DETERMINING DISABILITY:
SIMPLE STRATEGIES FOR CLINICIANS

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DETERMINING DISABILITY:
SIMPLE STRATEGIES FOR CLINICIANS

EXECUTIVE SUMMARY

This manual is intended to assist clinicians who are asked to provide documentation of disabilities in support of their patients' applications for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI).

The manual is limited in scope, describing an efficient and effective approach to documenting certain *physical* conditions which are commonly encountered by primary care providers serving poor and homeless adults. Mental health problems, which may also qualify many patients as disabled, are not addressed here because of the relative complexity of these determinations. Likewise, disability determination for children is not addressed because the law on this topic is in flux as this manual is being prepared. Numerous legal and technical questions regarding eligibility for SSI and SSDI are not addressed in this manual.

Eligibility for SSI and SSDI is determined by the Social Security Administration (SSA) and by state agencies following the **sequential evaluation process** described below. Diagnostic information supplied by clinicians is considered at Steps 3 and 4 of the sequential evaluation process. In most cases, an applicant for SSI or SSDI should be working with a case manager, a social worker or an attorney to assure that additional required information is provided and that the application is properly prepared.

At Step 4 of the sequential evaluation process, clinicians are asked to make relatively subjective determinations regarding the "residual functional capacity" of their patients. These determinations are typically complex, time-consuming and frustrating for providers.

At Step 3 of the sequential evaluation process, however, objective data documenting certain conditions can **automatically** qualify a patient for disability benefits, eliminating the need for Step4 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 for efficient and effective determinations of disability and provides criteria from this list for several conditions frequently encountered in primary care practices.

> *I have cared for a 40-year-old man for the past decade. His multiple medical problems include insulin-dependent diabetes mellitus, pulmonary hypertension and right-heart failure secondary to obstructive sleep apnea, recurrent deep venous thromboses requiring anticoagulation, polysubstance abuse, and morbid obesity. I exhaustively reviewed his five-volume medical chart at the hospital and spent two hours composing a six-page medical evaluation and letter for his SSI claim. Several weeks afterwards I finally took the time to read through the Listing of Impairments, and was shocked to find that I could have simply documented his height and weight during the past year to establish that he exceeded the criteria for obesity by over 100 pounds, easily qualifying him as disabled.*

INTRODUCTION

Clinicians caring for low-income and impoverished patients know how physical and mental disabilities can prevent our patients from participating in the work force and further entrap them in poverty. SSI and SSDI programs constitute a safety net for disabled persons, providing both an income stream (monthly disability checks)and health insurance (Medicaid or Medicare). Medical evidence is required to establish eligibility for SSI or SSDI and patients appeal to clinicians, relying on our expertise to provide needed medical documentation. The outcome of the disability determination process is perhaps the single most important factor in minimizing the health risks associated with poverty and assuring a better quality of life for our patients. Establishing health insurance for a previously uninsured patient also benefits the health care provider.

Yet, most clinicians dread the entire determination process. For many of us, disability determinations are hopelessly complex, mysterious, onerous and time-consuming. The era of managed care, with its demands for productivity and efficiency, has increased our frustration. The demand for determination and re-determination of disability has increased markedly in the late 1990s as other income supports have deteriorated and as substance abuse disorders were eliminated as a basis for disability.

Community health centers, health care for the homeless projects and other safety net providers have been deluged with requests for assistance. Much time is spent seeking out and reviewing medical records and composing medical evaluations, often without a clear understanding of the process in which we are participating or the criteria against which a disability claim will be judged.

This manual offers:

1) a brief introduction to the major federal disability programs, SSI and SSDI;
2) a description of the sequential evaluation process utilized by the Social Security Administration for the determination of SSI and SSDI;
3) a review of the essential but arcane Listing of Impairments used by the Social Security Administration;
4) excerpts from the Listing of Impairments describing criteria for specific disabling conditions frequently encountered among adult primary care patients; and
5) guidelines for effective letter-writing.

A clinician who understands the sequential evaluation process and uses the Listing of Impairments can quickly and accurately provide medical documentation necessary for disability claims.

THE FEDERAL DISABILITY PROGRAMS:SSI AND SSDI

The Social Security Administration (SSA) administers two major programs for people with disabilities, Supplemental Security Income and Social Security Disability Insurance. The medical standards for disability are the same for both programs.

SSI is a federally financed needs-based program that guarantees a national income level ($494.00 per month in 1998) for aged, blind, and disabled persons with limited income and resources. Many states provide supplemental cash assistance as well, and most states automatically provide Medicaid to persons who qualify for SSI.

SSDI provides monthly cash benefits for disabled persons 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 disability standard and must be fully insured for disability benefits, i.e., worked in 20 of the past40 calendar quarters. Disabled persons on SSDI do not automatically receive Medicaid, but they are eligible for Medicare after they have received SSDI benefits for 24 months.

THE SEQUENTIAL EVALUATION PROCESS

In evaluating disability claims, the SSA uses the sequential evaluation process. The role of outside clinicians is to provide documentation of physical or mental conditions that may constitute disabilities. This manual focuses on physical conditions which may be established during Step 3 of the sequential process, but it is important for clinicians to understand the overall SSA process in order to provide knowledgeable assistanceto our patients. Moreover, if a patient obviously does not meet the requirements of Steps 1 and 2, there is little point in developing documentation for Step 3.

The law defines disability for adults as

> *the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) 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.*

The SSA uses the following five-step sequential evaluation process to determine disability for adults under this definition.

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

Step 1 addresses whether the individual is currently working in a significant manner. SGA is the performance of significant physical or mental duties that are "productive" in nature. The work can be full-time or part-time. Determining SGA can become very complicated, although in general anyone with gross wages of $500or more per month is considered to be engaging in SGA, whereas anyone earning less than $300 per month is not involved in SGA. The SSA considers the $300 – 500 per month range a gray area. Many other issues can become factors in this determination, including whether an individual receives a subsidy, has impairment-related work expenses, participates in sheltered employment, or has had unsuccessful work attempts. In most cases, clinicians will rely on case workers or attorneys to address this area of the disability application.

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. An impairment is "severe" when the ability of the applicant to do basic work activities is significantly limited, including 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 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, but may be provided more appropriately by others who have observed the applicant attempt to perform basic work activities in job or social settings.

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. Other conditions can equal a listed impairment when the impairment causes the same degree of functional limitations as the listed impairment. Step 3 is the critical step for physicians, psychologists and others who are responsible for completing medical evaluations of individuals seeking disability determination status.

The critical lesson for providers is that **persons who meet 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 below.

If YES, stop. Disability has been established. If NO, proceed to Step 4

Step 4: Does the applicant have the residual functional capacity(RFC) 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 prior relevant work by determining the residual functional capacity (RFC). The RFC is essentially the activity the individual is still able to do despite the functional limitations of all of his/her impairments. The 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. If SSA determines that the individual has the functional capacity to perform past work, then the disability claim is denied.

If NO, proceed to Step 5

Step 5: Does the applicant have the RFC to perform any other job that 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. SSA looks at work available in the regional or national economy and considers whether the RFC of the individual and other vocational factors (age, education and literacy, and work history) allow the individual to perform such work. Disability benefits will be denied if such other jobs exist in significant numbers in the regional economy.

If NO, disability is approved

The Listing of Impairments Part A applies to adults age 18 and over. Part B provides additional medical criteria for children. The list is divided into 13 organ systems, numbered from 1.00 to 14.00; note that there is no number10.00.

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
11.00 Neurological
12.00 Mental Disorders
13.00 Neoplastic Diseases
14.00 Immune System

For each of these major body systems, the Listing of Impairments describes criteria for specific disabling impairments that are considered severe enough to prevent an adult from doing any gainful activity. 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 least12 months.

All clinicians who are asked to provide medical evaluations or reports for patients seeking disability should become familiar with the categories and the specific language of the Listing of Impairments. Disability assessments become easier and more focused when providers are familiar with the 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 each individual criterion for a particular impairment. 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 who are seeking to understand whether they might be eligible for disability.

> *A 30-year-oldwoman with a six-month history of low-back pain presented to our clinic requesting assistance with a disability determination. I was able to review with her the exact criteria necessary for eligibility, and she was easily able to understand that she did not have the X-ray findings or the neurological deficits necessary to qualify for SSI.*

The full Listing of Impairments should be available to clinicians at sites where disability determinations might be made. As noted above, the Listing is published at **20CFR404, Subpart P, Appendix I**. The Code of Federal Regulations(CFR) is available in federal depository libraries and on the Internet (go to **www.ssa.gov** for access to Social Security regulations). Local Social Security offices may also be able to provide the current Listing of Impairments. Because disability law has changed significantly in the last few years, *readers are cautioned to rely only on current sources for this material.*

To familiarize clinicians with this process, criteria for several common conditions appear below.

COMMON ADULT ILLNESSES AND CONDITIONS

We reviewed the Listing of Impairments to find criteria for several illnesses frequently encountered in primary care practices. In some cases we distilled the key criteria, while in other cases—particularly with HIV infection—we included virtually the entire text from the Listing of Impairments. These examples of common diagnoses are intended to save time and minimize frustration, and to help providers become familiar with using the Listing of Impairments to help with other more complicated cases.

Clinicians developing information for disability determination are advised to consult the most recent version of the officially published Listing of Impairments rather than relying on these excerpts.

1.02 Rheumatoid arthritis and other inflammatory arthritis

Eligibility requires **both** A and B:

A. H/O persistent joint pain, swelling and tenderness involving multiple major joints and with signs of inflammation (swelling and tenderness) on current P.E. despite prescribed therapy for at least three months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; **and**

B. Corroboration of diagnosis at some point in time by:

1) Positive RF (rheumatoid factor); **or**

2) Positive ANA; **or**

3) Elevated ESR; **or**

4) Characteristic histologic changes in BX of synovial membrane or subcutaneous nodule.

1.05 Spine disorders: Arthritis, osteoporosis, herniated disc, spinal stenosis

Essential for the evaluation of low-back pain! Any **one** of the following constitutes eligibility for disability:

A. Arthritis manifested by ankylosis or fixation of the cervicalor dorsolumbar spine at 30 degrees or more of flexion measured from the neutral position, with X-ray evidence of:

1) Calcification of the anterior and lateral ligaments; **or**

2) Bilateral ankylosis of the SI joints with abnormal apophyseal articulations;

or

B. Osteoporosis, generalized (established by X ray) and manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of **either**:

1) Compression FX of a vertebral body with 50 percent loss of height (without h/o trauma); **or**

2) Multiple FXs of vertebrae without direct trauma;

or

C. Other vertebrogenic disorders (e.g., herniated disc, spinalstenosis) with **both** of the following persisting for at least three months despite prescribed treatment and expected to last 12 months:

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.

1.09 Amputation or Anatomical Deformity

A. Both hands; **or**

B. Both feet; **or**

C. One hand and one foot.

1.10 Amputation of One Lower Extremity

A. Hemipelvectomy or hip disarticulation; **or**

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; **or**

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to **one** of the following:

1) Vascular disease; **or**

2) Neurological complications (e.g., loss of position sense);**or**

3) Stump too short or stump complications that have persisted or expect to be persistent for at least 12 months from onset; **or**

4) Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

3.02 Chronic Pulmonary Insufficiency

A. **Chronic obstructive pulmonary disease (COPD)** due to any cause, with the FEV1 equal to or less than the values below. PFTs must be performed pre- and post-bronchodilator therapy unless otherwise contraindicated.

Height	FEV1
60" or less	1.05L
61 – 63	1.15
64 – 65	1.25
66 – 67	1.35
68 – 69	1.45
70 – 71	1.55
72 or more	1.65

or

B. **Chronic restrictive ventilatory disease**, due to any cause,with the FVC equal to or less than the values below:

Height	FVC
60" or less	1.25L
61 – 63	1.35
64 – 65	1.45
66 – 67	1.55
68 – 69	1.65
70 – 71	1.75
72 or more	1.85

or

C. **Chronic impairment of gas exchange** due to documented pulmonary disease **with**

1) Single breath DLCO < 10.5 ml/min/mm HG or < 40 percent predicted; **or**

2) ABG values of PO_2 and PCO_2 (measured simultaneously, at rest, breathing room air, awake, and sitting or standing) in a clinically stable condition on at least two occasions, three or more weeks apart within a six-month period, equal to or less than the values specified in the tables below; **or**

3) ABG values of PO_2 and PCO_2 during steady state exercise, breathing room air(level of exercise equal to or less than 17.5 ml O_2 consumption/kg/min) equal to or less than the values specified below.

PCO_2 (mm Hg)	PO_2 (< 3,000 ft.)	PO_2 (3,000– 6,000 ft.)	PO_2 (> 6,000 ft. above sea level)
30 or below	65	60	55
31	64	59	54
32	63	58	53
33	62	57	52
34	61	56	51
35	60	55	50
36	59	54	49
37	58	53	48
38	57	52	47
39	56	51	46
40 or above	55	50	45

3.03 Asthma

The criteria for disability for asthma are the following:

- Episodic attacks,* in spite of prescribed treatment, that require intervention by a medical provider;
- At least once every two months or at least six times a year;
- Each inpatient hospitalization > 24hours for control of asthma counts as two attacks; and
- An evaluation period of at least 12consecutive months must be used to determine the frequency of attacks.

* **Asthma "attacks"** are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as IV bronchodilator or antibiotic administration or prolonged nebulizer treatment in a hospital, emergency room, or equivalent setting.

4.02 Chronic Heart Failure

While on a regimen of prescribed treatment, with **one** of the following:

A. Cardiac enlargement by appropriate imaging techniques(e.g., cardiothoracic ratio > 0.5 on PA CXR with good inspiration, or LVED diameter of > 5.5 cm on 2D echo), resulting in inability to carry on any physical activity, and with symptoms of inadequate cardiac output, pulmonary congestion, system congestion, or anginal syndrome at rest; e.g., recurrent or persistent fatigue, dyspnea, orthopnea, anginal discomfort;

or

B. Documented cardiac enlargement by appropriate imaging techniques or ventricular dysfunction manifested by S_3, abnormal wall motion, or LVEF of 30 percent or less by appropriate imaging techniques; **and**

1) Inability to perform on an exercise test at a workload equivalent to fiveMETs or less due to symptoms of chronic heart failure, or—in rare instances—a need to stop exercising at this level of work because of

a) Three or more consecutive PVCs or three or more multiform beats; **or**

b) Failure to increase systolic BP by 10 mm Hg, or decrease in systolic BP below the usual resting level; **or**

c) Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion; **and**

2) Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest.

or

C. Corpulmonale

4.04 Ischemic Heart Disease

Chest discomfort associated with myocardial ischemia, while on a regimen of prescribed treatment, with **one** of the following:

A. Symptom-limited ETT with **at least one** of the following at a workload equivalent to five METs or less:

1) Horizontal or down-sloping ST depression (in the absence of digoxin and/or hypokalemia) of at least 1 mm that has a typical ischemic time course of development and persists for at least one minute during recovery; **or**

2) Up-sloping ST junction depression (in the absence of digoxin and/or hypokalemia) in any lead (except AVR) of at least 2 mm or more for at least 0.08 seconds after the J junction and persisting for a least one minute during recovery; **or**

3) At least 1 mm ST elevation above resting baseline during both exercise and three or more minutes of recovery in EKG leads with low R and T waves in the leads with the ST elevations; **or**

4) Failure to increase SBP by 10 mm Hg, or decrease in SBP below the usual clinical resting level; **or**

5) Documented reversible Thallium perfusion defect at an exercise level equivalent to five METs or less;

or

B. Impaired myocardial function, documented by evidence of hypokinetic, akinetic, or dyskinetic myocardial free wall or septal wall motion with LVEF of 30 percent or less, and an evaluating physician has concluded that ETT would present a significant risk to the individual, resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

or

C. Coronary artery disease (CAD) on angiography, and an evaluating physician has concluded that ETT would present a significant risk to the individual, with **both 1 and 2:**

1) Angiographic evidence revealing:

   a) Zero percent or more narrowing of non-bypassed left main coronary artery; **or**

   b) Seventy percent or more narrowing of another non-bypassed coronary artery; **or**

   c) Fifty percent or more narrowing involving a long (> 1 cm) segment of a non-bypassed coronary artery; **or**

   d) Fifty percent or more narrowing of at least two non-bypassed coronary arteries; **or**

   e) Total obstruction of a bypass graft vessel; **and**

2) Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitations, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest.

5.04 Peptic Ulcer Disease

PUD must be demonstrated by UGI or endoscopy, with **one** of the following:

A. Recurrent ulceration after definitive surgery persistent despite therapy; **or**

B. Inoperable fistula formation; **or**

C. Recurrent obstruction demonstrated by UGI or endoscopy; **or**

D. Weight loss of three months duration despite prescribed therapy and expected to last at least 12 months. The weight must be equal to or less than the values specified in the tables below.

MEN		WOMEN	
Height	**Weight**	**Height**	**Weight**
61"	90 lbs	58"	77 lbs
62	92	59	79
63	94	60	82
64	97	61	84
65	99	62	86
66	102	63	89
67	106	64	91
68	109	65	94
69	112	66	98
70	115	67	101
71	118	68	104
72	122	69	107
73	125	70	110
74	128	71	114
75	131	72	117
76	134	73	120

5.05 Chronic Liver Disease

The presence of **one** of the following:

A. Esophageal varices (EV) with massive UGIB (consider the disability for three years following the last massive hemorrhage); **or**

B. Performance of any shunt operation for EV (consider the disability for three years following the surgery); **or**

C. Bili > 2.5 on repeated exams over five months; **or**

D. Ascites > five months, documented by paracentesis or persistent alb < 3.0; **or**

E. Hepatic encephalopathy; **or**

F. Chronic liver disease, confirmed by biopsy, and **one** of the following that persists for three months or longer:

   1) Ascites; **or**

   2) Bili > 2.5; **or**

   3) Hepatic cell necrosis or inflammation, as evidenced by prolonged PT or elevated liver enzymes (AST and ALT).

9.08 Diabetes Mellitus

With **one** of the following:

A. **Neuropathy** demonstrated by significant and persistent disorganization of motor function in at least two extremities resulting in sustained disturbance of gross and dextrous movements, or gait and station; **or**

B. **Acidosis** every two months on average documented by pH, PCO_2, or HCO_3; **or**

C. **Amputation** at—or above—the tarsal region due to diabetic necrosis or peripheral arterial disease: **or**

D. **Retinitis proliferans** with documented visual impairment.

9.09 Obesity

Weight equal to or above the values in the tables below, and **one** of the following:

A. Pain and limitation of motion in a joint or in the spine and demonstration of DJD on imaging; **or**

B. HTN with DBP > 100; **or**

C. Chronic venous insufficiency with varicosities, pain on weight-bearing, and persistent edema; **or**

D. Respiratory disease with FVC < 2L, or resting hypoxemia.

OBESITY TABLES

MEN		WOMEN	
Height	**Weight**	**Height**	**Weight**
60"	246 lbs	56"	208 lbs
61	252	57	212
62	258	58	218
63	264	59	224
64	270	60	230
65	276	61	236
66	284	62	242
67	294	63	250
68	302	64	258
69	310	65	266
70	318	66	274
71	328	67	282
72	336	68	290
73	346	69	298
74	356	70	306
75	364	71	314
76	374	72	322

12.06 Anxiety Disorders

The requirements of A and B, **or** A and C, must be met for eligibility:

A. Medically documented findings of **one** of the following:

1) Generalized persistent anxiety accompanied by three out of the following four:

   a) Motor tension;
   b) Autonomic hyperactivity;
   c.) Apprehensive expectation;
   d.) Vigilance and scanning; **or**

2) Persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; **or**

3) Recurrent severe panic attacks on average of at least once a week; **or**

4) Recurrent obsessions or compulsions, which are a source of marked distress; **or**

5) Recurrent and intrusive recollections of a traumatic experience.

and

B. Resulting in at least **two** of the following:

1) Marked restriction in ADLs;

2) Marked difficulties in maintaining social functioning;

3) Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner;

4) Repeated episodes of deterioration or decompensation in work which cause the person to withdraw from that situation or experience exacerbation of signs and symptoms;

or

C. Resulting in complete inability to function independently outside the area of one's home.

14.08 HIV Infection

Documentation of HIV infection and **one** of the following:

A. Bacterial infections:

1) Mycobacteria linfection (MTB, MAI, or M. kansasii) at a site other than the lungs, skin, or cervical or hilar nodes; or pulmonary TB resistant to treatment; **or**
2) Nocardiosis; **or**
3) Salmonella bacteremia, recurrent non-typhoid; **or**
4) Syphilis or neurosyphilis (evaluate sequelae underaffected body system); **or**
5) Multiple or recurrent bacterial infection(s), including PID, requiring hospitalization or IV antibiotics three or more times in one year.

or

B. Fungal infections:

1) Aspergillosis; **or**
2) Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs;**or**
3) Coccidiomycosis, at a site other than the lungs or lymph nodes; **or**
4) Cryptococcosis, at a site other than the lungs; **or**
5) Histoplasmosis, at a site other than the lungs or lymph nodes; **or**
6) Mucormycosis.

or

C. Protozoan or helminthic infections:

1) Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for one month or longer; **or**
2) Pneumocystis carinii pneumonia or extra-pulmonary infection; **or**
3) Strongyloidiasis, extra-intestinal; **or**
4) Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D Viral infections:

1) CMV at a site other than the liver, spleen, or lymph nodes; **or**
2) HSV causing:
    a) Mucocutaneous infection lasting for one month or longer; **or**
    b) Infection at a site other than the skin or mucous membranes(e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); **or**
    c) Disseminated infection; **or**
    d) Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; **or**
    e) Progressive multifocal leukoencephalopathy; **or**
    f) Hepatitis, as described in Chronic Liver Disease (5.05) criteria above.

or

E. Malignant neoplasms:

1) Carcinoma of the cervix, invasive, FIGO stage II and beyond; **or**
2) Kaposi's sarcoma with:
    a) Extensiveoral lesions; **or**
    b) Involvement of the GI tract, lungs, or other visceral organs;**or**
    c) Involvement of the skin or mucous membranes; **or**
3) Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease); **or**
4) Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment (e.g., eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease).

or

G. Hematologic abnormalities:

1) Anemia;**or**
2) Granulocytopenia; **or**
3) Thrombocytopenia.

or

H. Neurological abnormalities:

1) HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses; **or**
2) Other neurological manifestations of HIV infection (e.g., peripheral neuropathy).

or

I. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline and, in the absence of a concurrent illness that could explain the findings, either:

1) Chronic diarrhea with two or more loose stools daily lasting for one monthor longer; **or**
2) Chronic weakness and documented fever > 38 degrees C (100.4F) for the majority of one month or longer.

or

J. Diarrhea, lasting for one month or longer, resistant to treatment, and requiring IV hydration, IV alimentation, or tube feeding.

or

K. Cardiomyopathy.

or

L. Nephropathy.

or

M. One or more of the following infections (other than described in Sections A – L above) resistant to treatment or requiring hospitalization or IV treatment three or more times in one year:

1) Sepsis; **or**
2) Meningitis; **or**
3) Pneumonia; **or**

4) Septic arthritis; **or**
5) Endocarditis; **or**
6) Sinusitis (documented radiographically).

or

N. Repeated manifestations of HIV infection (including those listed in Sections A – M above, but without the requisite findings, e.g., carcinoma of the cervix not meeting the criteria in 14.08 E malignant neoplasms, diarrhea not meeting the criteria in 14.08 J, or other manifestations, e.g., oral hairy leukoplakia, myositis) resulting in significant, documented symptoms or signs(e.g., fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the marked level:

1) Restriction of ADLs; **or**
2) Difficulties in maintaining social functioning; **or**
3) Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Note: No changes have been made in these criteria for disability due to HIV infection for several years and none are currently anticipated. While this listing can appear overwhelming, a few helpful hints may simplify the process for the wary clinician:

- *AIDS is not mentioned in this entire listing.* Thus, some asymptomatic HIV-infected individuals with CD4 counts less than 200 meet the CDC definition for AIDS but do *not* meet the disability criteria listed above.

- *CD4 counts and viral loads are not cited* and SSA does not directly consider these values in determining disability except as supporting evidence.

- Sections A – M are relatively straightforward ; e.g., HIV infection with a diagnosis of PCP on bronchoscopy suffices for the determination of disability. The clinician is responsible for providing documentation, however, such as pathology results from a biopsy of Kaposi's sarcoma.

- Section N is very helpful for clinicians and offers wiggle room for patients who do not meet the stricter criteria in Sections A – M. "Repeated manifestations of HIV infection" can be broadly interpreted—at least in some states—to include diarrhea, rashes and even side effects of needed medications. Some states consider a falling CD4 count and a rising viral load as a manifestation of HIV infection. These manifestations must be accompanied by such signs and symptoms as fatigue, fever, night-sweats, malaise, weight loss, etc., and accompanied by marked restriction of Activities of Daily Living or marked difficulties in social functioning, or marked difficulties in

completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

SSA'S DESCRIPTION OF THE LISTING OF IMPAIRMENTS

The Listing of Impairments appears in the Code of Federal Regulations, 20CFR404, Subpart P, Appendix1. The following description of the Listing of Impairments appears at 20CFR416.925:

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.

Adult and childhood diseases. The Listing of Impairments consists of two parts:

1) 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.

2) Part B contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18.

How to use the Listing of Impairments. Each section of the Listing has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are 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. Medical findings consist of symptoms, signs and laboratory findings.

Diagnoses of impairments. We will not consider your impairment to be one listed in Appendix 1 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 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.

Sources: 45 FR 55621, August 20,1980, as amended at 56 FR 57944, November 14, 1991; 62 FR 6424,February 11, 1997; 62 FR 13539, March 21, 1997

LETTER-WRITING GUIDELINES

Requests for clinicians to write letters documenting disabling conditions 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 Office as it investigates an applicant's claim. The following guidelines for such letters are derived from *An Advocate's In-Depth Guide to Social Security Disability and Medical Letter Guide,* prepared by attorney Peter H. D. McKee (1613 Smith Tower, 506 Second Avenue ,Seattle, WA 98104; e-mail: tddm@aol.com).Although McKee's publication focuses on disabilities related to mental health conditions, his recommendations are useful for medical conditions as well.

1) *Review* the Listing of Impairments for each health problem that your patient has. Note the clinical findings and symptoms delineated in the Listing for each relevant impairment.

2) *Compare* the specific clinical findings and symptoms with the findings that you or any other medical provider has recorded in your patient's medical record.

3) *Write* a specific letter that

   - Gives your general past history of treatment and dealings with the patient;
   - Provides a blunt observation of the severity of the patient's disability;
   - Takes each disorder one at a time as defined by the Listing of Impairments and compares the exact findings or symptoms of the relevant listed impairment with the specific findings or symptoms of your patient; and
   - Uses the recognized medical terms or measurements described in the Listing of Impairments.

If your letter clearly establishes your patient's eligibility based on a listed impairment, there is no need to go on to assess how these conditions limit your patient's daily activities. The following letter demonstrates the application of these guidelines.

ABOUT THE AUTHOR

James J. O'Connell, M.D., is President of the Boston Health Care for the Homeless Program. Dr. O'Connell originally presented this material during a workshop at the National Association of Community Health Centers' Community Health Institute in August 1997.

ABOUT THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, INC.

The National Council is a membership organization of health care providers dedicated to working with homeless people. The Council gives voice to the needs of homeless people in the evolving health care system. We train and support workers who provide care to hundreds of thousands of homeless people. We publish, organize, mobilize, educate, advocate, and consult. We promote a national health care system in which everyone's right to health care is guaranteed.

We collaborate with others to increase the supply of affordable housing and to shape welfare and employment policies so that everyone has a livable income. We work for a time when homelessness will be unknown.

Currently, the National Council has an organizational membership of 25 agencies and an individual membership of over 300 clinicians. The individual membership comprises the Health Care for the Homeless Clinicians' Network.

ABOUT THE HCH CLINICIANS' NETWORK

Members of the HCH Clinicians' Network share a passionate commitment to combating and preventing homelessness while improving the health and quality of life of homeless people. The Network provides opportunities for education, information sharing, peer support, and networking.

Membership in the Network is open to any hands-on provider of care to homeless individuals. Members include nurses, physicians, nurse practitioners, physician assistants, case managers, outreach workers, psychologists, social workers, dentists, pharmacists, mental health therapists, substance abuse counselors, and other practitioners working in the fight against homelessness.

Operated by the National Council, the Network is supported by the U.S. Department of Health and Human Services, Bureau of Primary Health Care, Division of Programs for Special Populations; program revenue; and annual membership dues.

To learn more, visit our Web site at www.nhchc.org or call 615/226-2292.