcoholic patient (or any other substance-addicted person) may not be physically affected by his/her addiction to a degree sufficient to establish disability under an appropriate listing. Such a person may nonetheless be disabled, because residual functional capacity is so constricted that he/she cannot work on a sustained basis.

This is applicable, not only to persons suffering from substance addiction disorders, but also to persons suffering from mental or emotional disorders and other mental impairments. Include in your report, if applicable, that the patient seems continually depressed, maintains a flat affect, has mentioned thoughts of suicide, or any other indicators of mental impairments (from National University of Health Sciences Independent Medical Examination (IME) and forensics programs).

This information can be extremely helpful, even crucial evidence. Often the SSA can be persuaded to order psychiatric evaluations, uncovering significant evidence on the claimant’s behalf. At the very least, it can possibly suggest another “angle on the case” for the claimant’s attorney or advocate to explore. And where the claimant already has had a psychiatric evaluation, your information can provide invaluable documentation in support of the psychiatric claim.

**Conclusion**
In the best of all possible worlds, everyone in need of medical treatment would get it without having to ask. The sad reality is that the cost of medical care has placed a nearly impossible burden on the person who is sick or injured and unable to work. Access to medical coverage is a legitimate medical necessity for everyone, and an integral part of adequate treatment of the disabled.

More than that, each of us gets a chance to make a contribution or leave a footprint that represents our own peculiar signature in the world. Especially for those of us who are more fortunate than others, there is a special burden to seek and obtain the necessary skill sets to be able to present our patients’ conditions in the most appropriate and convincing light. ▼

**References**