4.1 Introduction

This chapter discusses acceptable medical evidence sources and the types of evidence to be used in evaluating disability claims. It describes medical evidence development by the Disability Benefits Division (DBD), directly and through the field offices. It also gives guidelines for the evaluation of that medical evidence. Since development and evaluation are so closely related, it will be necessary to refer to the evaluation guidelines with some frequency in order to determine which forms of medical evidence should be developed, particularly when developing additional evidence.

The appendices to this chapter contain various guides useful in development of medical evidence, a body systems guide useful for development and evaluation with a glossary of terms and abbreviations, the field office's guide for developing medical evidence and the schedule of specialized medical services and fees.

4.2 Acceptable Medical Sources And Evidence

4.2.1 Acceptable Medical Sources

Although evidence from non-medical sources may be helpful in adding to the total record, evidence from a medical source is required to determine the existence or severity of an impairment. In order to have complete and accurate case records to make disability determination decisions, the RRB will obtain and consider all evidence that may or may not support the applicant’s claimed impairment(s). Reports about the applicant's impairments must come from acceptable medical sources. Acceptable medical sources are:

- Licensed physicians, (including psychiatrists),
- Licensed osteopaths,
- Licensed optometrists for the measurement of visual acuity and visual fields (we may need a report from a physician to determine other aspects of eye diseases),
- Licensed or certified clinical psychologists, and
- Persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanitarium, mental institution or health care facility.

Information submitted by optometrists, audiologists, chiropractors, naturopaths or other practitioners not licensed to practice medicine or surgery should be made a part of the record. However, when the only evidence in file is from one of these sources and the other information in file identifies a severe impairment, a consultative examination may be scheduled to determine if the claimant is disabled.

Although a measurement of visual acuity and visual fields reported by an optometrist may be used, diagnosis, prognosis, or remediability of visual impairment can be evaluated only on the basis of a licensed physician's report.

Although the results of I.Q. tests administered by educational psychologists, vocational rehabilitation counselors, or specially trained school system personnel are acceptable as evidence of impairment, the severity of the impairment can only be evaluated on the basis of standardized tests administered by psychologists or psychiatrists qualified by training and experience to perform such tests.

4.2.2 Definition Of Treating (Personal) Physician

A "treating (personal) physician" is a doctor to whom the claimant has been going for treatment on a continuing basis. A claimant may have more than one treating physician.

4.2.3 Definition Of Non-Treating (Consulting) Physician

A "non treating" or "consulting" physician is a doctor (often a specialist) to whom the claimant is referred for an examination once or on a limited basis, at the expense of RRB or SSA.

4.3 Development

4.3.1 Nature Of Development

Medical evidence consists of reports about the disability from acceptable medical sources. Usually only recent (last 12 months) medical evidence will be developed by the field. Older evidence will be developed for establishing that a child's disability began before age 22, for establishing that a widow's disability began within the prescribed period, for establishing the claimants alleged disability onset date, or at the request of DBD in other cases.

Medical evidence should be obtained from the personal physician whenever possible, since greater weight is given to the opinion of the personal physician who has treated a patient over a period of time.

The main thrust of development action should be towards resolving questions about onset, severity, and duration of the impairment. In closed period disability cases, development should also aim at determining the date on which disability ceased.

4.3.2 Definitions Pertaining To Medical Evidence

A. MEDICAL ASSESSMENT - A medical assessment describes a person's ability to do work related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, and speaking.

In case of mental impairment, it describes the person's ability to reason or make occupational, personal, or social adjustments.

B. MEDICAL EVIDENCE - Medical evidence consists of reports from acceptable sources (see 4.2.1) about the disability. Substantial evidence is such relevant evidence as a reasonable person would accept as adequate to support a conclusion regarding disability.

C. MEDICAL FINDINGS - Medical findings consist of symptoms, signs and laboratory findings:

1. Symptoms - This is the claimant's own description of his(her) physical or mental impairment.

2. Signs - These are anatomical, physiological, or psychological abnormalities which can be observed, apart from his(her) symptoms. Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomenon which indicate specific abnormalities of behavior, affect, thought, memory, orientation, and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

3. Differences Between Symptoms and Signs - Although there are many instances in which a particular manifestation might be considered as a symptom in one context and as a sign in another, it is recognized that there are qualities that distinguish one from the other. First, signs are more difficult for the claimant to fashion or control. Second, there are distinctive, characteristic signs that clinicians repeatedly associate with particular symptoms. Third, signs can be observed by the clinician or can be elicited in response to a stimulus or action by the clinician. Fourth, they require professional skill and judgment to evaluate their presence and severity as opposed to the mere noting and reporting of a claimant's statements.

4. Laboratory Finding - These are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. They include chemical tests, electrophysiological studies, (electrocardiogram, electroencephalogram, etc.), roentgenological studies (X-rays), and psychological tests.

4.3.3 Authorization To Release Medical Evidence

Authorization to release medical evidence must be obtained from the applicant and enclosed with a request for medical evidence unless:

- DBD is paying for the medical services;

- the evidence request is a routine use under the Privacy Act, (i.e., SSA or OPM); or
- authorization was previously submitted to this medical source and DBD is requesting additional medical evidence.

NOTE: Requests to VA for medical evidence require authorization unless we are paying for the medical services.

RRB Form G-197 is used to secure authorization to release medical evidence.

4.3.4 Type Of Medical Evidence Development

Development of medical evidence is usually initiated by the field office, but there are some cases where DBD initiates development. The following types of medical evidence should be considered in the development process.

A. Personal Physician Records - Whenever possible, personal physicians are to be contacted for evidence needed for evaluation because of their knowledge of the claimant's medical problems through diagnosis and treatment.

Greater weight is given to the opinions of personal physicians who have treated a patient over a period of time.

Because the personal physician is not always aware of the specific information necessary for our purposes, the clinical findings, as submitted, may not be sufficient to allow proper adjudication. If this is the case, it should not be assumed that the additional required information is not contained in the physician's records; rather, the needed information should be requested from the personal physician.

Medical evidence from the personal physician is acceptable in the following forms:

- Form G-250, Report of Examination,
- Form G-260, Report of Epilepsy convulsions,
- Narrative report on the physician's business stationery, and
- Copies of the physician's patient records.

B. Records from Hospitals or Other Institutions - The best hospital/institution record consist of a copy of the discharge summary or final report. If such a report is not available, a copy of admission history, physical findings, laboratory, and X-ray findings, as well as diagnosis, should be obtained. Field offices use a RL-11b letter to request these records.

C. Employer Records - Many employers can furnish valuable medical evidence through their medical departments or affiliated hospital association. An employer can also advise us whether the applicant was disqualified from service because of this physical condition.

Medical evidence should be requested from an applicant's railroad and nonrailroad employer by the field office with an RL-11D1, *Request for Medical Evidence from Employers,* letter to obtain any medical evidence of an employee's disability that they may have for the last 18 months. Form G-197, *Authorization to Disclose Information to the Railroad Retirement Board,* must be signed by the applicant or his/her authorized representative and attached to Form RL-11D1.

Medical evidence should be requested from an occupational disability applicant's railroad employer by the field office with an RL-11, *Letter For G-3EMP Disqualification Request for Medical Evidence from Railroad Employers*, letter if the applicant claims disqualification by his employer due to his physical condition. Some employers attach other forms or reports in lieu of completing some or all items of the G-3EMP. Accept these attachments as if the information had been entered on the Form G-3EMP.

NOTE: Form G-3EMP should not be release if the applicant does not meet the requirements for an occupational disability. (See DCM 3.2.1)

Form G-197, *Authorization to Disclose Information to the Railroad Retirement Board,* must be signed by the applicant or his/her authorized representative and enclosed with the RL-11 and G-3EMP forms. The field office assumes in these cases that a specialized examination will not be necessary.

D. Records from Other Agencies -

1. SSA - The field office requests copies of medical evidence from SSA by releasing RR-5 to the Disability Review Section at Great Lakes Program Service Center.

2. VA - The Veterans Administration maintains records in its hospitals and its regional offices. VA sources of information include VA hospitals, outpatient clinics, physicians, military services, and other hospitals. The VA will provide medical evidence on record and, where a veteran is currently hospitalized, medical information about the veteran's current condition. The field office will request VA records by releasing Form RL-11a. Before releasing Form RL-11a, the field office will evaluate the usefulness of VA medical evidence if it is not current.

3. Worker's Compensation/Public Disability Benefit - Medical evidence will be requested only if the agency is considered a "key" source. A key source is

a hospital or clinic which has treated or examined the employee since or shortly before the earliest possible disability onset date.

The field office will not request medical evidence from the paying agency if the applicant has been rated by SSA, because SSA probably has the evidence in their records.

The field office releases an RL-11d letter to the address shown on form G-214 (Worker's Compensation and Public Disability Benefit Questionnaire). All requests for federal civil service records will be sent to OPM.

OPM will provide medical evidence for a former civil service employee who has filed for a civil service disability benefit. Their records often include evidence from a claimant's physician, a Certificate of Medical Examination together with a detailed report of clinical and laboratory findings, and a report from the employing agency describing the claimant's job duties and ability to perform them.

4. Supplemental Security Income (SSI) or Other Income Maintenance - The field office will request medical evidence by releasing an RL-11d to the paying agency.

E. Specialized Examination - If medical evidence obtained from the previous listed records does not appear sufficient for disability rating purposes, the field office will schedule a specialized examination.

4.3.5 DBD Requests To Field Offices For Development

Medical evidence for an applicant living in the United States (including Alaska and Hawaii), Puerto Rico, Mexico, or Canada should be developed through the servicing RRB field office. (The Chicago field office is responsible for all claims for an individual living in Puerto Rico. See FOM1 Article 1, Appendix H for list of the RRB field office assignments to Canada and FOM1 Article 1, Appendix I for the list of RRB field office assignments to Mexico.)

A. If a disability application is received and no medical evidence is being developed, release a memo or electronic mail requesting the field office to develop the necessary data.

B. Release a memo or electronic mail message requesting the field office to contact the personal physician if additional medical data is necessary and you believe the personal physician may have the necessary data. However, the disability examiner will only request the field office to obtain additional medical evidence from the treating physician if the medical evidence is not too technical, such as a request for a copy of a particular record. In most cases, the disability examiner should request the additional medical evidence directly from the treating physician by releasing a letter of by a phone call to the physician.

C. Schedule specialized examinations when information in file indicates the personal physician does not have the necessary data and

- the data previously obtained is insufficient for a disability rating; or
- the information is received indicating the disability annuitant may have recovered; or
- a disability freeze denial letter was never released and it has been more than a year since the disability rating was done. The medical condition of the applicant should be reevaluated.

Copies of medical evidence in file should be sent with all requests to schedule examination No. 12 (neurological examination) or No. 13 (psychiatric examination). If both examinations are scheduled at the same time, send two copies of the medical evidence. When there is no medical evidence in file, state "no medical evidence in file."

Specialized examinations should not be scheduled less than 3 months after the claimant had a cerebral vascular accident, surgery or hospitalization.

D. Request the field office by memo or electronic mail to request any necessary medical records from hospitals, employers, or other agencies (see exceptions in DCM 4.3.6).

E. If an AA-1d (alone or with an AA-1) and medical evidence are needed, release G-239 to field office.

F. If the AA-1d indicates that the employee has been disqualified by the railroad and the applicant meets the requirements for an occupational disability annuity (See DCM 3.2.1), instruct the field office to obtain a Form G-3EMP or a disqualification notice.

G. DBD releases a special letter, "Six Month Heart Letter," when it is too soon to determine whether a condition will cause permanent total disability for all regular employment. Additional medical evidence will be requested through the field office after a specified period of time. Use of this letter is not limited to heart condition cases.

4.3.6 DBD Development Directly From The Source

A. If additional data is necessary from the personal physician and the request is very technical and difficult to explain to the field office, the disability examiner may release a letter or call the physician to request the necessary data. If the disability examiner receives the medical evidence from the physician over the phone, the disability examiner must send a copy of the phone conversation (Form G-94b) to the physician for the physician's signature.

B. If an application for Social Security disability benefits (Title II [Disability Insurance Benefits; DIB] or Title XVI [Supplemental Security Income; SSI]) has been filed, the Social Security Administration (SSA) has not furnished their evidence, and the field office has not requested it, request SSA's evidence and decision by Form RR-5 from Great Lakes Program Service Center. When the case needs to be expedited, the examiner should request the medical evidence by phone or by email. See DCM 11, RR-5 for details on how to request evidence from SSA. See DCM 4.3.8C2 for details on how to trace for evidence from SSA.

C. When the applicant indicated he has applied for or is receiving a disability benefit from the Office of Personnel Management, request OPM's evidence and decision by special letter. Employee authorization is not required as this request is a routine use under the Privacy Act.

D. When a disability application is submitted by a resident of a foreign country:

1. If no medical evidence is submitted, request the necessary medical data by releasing a letter to the applicant.

2. If insufficient medical data is submitted, request additional data from the personal physician if medical evidence submitted was current and it appears the physician would still be treating the applicant.

3. If insufficient medical data is submitted or if medical evidence received was not current or other information in file indicates the personal physician does not have the necessary data, schedule specialized medical examinations through the American Embassy or Consulate if the individual resides in a country other than Canada or Mexico. Refer the case to P&S – RAC for necessary information pertaining to the American Embassy or Consulate. Form RL-259 is used to request a medical examination through an American Embassy or Consulate after P&S - RAC returns the case. (See DCM 11 RL-259 for specific information about the form.)

   If the individual lives in Canada or Mexico, attempt to order specialized examinations with the RRB medical examination provider, QTC Medical Services, Inc. through FMIS.

   If QTC's attempt to schedule a specialized examination for an individual residing in Mexico is unsuccessful, refer the case to P&S - RAC for necessary information pertaining to the American Embassy or Consulate. Use Form RL-259 after P&S - RAC returns the case.

   If QTC's attempt to schedule a specialized examination for an individual residing in Canada is unsuccessful, contact the assigned field office to obtain the name, telephone number, and fax number of a current or past treating physician and/or psychologist who may be willing to perform the examinations following RRB examination protocol. Fax the examination protocol (and, if

necessary, a cover letter) to the physician and/or psychologist once that information is obtained. Complete the disability rating using the available evidence in file if it is not possible to schedule a specialized examination and no other evidence is expected.

NOTE: Development of a disability application from an individual residing in Canada or Mexico is handled by an assigned RRB field office. See FOM1 Article 1, Appendix H for list of the RRB field office assignments to Canada and FOM1, Article 1, Appendix I for the list of RRB field office assignments to Mexico.

E. When an application is submitted from a resident of an American possession or Puerto Rico:

1. Request the necessary medical evidence by releasing a letter to the applicant. (Exception: Do not follow this procedure if the personal physician lives in an area serviced by a field office. The Chicago field office is responsible for development involving individuals living in Puerto Rico.)

2. If medical evidence submitted is insufficient and the personal physician does not have the necessary medical data, attempt to order specialized examinations with the RRB medical record provider, QTC Medical Services, Inc. through FMIS.

4.3.7 Determining When To Develop Medical Evidence

Medical evidence should be developed from the earliest date following the alleged onset of disability. Certain basic evidence (such as hospital records for a claimant who alleges a recent heart attack) should be developed as early as possible, even though it may be necessary to obtain additional information at a later date before final adjudication can take place.

Most claimants have impairments which are by nature either static or progressive and, therefore, significant improvement within 12 months is not expected. Since severity is the main issue in such cases, most can be documented and evaluated immediately. Avoid unnecessary development. For instance, if the impairment has already been found to be severe and it is of a chronic or progressive nature, additional evidence would be unnecessary. However, even if the impairment is static or progressive, care must be taken to establish that the duration requirement is met and the onset date is correct if it differs from the claimant's alleged onset date.

If the initial evidence indicates that the claimant is not currently disabled, a determination of "not disabled" can be made, unless there is a closed period of disability.

If initial evidence is not sufficient to establish that the claimant's impairment is currently disabling, develop additional medical evidence immediately.

If the claimant's condition is likely to improve but the initial evidence is not sufficient to establish that he or she could be expected to return to work within 12 months after onset, delay development until such time as the condition can be expected to have stabilized. The on-site medical consultants in DBD will provide advice regarding when development should be undertaken.

4.3.8 Tracing On Evidence Necessary To Make A Disability Determination

A. General

The following tracing schedule is intended as a general guide for normal handling of outstanding evidence. Since each case has different circumstances, use discretion in deciding when it is appropriate to trace, the method of tracing and how long to delay a determination while continuing to trace.

General information regarding tracing of necessary disability evidence is found in RRB regulation 20 CFR section 220.45(b).

B. Abandonment

If the claimant cannot be contacted in person or by phone, the field office will send a letter to the claimant's last known address requesting they contact them within 2 weeks. If no response is received in that time, the field office will abandon development and contact DBD or Reconsideration Section (RECON). If the disability adjudicator notices that an applicant has not been in contact with the field office for an extended period, bring this to their attention and request an abandonment letter be released. If the claim is abandoned, DBD or RECON should then make a disability determination based on the information in file. See DCM 4.4 for additional information regarding abandonment.

Field office managers shall determine that development of evidence should or should not be abandoned for lack of cooperation in accordance with FOM1 1325.15.3 and FOM1 1325.20.7. When abandoning attempts to secure any information, the field office should provide the results of all attempted contacts that led to the abandonment.

C. Tracing Schedule

1. Medical Evidence - Indicated on the G-626 as to be submitted or requested by DBD or RECON:

   1st Tracer - 20 calendar days after the initial request. Send an electronic mail message to the manager of the field office involved. The electronic mail message should be identified as a tracer so as not to be confused with an initial assignment.

2nd Tracer - 10 calendar days after the first tracer, if no response is received, send the second tracer via electronic mail to the network manager (responsible for the field office that the first tracer was sent to) for the status. Identify the electronic mail message as a second tracer.

3rd Tracer - 10 calendar days after the second tracer, if no response is received, refer the case to your supervisor or senior examiner who will send any additional tracers via electronic mail to the Associate Director of Field Service if a response is still outstanding. Identify the electronic mail message as a third tracer.

2. SSA Evidence and Decisions - Whenever possible, SSA medical and vocational evidence and decisions should be developed for RRB disability determinations. However, claims adjudicators should not defer the processing and certification of RRB disability claims for a determination by SSA. If, at the time of filing, the claimant indicates he/she has filed at SSA, the field office should release a RR-5. If, after filing, the claimant informs RRB that he/she has filed with SSA, DBD or RECON should release a RR-5. See DCM 11, RR-5 for guidance on how to request evidence from SSA.

   Trace as follows (also use this tracing procedure for the G-26F):

   RR-5/G-26F

   a) If DBD or RECON has received no response to an RR-5/G-26F request within 30 days, email (Form G-460) to GLPSC-DPB (formerly DRS). The email address is: CHI.ARC.PCO.DPB.RRB@ssa.gov. The e-mail subject line should include “Tracing on the RR-5”.

   b) GLPSC-DPB will respond to status requests to DBD or RECON either by fax at 312-751-7167 or by email.

   c) If the medical evidence or a status report has not been received within 15 days of the email follow-up, DBD or RECON should contact the SSA GLPSC-DPB main line at 312-575-4700.

   d) If no status or response is received at this point, the DBD Initial or Post Section Supervisory Claims Examiner or Chief of RECON will contact the DPB Section Chief at 312-575-6295 within 5 working days.

   e) If issues still cannot be resolved at this level, the DBD supervisor or Chief of RECON should make any further referrals through RRB's SSA coordinator (x4396).

   f) If the request involves a critical or sensitive case, e.g., Congressional or Board member interest, RRB will alert SSA to this fact when making the initial RR-5/G-26F or follow-up request. While referral though the SSA coordinator is always available with critical or sensitive cases, every effort should be made to obtain the needed evidence through the established procedures.

g) If GLPSC-DPB encounters problems with DBD or RECON requests for or receipt of medical evidence, they should contact the DBDInitial or Post Section Supervisory Claims Examiner or Chief of RECON.

h) If issues still cannot be resolved, GLPSC-DPB will make any further referrals though its RRB coordinator.

NOTE: GLPSC-DPB will make every effort to obtain needed medical evidence as expeditiously as possible. However, there are circumstances over which GLPSC-DPB has no control. Delays can be encountered in retrieving files from certain locations, folders can be lost or mis-filed, and certain components will not release the folder until its actions have been completed. GLPSC-DPB will advise DBD or RECON when delays are encountered or a folder cannot be located. The fact that GLPSC-DPB indicates that a folder cannot be located should not by itself be a reason to refer the issue to the SSA coordinator.

3. Evidence from Other Government Agencies (except evidence through an American Embassy or Consulate) - If the application indicates medical evidence, or any other information, may be available from other government agencies (i.e., VA, State agencies, etc.,) examiners should attempt to obtain it. See RCM 10.6 for what forms need to be completed or for the address to send a letter to request information.

   1st Tracer - 30 calendar days from the date the form or letter were released, send another copy marked "Second Request."

   2nd Tracer - 10 calendar days after the first tracer release another tracer indicating this is the third request. If the information is not received after the second tracer, abandon efforts to obtain it and make a disability determination based on all other evidence that is developed.

4. Evidence from an American Embassy or Consulate - If evidence was previously requested through an American Embassy or Consulate but no information has been received within 90 days of the date that Form RL-259 was released, refer the case to P&S - RAC for further guidance.

5. Railroad Employer Information - Material to be obtained from a railroad employer (i.e., G-88a, G-3EMP, medical evidence, etc.,) is traced through the field office that is in the railroad contact official's area. The Contact Official Book shows who the railroad contact official is and his/her location.

   1st Tracer - 30 calendar days from the initial request. Send an electronic mail message to the manager of the field office involved. The electronic mail should be identified as a tracer so as not to be confused with an initial assignment.

   2nd Tracer - 10 calendar days after the first tracer, if no response is received, send the second tracer via electronic mail to the network manager (responsible

for the field office that the first tracer was sent to) for the status. Identify the electronic mail message as a second tracer.

If the information is not received after a second tracer abandon efforts to obtain it and make a disability determination based on all other evidence that is developed.

6. Other Data Requested, Not Covered Above - Any other evidence requested, but not covered in the above, should be traced as follows:

   1st Tracer - 30 calendar days after the initial request. Send an electronic mail to the network manager who is responsible for the field office for the status. The electronic mail message should be identified as a tracer so as not to be confused with an initial assignment.

   2nd Tracer - 10 calendar days after the first tracer, if no response is received, send a second tracer via electronic mail to the network manager (responsible for the field office that the first tracer was sent to) for the status. Identify the electronic mail message as a second tracer.

   3rd Tracer - 10 calendar days after the second tracer, if no response is received , consult with your supervisor or senior examiner before abandoning efforts to obtain it and making a disability determination based on all other evidence that is developed. If an additional tracer is necessary, send it via electronic mail to the Associate Director of Field Service. Identify the electronic mail message as a third tracer.

4.3.9 Guidelines For The Inclusion/Exclusion Of Cases From Processing Statistics

At times, extenuating circumstances, beyond the control of the Disability Section or the RRB Medical Contractor exist that delay a disability decision. It is essential to exclude these cases from the timeliness statistics in order to accurately reflect the agency's performance in rating disability cases. However, it is very important that cases be excluded from timeliness statistics only when warranted by circumstances. Therefore, the following sections provide a guidelines and individual responsibilities for excluding cases from processing statistics.

4.3.9.1 Examples for timeliness exclusions:

Use the following examples for guidelines when cases are allowed to be excluded from processing statistics.

A. Claimant Delay - The claimant causes a consultative examination to be delayed.

   Example: The claimant is a no-show for an examination, requests a later date for an examination, or requests a different location for the examination; or the

medical provider, through no fault of their own was unable to contact the claimant timely.

NOTE: The examiner must have ordered the exam within a timely manner from when the application was filed.

Example: The application was filed November 12, 2014. The examiner was assigned the case on November 20, 2014. All information was submitted from the field office by January 01, 2015. The examiner does not order the exam until January 07, 2016. When the contractor attempts to schedule the claimant for exam, the claimant needs the date of appointment to be changed. This case should not be excluded from timeliness because examiner failed to order the exam timely.

B. Recovery Delay - The claimant has an impairment that requires a recovery period or has undergone a medical treatment that may improve his/her condition, and a reassessment of the condition must be conducted after the recovery period.

Example 1: A 40 year old claimant files on February 13, 2016, for a Total and Permanent disability due to a herniated intervertebral disc in the lumbar spine. On April 20, 2016, s/he undergoes a discectomy. An assessment of his/her condition, to see if the condition has improved from surgery, should be conducted 3 months after surgery. This case should be excluded from the timeliness reports.

Example 2: Claimant underwent surgery July 2, 2016 (discectomy and fusion) and files a disability application July 24, 2016. The examiner pends the case for October 2, 2016, to see if the claimant's condition improved from surgery. Examiner traces for follow-up medical evidence and is told claimant has an appointment scheduled with his/her surgeon for October 8, 2016. Follow-up medical evidence is received or scanned into imaging October 24, 2016. Since development was suspended pending follow-up medical evidence, the case should be excluded from the timeliness reports.

C. Evidence Delay - Medical or non-medical evidence which (in the examiner's judgment) is vital to a proper disability determination has been requested from a specific source (i.e., hospital, doctor, government agency, etc.). The claimant, field office, and Disability have all tried to obtain this evidence, but the source has not responded. Depending on the nature of the delay, this evidence should be abandoned as cited in DCM 4.3.8B and the claim may be excluded from timeliness reports if the delay is justified.

Example 1: The claimant has been a patient in a mental institution for a year prior to a representative payee filing an application at the Railroad Retirement Board. The representative payee has signed all releases for medical evidence from the institution, but, due to confidentiality, the institution will not release any

information from the past year without a court order. This type of a claim should be excluded from timeliness reports since a legal issue that may take an extended amount of time must be decided.

Example 2: An applicant files an application for disability on August 1, 2016, based on coronary artery disease. The field office indicates medical records are to be submitted. On August 25, 2016, Disability receives some of the medical records (some examinations and hospital records). An examiner reviews the file September 2, 2016, and pends the file until September 30, 2016, for the additional evidence. An examiner reviews the file on October 3, 2016 and e-mails the field office for the outstanding evidence. The field office e-mails Disability on October 6, 2016, stating they are having difficulty obtaining the applicant's treadmill stress test and catherization report but hope to get it soon. The examiner determines this medical evidence is vital to the rating and opts to wait for this evidence rather than order examinations. On October 29, the field office e-mails Disability stating the doctor will provide the reports soon. On November 14, 2016, final medical records are received or scanned into imaging. This case should be excluded from the timeliness report.

Example 3: The claimant states on his/her AA-1d that his/her personal physician has treating notes, examination reports, X-rays, etc. The examiner believes this medical evidence is vital to a proper disability determination. However, the physician does not release the medical records timely, despite tracing from Disability/Field Office. This case should be excluded, even if additional medical evidence still needs to be developed. However, if the disability examiner is informed at the time of filing that the personal physician refuses to release medical evidence due to situations such as an unpaid past due bill, law suits, etc. then the case should not be excluded since the disability examiner should have begun developing the necessary information from another source.

Example 4: The claimant filed an application on August 1, 2016. The SSA DEQY revealed self-employment earnings. An AA-4, *Self-employment and Substantial Service Questionnaire,* and a G-252, *Self-Employment/Corporate Office Work and Earnings Monitoring*, were released to the claimant. A copy of the client's federal tax returns was also requested. Medical development continued while pending the outstanding self-employment forms. The claimant did not submit the AA-4/G252 or the copy of the Federal tax returns was delayed until December 1, 2016. This case should be excluded from the timeliness report due a non-medical evidence delay.

D. Filing Delay - The filing date is prior to the date the application is submitted and one of the following circumstances exists:

- The claimant was deterred from filing an application; or

- A protected filing date is to be used as the official filing date;

  NOTE: The field office does not always indicate that a protected filing date is involved. Check the application filing date, the date the paper file is received or the application is scanned into imaging, and the date the application is signed. In addition, you should check the remarks of the G-626, contact log and APPLE Summary Screen PF24 to see it the field office indicated that there was a protected filing date.

  Example: An application is received in Disability December 15, 2016. The filing date is October 31, 2016, and the examiner notes the application was not signed until November 28, 2016. This case should be excluded from the timeliness report.

- The claimant previously filed at SSA and SSA's filing date will be used.

E. Confinement Delay - The claimant files an application for a disability and, at any time during development, is confined to a correctional institution.

F. Other Delay – Some other reasons for time lapse exclusions are:

- The claimant does not reside in a field office area and development of medical evidence is conducted through an American Embassy, the State Department, or other agency.

- The file containing an active disability application is requested by another bureau, which has a higher priority action.

  Example: A spouse files an application for an annuity based on a disabled child while the Reconsideration Section is working on a reconsideration request for an earlier onset date from the employee. Since this file may be in Reconsideration for an indeterminate amount of time, it should be excluded from timeliness reports.

- The claimant files an application for a disability and a previous disability decision is in the appeals process, at any level. No action can be taken on the new application until the appeal has been completed.

- Another unit mishandles a file or mistakenly sends the file to Claim Files and causes a delay in making a determination.

4.3.9.2 Responsibilities

These guidelines should be used in deciding inclusion/exclusion of timeliness statistics ***in initial disability cases only***. There may be other situations beyond Disability's or the RRB Medical Contractor's control that are not covered by the guidelines that could cause a delay in rating.

A. Examiner Action:

If an examiner feels that a case should be excluded because it meets the guidelines or for any other reason not covered by the guidelines, s/he should:

- Complete D-Brief, or the OLDDS screen (if D-Brief is not being completed) with the correct exclusion code (See DCM 12.5.6.7).

- Complete Form G-226, *Time Lapse Exclusion Case*, and send it to the Disability Initial Authorization folder.

  NOTE: The G-226 form must be completed by the initial examiner prior to sending the case to authorization.

- After the G-226 is sent to the Disability Initial Authorization folder, send an email to the Disability Initial supervisor with a cc to the Disability Post supervisor and the Disability Director. In this email, indicate that there is a G-226 in the Disability Authorization folder for claim number xxx-xx-xxxx which needs to be reviewed and approved.

- If exclusion is approved – Once the examiner receives an email back from the director or supervisor that the form was approved and is on imaging, the case can be sent to the authorization folder.

- If exclusion is denied – Once the examiner receives an email back from the director or supervisor that the exclusion was denied, the examiner is to update DBrief and/or OLDDS to reflect that the case was not excluded from timeliness, and the case can then be sent the case to the authorization folder.

B. Supervisor Action:

Only the Disability Director and Supervisors are authorized to sign off on the form. After receiving an email from an examiner that a G-226 is in the Disability Initial Authorization folder, the director or supervisor will:

- Approval – The director or supervisor will review the form and if s/he agrees with the exclusion, will approve it and release the form to imaging. Once the form is sent to imaging, the director/supervisor will send an email back to the examiner advising the examiner that the exclusion was approved and the form is imaged.

  NOTE: The exclusion must be reviewed, approved or denied, and imaged by the Disability Director or Supervisor prior to sending the case to authorization.

- Denial - If the Disability Director or Supervisor disagrees with the exclusion, s/he will send an email to the examiner with the reason for the disagreement.

See DCM 11.2 G-226 for form completion instructions.

4.4 Abandonment

4.4.1 Responsibility For Development

Although the field office has the main responsibility for developing medical evidence, it is the claimant's responsibility to cooperate with and assist the field office in obtaining existing evidence and to provide information as to his/her condition and treatment.

The claimant, in most cases, can be expected to provide records from the personal physician. The field office will provide any assistance the claimant may need in obtaining such records.

4.4.2 Abandoning Development For A Specific Report

While a claim is being developed, the field office will generally pend a request for medical evidence for 30 days, at which time a tracer or second request will be made, generally in addition to a follow-up phone call. If no response is received after 15 days, efforts to obtain that piece of medical evidence will be abandoned, unless it is known that the evidence can be obtained within a reasonable period. The field office will advise DBD or RECON of their action. (See FOM1 1325.15.3 and FOM1 1325.20.7)

4.4.3 Abandoning A Request For Specialized Examination, Laboratory Test Or X-Ray

If a claimant fails to report for a specialized examination, laboratory test or X-ray, the field office will contact the claimant. If the claimant is willing to submit to the examination or test, it will be rescheduled. If the claimant is unwilling, or, without good cause, fails to report for the second appointment, the field office will abandon efforts to secure such medical evidence. The field office will advise DBD or RECON of their action.

4.4.4 Abandonment For Lack Of Cooperation

The field office will abandon medical evidence development for lack of cooperation by the claimant after it has been determined by the field office manager that the claimant was contacted in person or by phone, the importance of the claimant's cooperation was explained, the lack of cooperation is willful and future cooperation is unlikely.

If the claimant cannot be contacted in person or by phone, the field office will send a letter to the claimant's last known address requesting him/her to contact the field office within two weeks because the claim is still pending and the claimant's cooperation is needed. Field Service will send a copy of all tracer letters to imaging and update Contact Log documenting all tracing actions. If no response is received within two weeks, the field office will abandon development.

When the field office abandons for lack of claimant cooperation, a report will be submitted via E-mail to the DBD Group Mailbox or, if known, the personal E-mail inbox of the Reconsideration Section disability adjudicator covering the actions taken and the reason for abandonment. (See FOM1 1325.15.3 and FOM1 1325.20.7)

4.4.5 Action By Disability Benefits Division When Medical Evidence Cannot Be Obtained

If development of medical evidence is abandoned, it does not necessarily follow that the claim must be denied. Make a disability determination based on whatever evidence is available. If no medical evidence was submitted, a determination should be made based on non-medical evidence in file.

If the field office reports that efforts to obtain medical evidence have been unsuccessful, but there is non-medical evidence or reports from practitioners who are not licensed to practice medicine, the claim may be denied without further development, provided the evidence in file indicates there is not a severe impairment (an RFC must be obtained based on what is in file). The denial letter should cite the failure to submit medical evidence and the efforts to secure it as well as the factors contained in the existing evidence which support a finding of "not disabled."

If there is reason to believe that a claimant's lack of cooperation is due to incompetence, have the field office seek a representative to act in the claimant's behalf for medical evidence development.

If the claimant is unable to cooperate with requests for medical evidence or specialized examination because of illness or some other valid reason, and a favorable determination cannot be made without such evidence, the case should be pended and the field office should make arrangements to obtain the evidence at a later date.

NOTE: In single freeze cases where a case is being denied due to abandonment, the examiner is to deny the case on OLDDS without having it authorized by another claims examiner. For this situation the examiner can submit and review the case on OLDDS themselves. This is done by entering a "Y" in the SUBMIT field and then entering the date and a "Y" in the REVIEW field.

4.5 Transmittal Of Medical Evidence

4.5.1 Application For Monthly Disability Annuity

A. The field office will submit medical evidence with the application even if all the medical evidence is not available for submission. Any medical evidence the field office has will be submitted since DBD may be able to make a favorable disability determination without all the medical evidence available.

B. After the application is transmitted, the field office will submit any additional medical evidence received via Form G-26b. The G-26b will indicate:

- what medical evidence is attached,
- what medical evidence is still being developed, and
- the expected date the outstanding evidence will be submitted.

4.5.2 Medical Evidence Submitted on a CD

In some instances DBD may receive medical evidence from other governmental agencies, hospitals, doctors, etc. on a CD. In these cases examiners will need to open the CD to determine exactly what is being submitted. Disability claims examiners need to take the following action:

A. Medical Evidence Received on CD from a Treating Source

1. CDs that can be opened and have:

   a. Medical Evidence that has images only – In cases where the CD is opened and shows that it contains images only, check the file to see if a corresponding written report has been already placed in the file. If a corresponding report is in file, enter a note to file that only images appear on the CD, but that a corresponding written report is in the file. If there is no corresponding written report, contact the field office to obtain the report.

   b. Medical evidence that has images and reports – Make the determination that the written report corresponds to the images being shown. When the images and reports correspond print the report out for the file. In the cases where the images and reports do not correspond, it will be necessary for the examiner to contact the field office to obtain the report that corresponds with the images.

   c. Medical evidence that has written reports only – Print out a copy of all reports that are on the CD. Place a note in file to indicate that all medical evidence on the CD has been printed out and is in the file.

In all cases in which a CD is present, the CD along with all written reports are to be matched to the file.

2. If the CD cannot be opened, place the CD in an envelope with a note stating that the CD cannot be opened and place it in the file. Contact the field office and ask them to have the applicant obtain the information on the CD in another format. Instruct the field to tell the employee that if the information on the CD is images only, those images are not needed for our file. Instead the employee will need to obtain the report based on the images on the CD.

B. Medical Received on CD from SSA

These CDs are to be opened and the information contained on the CD is to be printed out. A note to file indicating that an action has been taken is to be created and dated (For example, “All M/E on the CD has been printed out and matched to the file.”). The printed reports and CD are then matched to file.

In some instances the amount of medical evidence on the CD may be very large. In those cases do not print out the large sources of data. Rather indicate on the note to file that all medical evidence has been printed out on the CD except for the noted medical evidence. You would then note the medical evidence you did not print out (this would be the medical evidence that involved large volumes of paper). For example, “All M/E on the SSA CD has been printed out and attached except for the 350 pages of VA records. If upon review of the file it is determined that these records are needed, contact the disability Quality Analyst.”

4.6 Specialized Examinations, Laboratory Tests And X-Rays

4.6.1 Authority To Schedule Specialized Examinations

All field office are authorized to request and schedule most specialized examinations, laboratory tests, and X-rays listed in DCM 4, Appendix C without prior approval from the Disability Benefits Division.

4.6.2 When Specialized Examinations Should Not Be Scheduled

Before taking action to schedule specialized examinations, consider if the information needed may be available from the records of the claimant's personal physician. Further, specialized examinations should not be contracted under the following circumstances:

A. Applicant is confined to a hospital or institution or was hospitalized within the last three months. Secure the hospital report.

B. Applicant is confined to his home because of his disability.

C. The applicant's disability is based solely on an obvious condition such as a loss of a limb. Schedule specialized examinations if employer or applicant source medical evidence is not sufficient for rating purposes.

D. Employer or railroad hospital association is expected to submit medical evidence, and that employer's source's evidence is usually adequate for rating purposes.

E. Applicant's personal physician is the only doctor in the area, and the applicant cannot travel.

4.6.3 When Specialized Examinations Should Be Scheduled

Take action to schedule specialized services for the following purposes:

A. clarification of clinical findings and diagnosis,

B. acquisition of highly technical or specialized medical information otherwise unavailable,

C. resolution of a pertinent conflict or contradiction in the evidence,

D. determination of current severity in continuance cases.

4.6.4 Field Office Determination Of Special Examinations To Schedule

The field office will use DCM 4 Appendix B to determine which specialized examinations to schedule.

The field office may call DBD if further assistance is necessary to determine which examinations should be obtained.

4.6.5 Processing Payment For Medical Examinations And Services

Payments for medical examinations and services are processed on the Financial Management Information System (FMIS). This system provides the necessary database for budgetary planning and assures compliance with provisions of the Prompt Payment Act which requires payment to providers within 30 days. There are essentially two steps to processing medical fee payments on FMIS. First, appropriated funds are obligated by completing a **M**edical **E**xam Order (ME) entry when services are scheduled with the provider. Upon receipt of requested services, a **M**edical Exam **P**ayment **V**oucher (MPV) entry is completed to set up payment. Both ME and MPV entries are centrally processed by the Disability Benefits Division (DBD). A copy of the MPV screens that verify payment and specify what exam(s) is being paid for should be put in the file for documentation purposes. The Bureau of Fiscal Operations (BFO) authorizes entries and payments are disbursed promptly to the provider.

4.6.6 Field Office Responsibility For Scheduling Special Examinations

The field office will schedule special examinations with the RRB medical record provider, QTC Medical Services, Inc. Medical examinations can be ordered through FMIS.

4.6.7 DBD Handling Of Claims For Payment

The data entry for both MOs and PVs required to effect payments to medical providers is centrally processed in the DBD-Support Section. The accuracy of data entered is the responsibility of the field office. Our responsibility is to assure that HSL messages sent by field offices are promptly retrieved from the HSL mailbox and entered immediately.

The field office is also responsible for submitting hospital or institution bills for copies or transcripts of records with Form G-370 (See Exhibit 13).

4.7 Disability Standards And Guides

4.7.1 Published Medical Guides

Disability claims adjudicators routinely refer to published medical reference information to assist in making sound disability determinations. The Railroad Retirement Board recognizes the need to allow disability claims adjudicators to access both print and electronic sources of medical reference as a legitimate business need for our customers. Therefore any online reference source may be accessed presuming that:

- It is necessary in the performance of the adjudicator's duties;
- No personally identifiable information (PII) pertaining to a Railroad Retirement applicant or annuitant is transmitted;
- No personal medical information is transmitted; and
- It is reasonably certain that the website does not host malicious software or is not otherwise inappropriate.

Click here for an Excel spreadsheet containing a list of some medical references available to disability adjudicators. If a reference is available online, hyperlinks are provided. Note the tabs at the bottom of the spreadsheet. Disability adjudicators needing to register at a website may do so with a personal logon.

There may be other websites which are not recognized but may also provide information useful to disability adjudicators. Requests to add other medical reference websites to the list may be referred through proper supervisory channels to Policy & Systems - RAC.

NOTE: Downloading software in order to obtain access to or view a website is not permitted without proper authorization.

Notify Policy & Systems - RAC of obsolete website addresses in the list through supervisory channels.

4.7.2 Additional Aids

Additional aids to reaching legal, just and equitable disability decisions are as follows:

A. Advanced training sessions - These sessions are tape recorded, and the tapes are available for reference or review.

B. Individual counseling by the section chief or on-site medical consultants.

C. Policy decisions and internal office memoranda.

D. Three-member Board decisions in appealed cases.

E. Legislative enactments, court decision summaries and legal opinions (L).

F. Audit Review Guide For Body Systems prepared by Consultative Examinations, Inc.

G. Social Security Rulings - Disability (SSR).

H. SSA's Instructor Manual for DDS Disability Examiner basic Training Program (includes SSA's Listing of Impairments).

I. Railroad Retirement Board Regulations.

J. Social Security Administration Regulations.

K. Provisional Occupational Disability Rating Schedule.

L. Law she Studies.

4.7.3 Mental Residual Functional Capacity Assessment

When evaluating an applicant’s mental residual functional capacity (RFC), RRB medical consultant’s complete Form SSA-4734. On this form each mental activity is to be evaluated within the context of the individual’s capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Any mental activity that indicates a limitation must be documented in the medical consultant’s rationale.

As a general guide, in mental cases when an applicant is markedly limited in any of the following activities an allowance may be warranted and the examiner may want to consider if a listing is met or equaled:

- The ability to remember locations and work-like procedures;
- The ability to make simple work-related decisions;
- The ability to ask simple questions or request assistance; and/or
- The ability to be aware of normal hazards and take appropriate precautions.

In addition, if the applicant is markedly limited in any of the following activities an allowance may be warranted:

- The ability to understand and remember detailed instructions;
- The ability to carry out very short and simple instructions;
- The ability to maintain attention and concentration for extended periods;
- The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances;
- The ability to sustain an ordinary routine without special supervision;
- The ability to complete a normal; workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods;
- The ability to accept instructions and respond appropriately to criticism from supervisors;
- The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes; and
- The ability to respond appropriately to changes in the work setting.

The rationale provided by the medical consultant must support the markedly limited restriction.

4.7.4 Manipulative Limitation Chart

The following describes the impact of bilateral restrictions of handling and/or fingering on the remaining occupational base. **This chart provides guidance for decision-making. The general conclusions in the chart do not direct any decisions and each case must be evaluated on its own merits. Consultation with a medical consultant is recommended.**

MANIPULATIVE LIMITATION	SEDENTARY UNSKILLED OCCUPATIONAL BASE	LIGHT UNSKILLED OCCUPATIONAL BASE	MEDIUM UNSKILLED OCCUPATION BASE
Occasional Fingering	Less than Sedentary (38)	Light Framework (856)	Light Framework (1510)
Occasional Handling	Less than Sedentary (3)	Less than Sedentary (40)	Less than Sedentary (48)
Occasional Handling and Fingering	Less than Sedentary (3)	Less than Sedentary (35)	Less than Sedentary (42)
Frequent Fingering	Sedentary Framework (113)	Light Framework (1579)	Medium Framework (2518)
Frequent Handling	Sedentary Framework (95)	Light Framework (1357)	Medium Framework (2181)
Frequent Handling and Fingering	Sedentary Framework (95)	Light Framework (1356)	Medium Framework (2180)

1. This chart assumes no other non-exertional limitations than those described in the chart.

2. The chart assumes the manipulative limitations are bilateral.

3. The term “fingering “ refers to fine manipulation, while the term “handling” refers to gross manipulation.

4. The numbers in ( ) are the numbers of DOT occupational titles remaining at each occupational base, considering the manipulative limitation noted (based on Denver DOT).

4.8 Types Of Impairments

4.8.1 Exertional Impairments

These are impairments which manifest themselves by limitations in meeting the physical strength requirements (e.g., lifting, carrying, walking, etc.).

4.8.2 Non-Exertional Impairments

These are mental, sensory or skin impairments (e.g. alcoholism, pain which is attributable to a psychiatric disorder, loss of hearing, loss of sight); or impairments which impose environmental restrictions (e.g. inability to tolerate dust or fumes.)

4.8.3 Non-Severe Impairment

An impairment is non-severe if it does not significantly limit the person's physical or mental abilities to do basic work activities. Basic work activities are the abilities and aptitudes needed to do most jobs, such as walking standing, sitting, lifting, seeing, hearing, speaking, understanding, carrying out and remembering simple instructions.

4.8.4 Alcoholism

The effects of alcoholism on a disability determination are explained in L79-232 and in the excerpt from the OHA Law Reporter Judicial Survey - Disability Based on Alcoholism and in L-2008-6 and L-2008-6.1.

If an individual is permanently addicted to alcohol and his addiction prevents him from engaging in regular employment, he is disabled within the meaning of the Railroad Retirement Act regardless of whether there exists any end organ damage. For purposes of this section, end organ damage is defined as damage to an organ, such as brain, liver, or pancreas that is caused by the addiction.

When alcohol or drug addiction is indicated, the answers to the following questions will determine whether entitlement to railroad retirement disability benefits exists:

1. Is the impairment permanent (that is: has it lasted, or can it be expected to last, for a continuous period of not less than 12 months)?

2. If the answer to the above is "yes," has it prevented the applicant from performing work duties in a regular and customary manner for substantial wages?

The criteria used for alcoholism can also be used for other types of drug addiction. It can always be applied to both occupational and total and permanent annuities, including decisions regarding survivor disability annuities and spouse annuities based on a disabled child. However, per L-2008-06, the date the application is filed will determine

whether or not these criteria can be applied to a disability freeze or the SSA portion of a disability decision for survivors and IPI cases.

Applications Filed Before January 1, 2008

For cases in which the application was filed prior to January 1, 2008, L79-232 may be used in disability freeze decisions and the SSA portion of survivor disability annuity and IPI child disability decisions, however, it should only be used if all other means of favorably rating the case have been exhausted.

Applications Filed January 1, 2008 or Later

Per L-2008-6 and L-2008-6.1, effective with cases in which the disability application is filed on January 1, 2008 or later, L79-232 cannot be applied to disability freeze decisions, or the SSA portion of any other disability decision. Therefore you must determine whether the claim can be allowed based on end organ damage or other impairments that are independent of the addiction. It may be difficult to determine whether an impairment, especially a mental impairment, is severe enough to be permanently disabling independent of the addiction. In such cases, a medical opinion must be requested. The consulting physician must be asked to provide an opinion as to which impairments, if any, would continue to exist, and the severity of the impairment(s) if the claimant were to maintain sobriety for 1 month. If the impairment(s) would not continue to be severe after one month of sobriety, that impairment(s) cannot be considered in the disability freeze decision for a case in which the application was filed January 1, 2008 or later. If there is no end organ damage or any other impairment upon which an allowance can be made independent of the addiction, the disability freeze or SSA portion of a disability decision must be denied.

However, per L-2008-6.1, an employee VDB may be payable from the ABD even if the DF is denied. Refer cases in which the annuity is granted based on L-79-232 and the DF is denied based on L-2008-6 and L-2008-6.1 to P&S to determine vesting status.

NOTE: A joint disability freeze case should be sent to SSA as usual. If RRB determines that the claimant would be disabled even without considering the addiction, and SSA disagrees, refer the case to the post lead examiner with a request to handle as a unilateral freeze.

A widow or survivor or child would not be entitled to Medicare or SSEB status in this situation. An IPI child cannot be included in the O/M in this situation. An IPI child can qualify a spouse for an annuity, but the child would not be entitled to Medicare and the spouse would not be entitled to SSEB tax status. Survivor cases of this type cannot be done on D-BRIEF, as it would not pre-fill the third page of OLDDS properly.

Use the following means of notification to annuitants in these decisions:

For employee DF denial decisions,

- use RL-260d as a notification letter if a total and permanent disability annuity has been granted;

- use RL-260 for occupational disability annuities.

For other annuity types, include the appropriate code paragraphs on the RL-121f letter to explain the Medicare denial and non-SSEB tax status. The text of these code paragraphs (2828-2831) can be found in RCM 10.5.180. A new question has been added to the dialogue box on the RL-121f letter: *Is the disability decision based solely on drug or alcohol addiction?* If the question is answered yes, one of the following paragraphs will be included in the letter:

- code paragraph 2828 for spouse with disabled child,
- code paragraph 2830 for disabled widow(er)s, and
- code paragraph 2831 for survivor disabled children.

Do not re-adjudicate cases filed before January 1, 2008.

NOTE: Do not use diagnostic codes 30505 or 30605 on cases in which an annuity or a freeze is being allowed based on end organ damage or impairments other than addiction. Instead, use the diagnostic code associated with the end organ damage or other impairment, such as the codes for liver disease, depression, or organic mental disorder. Only use codes 30505 or 30605 in cases in which the decision is based solely on the addiction itself.

In summary, the types of cases that are affected by L-2008-6 and L-2008-6.1 are:

- Disabled employees,
- Disabled widow(er)s,
- Remarried disabled widow(er)s,
- Disabled surviving divorced spouses,
- Disabled children, and
- Young mothers, fathers, widows, and widowers with a qualifying disabled child in care over the age of 18 whose disability is based on drug or alcohol addiction.

Because these individuals do not meet SSA's criteria for disability, they are NOT entitled to the following considerations unless/until they meet criteria based on age:

- Medicare coverage,
- PIA 1 and PIA 9 increases and corresponding Tier 1 re-computations,
- Consideration for annuity increase under the O/M formula, and
- Tier 1 payments taxed as SSEB.

4.8.5 Statutory Blindness

Statutory blindness is defined in law as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees meets the definition of statutory blindness.

This type of impairment is not based on refractive error, retina detachment or inflammatory disease.

Further information concerning statutory blindness can be found in POMS DI 26000.000.

4.9 Duration Requirements

4.9.1 Duration Of Impairment Defined

The "duration of impairment" refers to that period of time during which an individual is continuously unable, because of a medically determinable physical or mental impairment(s), to:

A. work in his regular railroad occupation for an RR Act 2(a)(1)(iv)

B. perform regular employment for an RR Act 2(a)(1)(v) disability case or RR a Act widow(er) or disabled child; or,

C. engage in any substantial gainful activity (SGA) for SS Act determination for a DF: or,

D. perform any gainful activity in the case of a remarried widow(er) or surviving divorced spouse.

It extends from the date of onset of "disability" to the time the impairment(s) does not prevent the individual from performing his regular railroad occupation, regular employment, substantial gainful activity, or gainful activity, as appropriate, as demonstrated by medical evidence or the actual performance of such work.

4.9.2 Duration Requirement For A Disability Annuity And Freeze (5- Month Waiting Period)

To meet this requirement, an individual must be permanently disabled for at least 5 full calendar months after the date the freeze earnings and disability requirements were met.

NOTE: A 5- month waiting period is not required if a previous period of disability ended within 5 years before the month the current disability began.

4.9.3 Permanently Disabled (The 12-Month Duration Requirement)

A. General - To be permanently disabled, a claimant must have a medically determinable physical or mental impairment or condition that:

1. has lasted, or is expected to last, for at least 12 consecutive calendar months, or, to result in death, and

2. prevents SGA.

B. Several Impairments Lasting Less Than 12 Months Each - If the claimant had two consecutive unrelated incapacitating impairments, each lasting less than 12 months, they cannot be combined to meet the 12 month duration requirement. Disability onset cannot be extended back to the date of the first impairment if that impairment itself was disabling for less than 12 months.

EXAMPLE 1: The individual had two unrelated incapacitating impairments, one lasting for only 9 months and the other developing 6 months after onset of the first and lasting for only 7 months. The duration requirement is not met since neither impairment lasted at least 12 months even though the individual's inability to work lasted for a total of more than 12 months.

EXAMPLE 2: Same facts as above except the second incapacitating impairment lasted at least 12 months. Onset of disability is the first day that the second impairment became disabling.

4.10 Acceptability Of Medical Information

4.10.1 Carrier Medical Information

Each railroad develops, and may change at any time, the manner of internal handling of the RL-11 request for completion of Form G-3EMP. When the response reaches the Disability Benefits Division (DBD), it has passed through a railroad's company channels to the source authorized to respond to all parts of our request. The G-3EMP is completed by the contact official designated for medical matters for a particular railroad employer. Upon review, there may be some cases that require additional investigation by DBD staff (ex: no signature or title, incomplete form, or discrepant information).

Some employers attach other forms or reports in lieu of completing some or all items of the G-3EMP. Accept these attachments as if the information had been entered on the Form G-3EMP. Railroad employers may also use several terms in lieu of the word/term "disqualification". Provided it is clear that the employee has been held out of service for any medical reason that has lasted, or can be expected to last, for a continuous period of not less than 12 months, accept it as a carrier disqualification.

4.10.2 Definition Of Carrier (Employer) Disqualification

For disability purposes, the term "carrier disqualification" means a railroad employer does not allow an employee to continue working, in his/her regular railroad occupation, for a medical reason.

4.10.3 General Carrier Medical Information

The information needed from the carrier in connection with an employee's claim for a disability annuity is indicated on Form G-3EMP, "Report of Medical Condition by Employer." This includes (generally);

A. Employee's name and address.

B. RRB claim number.

C. SSA number.

D. A detailed description of the employee's adverse medical conditions of which the employer is aware or copies of relevant past or present medical evidence that the employee may have.

E. The employer's opinion of whether the employee is able to work in his/her last occupation at present or in the future.

F. The employer's opinion of whether the employee is able to perform some type of work at present or in the future and the job title of this work.

G. An indication of whether the employee was disqualified for service in his regular railroad occupation. Any disqualifications or restrictions should be explained.

H. Certification by the appropriate employer officer that the above information is correct.

4.10.4 Medical Information From Illinois Central Gulf Railroad

The Chief Medical Officer of the Illinois Central Gulf Railroad will order or approve the medical examination of an employee only when either:

A. The case involves on-the-job injury; or,

B. The report or credentials of the individual's physician cause question; or,

C. The personal physician releases the employee to return to work and the medical department has question of the employee's ability.

Otherwise, the ICG accepts and acts according to the personal physician's opinion. They will not allow the man to work without his personal doctor's release and will not

have him examined in order to make an independent decision concerning his qualification to perform his job. He is, for all intents and purposes, disqualified by his personal physician's statement.

The chief medical officer at ICG does not "disqualify" based on the personal physician's report, but places the employee on extended leave of absence. To avoid continued paperwork, after an employee has been on a leave of absence for 3-5 years, he may order an examination by a company examiner on the basis of which the employee's qualification for work will be officially determined for the company records.

In the ICG employee cases where an extended leave of absence based on a personal physician's report is involved (e.g. as indicated on G-271 or G-3EMP), generally consider a leave of absence as a disqualification when there is indication that the employee will be held out of service for medical reasons for 12 months or more.

4.10.5 Effect Of Carrier Disqualification On Disability Rating

Refer to DCM 13, Section 7.

4.10.6 Physician Independence

This depends on the relationship of the physician to the applicant.

A. Personal Physician - The applicant's personal physician may have a familial, financial or other relationship to the claimant, e.g., as an actual or potential representative payee. Conflicts of interest should be avoided as much as possible.

B. Consulting Physician - All implications of possible conflicts of interest must be avoided. For example, the physician doing the examination or test must not be a full-time or part-time employee of the RRB or SSA, unless there is no other qualified medical resource available. In such instances, the physician cannot participate in the disability decision-making or review process on that claim. Also, the physician must not have any familial, financial, or other relationship to the claimant, e.g., as an actual or potential representative payee.

4.10.7 Content Of Medical Evidence

An accurate disability decision requires medical evidence which shows the nature of the claimant's impairment(s) and the extent of the impairment(s) from the date disability is alleged to have occurred. The compilation of evidence in the file should be sufficient to allow the disability examiner to make an independent determination as to the nature and limiting extent of the claimant's impairment(s) and the probable duration.

In general, medical evidence should include the following information:

A. A History of The Impairment - Its origin and the course of the condition, dates of any confinement, type of treatment response to treatment.

B. Current Objective Findings Which Support The Diagnosis and Document Any Physical or Mental Changes Which Have Occurred - Physical examination results, clinical and laboratory tests such as blood pressure, x-rays, EKG, blood test.

C. The factual medical data upon which the diagnosis and prognosis are based.

D. A Description of Objective Findings Regarding the Claimant's Functional Limitations and Remaining Functional Capabilities - Extent of movement in the affected areas, ability to reason, activities which cause shortness of breath, distance the claimant can walk, weight which claimant can lift, ability to handle objects and operate hand and foot controls, etc.

E. Certification by the physician or physiologist submitting the medical report.

NOTE: Copies of a personal physician's notes and records do not require a signature by the physician. However, if the personal physician submits a report of Physical Examination (Form G-250) or a formal narrative report, a signature is required by the physician to attest to the fact that the physician is responsible for the report contents, explanations, and conclusions.

4.10.8 Reports Of Consultative Examinations And Tests

Consultative examinations and tests purchased in connection with the adjudication of disability claims must be performed by qualified sources. The reports must provide as much information as possible to aid in the disability determination.

A. Physician Qualifications - The physician (or psychologist, audiologists etc.) doing the examination or test must be competent to do so. While it is not required that the physician be a specialist in the medical field in which the examination or test is requested, the physician's qualifications must indicate that he or she is licensed and has the training and experience to perform the type of examination or test requested. The physician's professional conduct and reputation must be such as to avoid an unfavorable reflection upon the government and erosion of public confidence in the administration of the disability program.

B. Report Content - The reported results of the history, examinations, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested.

Therefore, the extent and detail of information expected in a report of a general internal medicine examination will differ from that expected when a neurological, orthopedic, psychological, ophthalmological, otological or other examination is requested to address a specific issue. Moreover, the reporting of information will differ when the requested examination evidence relates to the performance of tests such as ventilatory function tests, treadmill exercise test, or audiological tests. When a complete examination is involved, the report should include:

1. The major or chief complaint(s) of the claimant.

2. Within the area of specialty of the examination, a detailed description of the history of the major complaint(s).

3. A description and disposition of pertinent "positive," as well as "negative", detailed findings based on the history, examination and laboratory tests related to the major complaint(s) and any other abnormalities reported or found during examination or laboratory testing.

4. The results of requested laboratory tests performed that are necessary as a result of the physician's examination.

5. Diagnosis and prognosis.

6. A medical assessment which shows the ability of an individual to do work-related activities or to function in a work setting.

EXCEPTION: Do not request a medical assessment for statutory blindness.

In addition to the above, the consultative physician must consider, and provide some explanation or comment on, the major complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory tests. The history, examination, examination, evaluation of laboratory tests results, and the conclusions must represent the information provided by the physician who signs the report.

C. Physician Signature - The physician actually performing the consultative examination or testing must personally review and sign the report; the signature of any other physician or person is not acceptable. This attests to the fact that the physician doing the examination or testing is solely responsible for the report of contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory tests results.

4.10.9 Action To Take When A Medical Provider Signature Is Required

Do not hold up the award or denial of a disability application or a DF decision when a signature is required on a disqualification notice (Form G-3EMP), a Medical Assessment of Residual Functional Capacity (Form G-250a) or a consultative examination. Instead, send a memo with the document to the field office for the

required signature and keep a copy of the document in file. While the field office is securing the signature, the disability determination can be processed. When the signed copy is returned, it should be filed down for documentation. If the signed medical evidence is altered or additional information is provided, review it and, if appropriate, reopen the case in accordance with RCM 6.2.

4.10.10 Report Content for Internal Medicine Examination

Report content will, of course, vary according to the type of consultative examination or special service requested. Requirements for various examination reports are described in Appendix A under the specific body systems involved.

The reporting requirements for a general internal medicine examination are as follows:

A. The report should state the major complaints alleged as the reason for inability to work.

B. The history portion of the report should discuss in narrative form each major complaint, including a detailed longitudinal description of pertinent past history of the impairment as well as a detailed description of the current complaints. As much as possible, pertinent claimant statements, such as description of symptoms, should be in the claimant's own words. The description of current complaints should cite the factors which increase the problem, the factors which provide relief, and how the claimant believes the impairment limits his/her functional abilities.

   In as much detail as possible the history should include the claimant's description of significant events related to the impairment such as changes in status of the complaint(s), hospitalization (name of hospital, hospitalization dates, findings and treatment) and ongoing treatment. The names and dosages of current medication should be mentioned.

   The past history should also describe other previous illness, injuries, operations and hospitalization, including the dates of each event. A family history should also be part of the report.

   The physician should state from whom the history was obtained and provide an estimate as to its reliability.

C. The physical examination narrative should describe the claimant's general appearance and actions pertinent to the complaint (e.g., if there is a complaint of musculoskeletal disease, how the claimant stool, walked, got on/off the examining table, etc.).

   Parts of the examination which relate directly to the claimant's major complaints should be described in particular detail, noting both negative and positive findings.

If a joint is found to have no abnormality of range of motion, it should be so stated. Otherwise, the specific range of motion, in degrees, should be stated for joints in which there is significant limitation of motion.

The report should include the claimant's height and weight without shoes, pulse rate and blood pressure.

D. The actual values for laboratory tests must be given. The laboratory should provide the normal ranges of values for that laboratory for the tests which were performed. Electrocardiographic tracings and spirographic tracings must be provided when such tests are performed.

The interpretation of laboratory tests, such as EKG, X-rays, ventilatory function tests, must correlate with the history and physical examination findings. If the formal reading or interpretation of laboratory tests has been provided by a physician other than the physician signing the report, the name and address of the physician providing the formal interpretation must be given.

E. Diagnosis and prognosis based on the clinical and laboratory findings must be supplied by the physician obtaining the history and performing the physical examination.

F. The physician signing the report must review the reported history and physical examination findings. The conclusions stated in the report must be consistent with the findings from the history, physical examination and any laboratory tests obtained in conjunction with the examination. All abnormalities should be explained. If a definitive explanation cannot be made, the physician should comment on the abnormality.

4.10.11 Weight Given To Testimony Or Treating Or Non-Treating Physician

Refer to L82-165, "Weight to be given testimony of treating physician."

4.10.12 Hearsay Evidence

An acceptable medical opinion as to disability must contain more than merely a statement that the claimant is disabled. It must be supported by clinical or laboratory findings.

With the exception of the on-site medical consultants, medical evidence from physicians who have not examined the claimant should be avoided because such evidence is vulnerable on appeal as "hearsay" evidence.

This problem is discussed in SSR 71-53c - "Section 205IG, Disability Insurance Benefits, Hearsay Medical Evidence as substantial Evidence, Use of Medical Advisers."

4.10.13 Age of Medical Evidence

It has been accepted practice in disability cases to require medical evidence that is less than a year old when making a disability determination. Historically, the only exception to this practice is in occupational disability cases where a disqualification notice was received. For these cases the required medical evidence needs to establish the disqualifying impairment. It is acceptable for this disqualifying medical evidence to be greater than a year old.

In addition, it is acceptable in single freeze cases only, to use medical evidence that is up to eighteen months old in cases where the medical evidence directs a disability grant. Medical evidence that is up to eighteen months old is considered current for these type ratings and makes it unnecessary to order new examinations or develop for additional medical evidence.

4.11 Use Of Medical Consultants

Prior to requesting medical advice, disability examiners must verify the following:

- eligibility criteria is met;
- sequential evaluation process has been met; and
- there is sufficient medical evidence in the last 12 months to establish that the impairment exists. Note: medical evidence in file should also support the alleged onset date.

If a conflict exists after verifying the information, refer the case for medical advice using Form G-137, Medical Consult Opinion.

4.11.1 When To Request Advice

The Disability and RECON examiners will refer any claim requiring medical advice to the medical consultant. The most common instances are:

A. Advice is needed concerning an examination to be scheduled, or interpretation of medical report or test results; (See 4.11.3)

B. Conflicting medical reports are contained in the evidence secured; (See 4.11.4)

C. Limiting effects of the applicant's impairments are not specifically or completely addressed in the medical reports secured, and the disability examiner needs to request that the medical consultant provide the residual functional capacity (RFC) remaining to the claimant; (See 4.11.5)

D. The case involves a joint freeze determination on Form SSA- 831-U5;

E. A protest of a denial, or a request for reconsideration has been made, and there is new evidence or a previous opinion is not in file; (See 4.11.6)

F. In continuance cases, when a severity assessment is needed to determine if the disability should continue or terminate using the medical improvement standards; (See 4.11.7)

G. To determine if the impairment(s) meets or equals the level of severity of impairments in the SSA Listing of Impairments. (See 4.11.8)

4.11.2 How To Request Advice

When Disability or RECON examiners need to request advice from the medical consultant in order to make disability decisions, Form G-137, *Medical Consultant Opinion*, should be used in the instances described above in DCM 4.11.1, *When to Request Advice*. The medical consultant will respond to the Form G-137 by sending:

- Form G-137SUP, *Medical Consultant Determination Worksheet, (*for disability based on the physical impairments in the case). A G-137a may be included and/or,
- Note to File, and/or,
- Form SSA-2506-BK, *Psychiatric Review Technique*, (based on psychological impairments) and/or,
- Form SSA-4734-F4-SUP, *Mental Residual Functional Capacity Assessment, (*based on psychological impairments*).*

Form G-137: Form G-137, *Medical Consultant Opinion*, is used by DBD and RECON examiners to refer a disability case to the medical consultant for a medical opinion. Form G-137 is completed by the examiner. Examples of when to use Form G-137 include but are not limited to the common instances described above in DCM 4.11.1, When to Request Advice, Items A through G.

Form G-137a: Form G-137a**,** *Medical Consultant Opinion - Continuation Sheet*. This form is used when the medical consultant needs additional pages for their opinion continuing from the G-137 SUP. On page 4 of the SUP, the box labeled "check if additional pages are included" should be checked). The G-137a is completed, signed, and dated by the medical consultant.

Form G-137SUP: Form G-137 SUP, *Medical Consultant Determination Worksheet*, is completed, signed, and dated by the medical consultant in response to the G-137 (in cases with physical impairments). The medical consultant completes Part 1 with the residual functional capacity (RFC) assessment and also completes Part II with comments and review of the medical records used to support

the Part I RFC. The Form G-137 SUP may also be used by the medical consultant to advise the examiner when the medical records are not sufficient to provide a RFC and to recommend what medical records to obtain.

Note to File: A completed, signed, and dated note to file of the medical opinion from the onsite medical consultant during the bi-weekly visit between the consultant and DBD examiner staff.

See DCM 11.2 instructions on the use, access, and completion of the Forms G-137, G-137a and G-137SUP.

Form SSA-2506-BK, *Psychiatric Review Technique* (used for psychological medical opinions only), and/or,

Form SSA-4734-F4-SUP, *Mental Residual Functional Capacity Assessment*

4.11.3 Advice Concerning Examination To Be Scheduled Or Interpretation Of Medical Evidence

Complete Form G-137; file on right side of folder, and route to the medical consultant. If the medical opinion is being requested on an urgent basis, write the word “URGENT” in the top margin of the G-137 and in the top margin of the route slip.

4.11.4 Conflicting Medical Reports

When conflicting medical reports are contained in the evidence secured, the disability examiner should resolve the conflict by requesting a medical consultant opinion. (See DCM 13.10.1.3) For example: Examiner should seek additional information to resolve conflicting medical reports between independent medical examinations and the claimant’s treating physician, i.e. health care professional. The disability examiner should complete Form G-137, Medical Consultant Opinion. The medical consultant will respond by completing Form G-137SUP, Medical Consultant Determination Worksheet.

4.11.5 Residual Functional Capacity (RFC)

The claimant's impairment(s) may cause physical and mental limitations that affect what the claimant can do in a work setting. RFC is what the claimant can do despite his or her limitations. If the claimant has more than one impairment, DBD will consider all of his or her impairments of which DBD is aware.

DBD considers the claimant's capacity for various functions such as physical and mental abilities. RFC is a medical assessment. However, it may include descriptions of the limitations that go beyond the symptoms that are important in diagnosis and treatment of the claimant's medical impairment(s) and may include observations of the

claimant's work limitations in addition to those usually made during formal medical examinations.

The descriptions and observations of the limitations, when used, must be considered along with the rest of the claimant's medical records to enable the disability examiner to decide to what extent the claimant's impairment(s) keeps him or her from performing particular work activities.

The assessment of the claimant's RFC for work is not a decision on whether the claimant is disabled, but is used as the basis for determining the particular types of work the claimant may be able to do despite his or her impairment(s). A claimant's vocational background is considered along with his or her residual functional capacity in arriving at a disability decision.

When DBD assesses the claimant's physical abilities, DBD assesses the severity of his or her impairment(s) and determines his or her RFC for work activity on a regular and continuing basis. DBD considers the claimant's ability to do physical activities such as walking, standing, lifting, carrying, pushing, pulling, reaching, handling, and the evaluation of other physical functions. A limited ability to do these things may reduce the claimant's ability to do work.

When DBD assesses a claimant's mental impairment(s), DBD considers factors, such as:

- his or her ability to understand, to carry out, and remember instruction; and
- his or her ability to respond appropriately to supervision, co-workers, and work pressures in a work setting.

Some medically determinable impairments, such as skin impairments, epilepsy, and impairments of vision, hearing or other senses, postural and manipulative limitations, and environmental restrictions do not limit physical exertion. If the claimant has this type of impairment in addition to one that affects physical exertion, DBD considers both in deciding his or her RFC.

If the limiting effects of the applicant's impairments are not specifically or completely addressed in the medical reports secured, the disability examiner should request a medical decision by completing Form G-137 and forwarding it with the folder to the medical consultant.

The medical consultant will complete Form G-137 SUP.

4.11.6 Protest Of Denial Or Request For Reconsideration

When a protest of a denial or a request for reconsideration is received, a disability examiner, other than the disability examiner who initially handled the case, must review the case as follows:

A. No New Information or Evidence Received - If no additional information or evidence has been presented and a doctor's opinion concerning the evidence is already in file and the disability examiner reviewing the case is in full agreement with the previous decision of denial, it is not necessary to refer the case for medical opinion again;

B. New Information or Evidence - When the applicant has presented new information or evidence, the case must be referred with Form G-137 for a medical opinion. The claims specialist will place this category of case in the consultant's "special tray" because of the time limits related to these actions.

4.11.7 Termination Of Benefits

When the disability examiner determines that termination of benefits is appropriate based on medical recovery of the annuitant, the case must be referred to the medical consultant.

This type of case is referred to the medical consultant to document the file in case of protest or appeal.

4.11.8 Finding Of Disability Is Based On SS Listing Of Impairments

To determine if the impairments equal the level of severity in the SS Listing of Impairments, refer the case to the medical consultant.

4.12 Use Of RR and SS Listing Of Impairments

4.12.1 Information Contained In The RR and SS Listing Of Impairments

The SS Listing of Impairments is a listing which contains examples of medical conditions which generally prevent an individual from engaging in substantial gainful activity. This is the basic guide used by the Social Security Administration for medical evaluation of all disability claims. Its purpose is to identify those individuals who clearly have disabling impairments.

If an applicant for social security benefits has a medical condition with the specific medical findings described in the listing or one that is the medical equivalent of any listed set of findings, a finding of disability is made on medical grounds alone. This is true provided the duration requirement is met, or is expected to be met, and there is no evidence to refute the finding (i.e., performance of substantial gainful activity or failure, without good reason, to follow prescribed treatment which could be expected to restore the ability to work.

The Railroad Retirement Board also uses the SS Listing of Impairments as the basis for the Listings of Impairments found in the Regulations [20 CFR Part 220 (Appendix 1 of Part 220)] under the Railroad Retirement Act. The majority of these Listings are essentially the same; however there are instances when the SS Listing of Impairments

will differ from the Listings in the RRB Regulations. This occurs when SSA enacts new legislation changing their Listing of Impairments, before the RRB has the opportunity to update the Listing of Impairments found in the RRB Regulations.

4.12.2 Applying The RR and SS Listing Of Impairments To RRB Disability Decisions

A. Using the RRB Listing Of Impairments in a RRB Disability Decision

Disability claims examiners must use the Listings of Impairments found in the Regulations under the RR Act (Appendix 1 of Part 220) when making an initial disability annuity rating (decisions made on page 2 of OLDDS) under the RR Act. This would encompass any employee (either occupational or total and permanent), child, widow(er), remarried widow(er) or surviving divorced spouse disability decision.

B. Using the SS Listing Of Impairments in a RRB Disability Decision

Disability claims examiners must use the Listing of Impairments found in the Regulations under the SS Act (Appendix 1 to Subpart P of Part 404) when making a period of disability (Disability Freeze) rating (decisions made on page 3 of OLDDS) under the SS Act. This would encompass any employee (either single or joint), child, widow(er), remarried widow(er) or surviving divorced spouse disability decision.

When a RRB disability claims examiner is making a disability decision in which a Listing is met or equaled, it is necessary for the examiner to review each Listing of Impairments (RRB and SSA) and cite the proper Listing under each Act.

For example, it is common practice that when an applicant indicates (s)he is receiving or has filed for disability at SSA, the RRB will make an effort to obtain any medical evidence and disability decision that has been made by SSA. In these cases when a decision from SSA is received and an allowance has been made by SSA that cites a Listing as the reason for the grant, the RRB examiner will need to review the RRB Listing of Impairment to determine if it corresponds with the SSA Listing of Impairments. When the Listings match, the examiner can proceed as usual. However, in cases in which the Listing cited by SSA does not exist in the RRB Listing it will be necessary for the RRB disability claims examiner to review the RR Listing to determine if another RR Listing may be met. If not, then the case should be sent to the RRB medical opinion provider to determine if another Listing can be met or equaled. In these cases, the applicant will still be found disabled, but the decision will need to cite the correct Listing citation under each Act.

4.12.3 Impairments Which Meet The Listing

An impairment "meets" a listing only when it manifests the specific findings described in the set of medical criteria for that listed impairment. Such a finding cannot be based on diagnosis alone.

The "level of severity" in the Listing is not defined in terms of residual functional capacity. When certain functional limitations are specified for a listed impairment, they relate only to the degree of dysfunction for that particular listing section and only to the specific function identified.

4.12.4 Impairments Which Equal The Listing

To determine if an impairment or combination of impairments "equals" the Listing a comparison must be made of the medical findings (the set of symptoms, signs and laboratory findings) in the claimant's medical evidence and the medical findings specified for the listed impairment most like the claimant's impairment(s). The claimant's impairment(s) can be considered "equal" to the Listing only if the medical findings are at least equivalent in severity to those specified in the Listing. A decision of equivalence can never be made based solely on symptoms.

Equivalence is established under the following three circumstances:

A. an unlisted impairment where signs, symptoms and laboratory findings describe severity equal to the most closely related listed impairment;

B. a listed impairment where the signs, symptoms and laboratory findings are not identical to those specified for that impairment, but reflect equivalent severity;

C. combined impairments where the signs, symptoms and laboratory findings reflect severity equal to the listed impairment most like the claimant's most sever impairment.

As in determining whether a Listing is met, it is incorrect to consider whether the Listing equaled is on the basis of an assessment of overall functional impairment. If a disability examiner believes that a Listing is equaled, the case must be sent to the medical consultant.

4.12.5 Evaluation Of Symptoms

Symptoms (e.g., pain, shortness of breath) are individual's own perception of the effect of a physical or mental impairment. Symptoms do not have a significant effect on a disability decision unless clinical and laboratory data and the medical history establish findings which can reasonably be expected to account for the symptoms. There must be objective evidence to justify the overall evaluation of severity.

When symptoms are alleged as a significant aspect of the impairment, but the criteria for a listed impairment are not met or equaled and severe impairment exists, the symptoms must be considered in evaluating disability. The following guide can be used in the consideration of symptoms.

A. Is there a medically determinable severe impairment? A finding of disability can only be based on a medically determinable severe impairment. "Medically determinable" means that the impairment has demonstrable anatomical, physiological or psychological abnormalities which manifest themselves through medical evidence consisting of symptoms, signs and laboratory findings.

   If no medically determinable severe physical impairment can be found which would produce a symptom the claimant alleges limits the ability to work, it is possible that the symptom may be the result of a medically determinable severe mental impairment. If a severe impairment, either physical or mental, cannot be established based on clinical and laboratory findings, the claimant cannot be considered to be disabled, regardless of the intensity of, or limitations allegedly imposed by, the symptom. Symptoms alone cannot justify the findings of a medically determinable severe impairment.

B. Is the Listing met or equaled? Once a medically determinable severe impairment has been established, determine whether the impairment meets or equals an SS Listing. When determining whether the impairment meets a Listing which includes a symptom as one criterion, it is generally required only that the symptom be present in addition to the required clinical and laboratory findings. This is true unless the Listing specifically states that the symptom must be of a certain intensity or must cause certain functional limitations.

   If a Listing is not met, consider whether the medically determinable severe impairment equals a Listing. The clinical and laboratory findings must be equal to or greater in severity than the requirements specified in the Listing, even though the intensity of the symptoms may exceed the Listing. The intensity of symptoms can never compensate for a missing clinical or laboratory finding.

C. What is the impact of the symptoms on residual functional capacity?

   If there is a medically determinable severe impairment, but the SS Listing is not met or equaled, a RFC assessment should be made. In an RFC assessment, symptoms are considered in terms of any additional functional limitations they impose beyond those clearly demonstrated by the objective medical finding alone. Since symptoms are subjective in nature and not reliably quantifiable, functional limitations imposed by symptoms must generally be inferred from the medical history, the objective (clinical and laboratory) physical findings, and a knowledge as to what symptom - related effects on functional capacity can reasonably be expected.

Conclusions about the presence and persistence of a symptom, its effects and any resulting reduction in RFC should be based on consideration of: alleged frequency and duration of the symptom, precipitating or aggravating factors; effect on daily activities; dosage effectiveness and side-effects of medication; recorded physician observations of the symptoms. Where pain is the symptom, its location and radiation must also be considered.

4.13 Death After Denial Or Cessation

4.13.1 Evidence Required

If a claimant dies within a year after denial of a disability claim or termination due to cessation of disability, secure a death certificate and examine the medical portion. The medical portion should show the cause of death and the underlying conditions which gave rise to the direct cause. The underlying cause (the disease or injury which initiated the train of events leading to death) is shown last. If the direct cause of death adequately describes the sequence of events, no underlying conditions need to be shown.

If the death certificate is not sufficient to determine whether the denial or cessation decision was correct, secure a copy of the hospital records if the claim died in a hospital. If hospital records are not available, obtain a medical report from the physician attending at death and any other available pertinent evidence.

4.13.2 Evaluating Evidence In Death Cases

If the evidence indicates that death resulted from violence or accident, the previous disability determination need not be re-examined. If the evidence submitted after the claimant's death established that the impairment was more severe than shown by the evidence previously developed, or if an additional impairment existed which was not previously disclosed, reopen the case to consider the new evidence.

If the case was denied because the duration requirement was not met and the new evidence indicates that the impairment resulted in death and was continuously severe enough to prevent substantial gainful activity, reopen the case to make a finding of disability. (See RCM 6.2).

Appendices

Appendix A Body Systems Evaluation Guide

A. GENERAL USE OF APPENDIX

This appendix is based on the "Audit Review Guide" that was prepared by Consultative Examination, Inc. It provides general medical data to aid the disability examiner in reaching a determination of "disabled" or "not disabled."

The listing of examinations to schedule are contained in Appendix C.

B. MUSCULOSKELETAL IMPAIRMENTS

1. BASIC CONSIDERATIONS

Consideration of impairments of the Musculoskeletal System in general is somewhat unique in that pain is considered to be part of the origin of the impairment and allowance is made for such consideration.

Nonpainful but disabling conditions are found in this impairment category as well.

As with other conditions, the impairment must be a medically verifiable condition wherein applicable instances pain is generally considered as a substantial and serious problem.

Nevertheless, where pain is considered to be a factor, allegation of pain alone is never a sufficient criteria for finding disability. The basic diagnosis of medically determinable condition must be documented and some accepted objective finding that correlates closely with pain must be present on physical examination.

Proper documentation requires a medical history (a description of events to date from a medical source; M.D. or D.O.)

Objective findings of the alleged disorder on physical examination along with laboratory and x-ray findings in support of the basic diagnosis are all part of adequate documentation.

Statements or quotations from the records of an M.D. or D.O. by an acceptable source (medical records technician, medical librarian, nurse, etc.) are considered sufficient medical evidence. On the other hand, statements from a nurse’s examination, nursing practitioner's examination, chiropractic examinations and treatment, observations by a psychologist and social worker may be helpful but are NOT considered medical evidence.

Most conditions in this impairment category carry a durational requirement (the expectation that the impairment will last at least 12 months or longer.)

Only reasonable expectations are required, NOT actual duration as a condition of finding of disability.

Some conditions also require that claimant be under medical care and the condition be unresponsive to treatment.

medical care is defined as professional care rendered by a licensed M.D. or D.O.

2. INFLAMMATORY ARTHRITIS

This diagnosis category includes impairments due to forms of arthritis that cause joint inflammation.

Documentation of disability requires the history of joint pain, swelling and tenderness. Outlining of applied therapy, medication taken and response to such therapy should also be included.

Physical examination must include signs of joint inflammation (swelling, redness, tenderness) and range of motion of the affected joint in degrees.

Proper documentation of the inflammatory arthritis should include laboratory tests indicating that the arthritis is active. Such a test is the erythrocyte sedimentation rate. Some other tests are also used to improve the accuracy and specificity of these non-specific tests. Rheumatoid factor test and antinuclear antibody test are the most widely used and acceptable ones for disability determination purposes.

3. OSTEOARTHRITIS

Arthritis affecting the major joints of the upper and lower extremities are referred to by this diagnostic category. Major joints are: hip, knee, ankle, shoulder, elbow, and wrist.

Documentation should include the history indicating the onset of joint pain, the accompanying symptoms (such as stiffness), history of any surgeries done on the joint (such as surgical arthrodesis, joint replacement, etc.) The postsurgical status should be described, as well.

Physical examination of the affected joint should document signs of swelling or effusion, the range of motion in degrees, and the description of anatomical deformities in detail (subluxation, contracture, ankylosis, instability, etc.) If ankylosis is found, the position and degrees of the ankylosed joint must be described. Knee instabilities must be discussed in detail.

Laboratory findings should include x-ray evidence of joint space narrowing, osteophyte formation and/or bony destruction.

4. DISORDERS OF THE SPINE

The history should include: exact location of the pain (usually it is neck or low back pain.) Any symptoms of nerve root compression should be listed in the history (i.e. sneezing or coughing will aggravate the pain) along with accompanying bladder or bowel incontinence.

History of fractures and clarification whether these fractures were traumatic or spontaneous are also important parts of documentation.

If surgery was done, the date and type of surgery should be elicited along with discussion of therapeutic results.

Physical examination should include: the presence of surgical scars, abnormal curvatures (such as kyphosis, scoliosis or lordosis) upon inspection. Visible muscle spasms and deformities of the spine should be noted, as well.

Other components of adequate documentation are muscle tenderness or paravertebral tenderness on palpation and range of motion (expressed in degrees) of both cervical and lumbosacral spine.

Neurological examination must include: a description of the claimant's gait and posture along with the ambulatory device if used. Discussion should be present as to the distance the claimant is capable of walking with and without the device.

Motor examination includes: muscle strength, size of muscle and abnormalities (such as atrophy or hypertrophy.) The muscle strength should be quantitated; the atrophy or hypertrophy should be documented by appropriate circumferential measurements expressed in inches or centimeters.

Sensory examination: should also be described in detail as to distribution. Reflexes (especially that of the Achilles and knee jerk) should be in file.

The straight leg raising test is helpful in determining the overall severity but it is to be correlated with other clinical findings particularly due to the fact that this test includes a great measure of subjectivity.

Laboratory examinations should include x-ray examinations. Calcified ligaments, ankylosis, compression fractures, osteoporosis, signs of arthritis, etc. are important findings in substantiating the presence of a musculoskeletal disorder.

5. FRACTURES

Documentation of fractures: should include the date of injury to determine the duration of disability, if present. The treating physician's advice as to weight bearing should also be included in the history.

Physical examination findings should evidence complications if they are present (i.e., ulcers or nonunion) as well as findings as to whether any motion can be manually induced at the fracture site. The latter is direct evidence of clinical solidity versus nonunion.

If the fracture affects the upper extremity: a description of the claimant's ability to use the arms and hands for grasping, pinching, reaching, pushing, pulling and reaching overhead is required.

If the lower extremity is affected: a description of gait and posture should be included along with a description of ambulatory devices, if they are used.

6. AMPUTATION

History of amputation should describe: which extremity is amputated, and the level of amputation must be specified. The reason for amputation must be clarified as the amputation might not be found disabling but the cause for the amputation (i.e., diabetes mellitus with gangrene) might reveal an additional underlying impairment.

In most cases of amputation, the history should also detail the potential use of prosthesis and its effectiveness.

Physical examination should describe the exact level of amputation (i.e., below the knee, above the knee, midthigh, etc.) The prosthesis should be described and how well the claimant uses it. The condition of the stump should be described with respect to erosions, ulcers and/or neurological complications.

In overall assessment of disability, the condition of the other extremity should also be taken into consideration.

7. OSTEOMYELITIS

Documentation of the history of this bone infection should include: the onset date, location, symptoms along with other local (i.e., drainage) or systemic (i.e., fever) manifestations. Evidence should be developed relative to therapy applied (i.e. surgery, antibiotics, etc.) and the response to therapy.

Physical examination should describe local findings, such as heat, redness or drainage as well as systemic findings such as fever.

Laboratory examinations needed to confirm the diagnosis include x-ray evidence of osteomyelitis, leukocytosis and elevated erythrocyte sedimentation rate.

8. GLOSSARY OF MUSCULOSKELETAL TERMS, SYNONYMS, ABBREVIATIONS

A/E	Above the elbow amputation
A/K	Above the knee amputation
Amb	Ambulatory

Amp	Amputation
ANA	Antinuclear antibody test
AP and Lat.	Antero-posterior and lateral
B/E	Below the elbow amputation
B/K	Below the knee amputation
DIP	Distal interphalangeal joint
DJD	Degenerative joint disease
ESR	Erythrocyte sedimentation rate
Fx	Fracture
GSW	Gun shot wound
HNP	Herniated nucleus pulposus
I & D	Incision and drainage
jt.	Joint
JRA	Juvenile rheumatoid arthritis
LLE	Left lower extremity
LUE	Left upper extremity
MCP	Metacarpophalangeal joint
MTP	Metatarsophalangeal joint
ORIF	Open reduction and internal fixation
Ortho	Orthopedics
OT	Occupational therapy
PA	Posterior-anterior
PIP	Proximal interphalangeal joint
PT	Physical therapy
RA	Rheumatoid arthritis

RF	Rheumatoid factor test
RLE	Right lower extremity
RUE	Right upper extremity
ROM	Range of motion
Trx	Traction
THR	Total hip replacement
S/P	Status post

C. CARDIOVASCULAR IMPAIRMENTS

1. BASIC CONSIDERATIONS - Appropriate documentation of impairments of the circulatory system generally requires three-dimensional structure which is found in many other body systems as well.

   This three-pronged approach begins with a detailed medical history of the claimant's complaints, allegations, and description of symptoms.

   This history is followed by a physical examination pertinent to the complaints and history supported by one or more ancillary objective tests to verify and quantitate, when possible, the severity of the impairment.

   Objective tests, often called laboratory findings, are comprised of various impersonal modalities such as ordinary x-rays, electrocardiograms (ECG, EKG), or more sophisticated techniques such as those based on the Doppler effect.

   Some of these procedures or tests may be ordered by the Railroad Retirement Board. Other invasive types of objective evidence, for instance the ones obtained through catheterization of the heart, may not be ordered as a consultative examination. The latter procedures carry a measure of risk and are ordered only by the treating physician. Objective evidence of this type is, of course, very valuable and should be obtained when they are available as evidence of record.

   In disability claims, the primary emphasis is not on diagnostic classification, but, rather, identifying the functional disturbance which may interfere with substantial gainful activity.

   Cardiac disability generally results from one of four types of heart disease:

   1. Congestive heart failure,

2. Ischemic heart disease,

3. Conduction disturbances,

4. Miscellaneous other heart conditions.

2. CONGESTIVE HEART FAILURE

A. In concert with the principles mentioned above, this circulatory system condition should be addressed with limited concern for the etiology (the cause of the disease-producing impairment of the heart function.) This will again be apparent when subsequent impairments refer back to this condition.

The first and usually the most obvious state of heart failure which causes significant functional interference is simply the persistent congestive heart failure which has been uncorrected by treatment. Documentary requirements for this condition consist primarily of proper medical history, physical examination, and clinical findings.

Evidence of physical examination, which is usually sought to establish the diagnosis of congestive heart failure, includes: signs of vascular congestion (such as hepatomegaly), peripheral or pulmonary edema, shortness of breath, enlargement of the heart, abnormalities of the jugular venous pulse, orthopnea etc.

Notice that proper documentation of this condition does not require any specific laboratory tests. The fact of prescribed treatment, however, must be documented in the evidence. The congestive heart failure must be found present in a relatively recent clinical examination.

There are situations in which there has been an improvement to the extent that congestive heart failure is not currently present, yet, the condition is of disabling severity because of advanced and persistent left ventricular enlargement and hypertrophy. In these instances, the claimant's history failure in spite of prescribed therapy at some point in the past and advanced and persistent left ventricular hypertrophy and enlargement is to be demonstrated by two objective tests:

1. Electrocardiogram, and

2. Chest x-ray.

The electrocardiogram must indicate ventricular enlargement and hypertrophy.

The chest x-ray must indicate significant extension of the cardiac shadow (left ventricle).

Certain valvular conditions and other types of cardiac disease along with congestive heart failure resultant of diseases of the lungs or the blood vessel can cause congestive heart failure as well. The required electrocardiographic and x-ray evidence should correspond with the underlying condition.

Whatever is the cause factor of congestive heart failure, if it is not currently present on clinical examination, it is an absolute requirement to have a history indicating the unquestionable presence of congestive heart failure at some point in the past in-spite of prescribed therapy. Current EKG findings and x-ray findings should be presently consistent with ventricular enlargement, hypertrophy, or other underlying cardiac (or pulmonary) conditions corresponding with the etiology of the heart failure.

3. ISCHEMIC HEART DISEASE

The establishment of this very complex and important heart condition is based upon a careful and detailed history. The cardinal symptom of this condition is chest pain. Multiple features of the alleged chest pain must conform to generally established criteria in order to attribute it to cardiac origin.

Since the possibility of chest pain arising from structures other than the heart muscle must be closely considered, a thorough description of the chest pain is an essential portion of the documentation. Documentation of the chest pain should cover nine characteristics:

1. Precipitating factors,
2. Location,
3. Character,
4. Duration,
5. Relieving factors,
6. Radiation,
7. Frequency,
8. Associated symptoms,
9. Ancillary tests and medications.

Medical reports lacking one or more of these characteristics are not necessarily deficient or incomplete; however, an optimally documented claim should contain information as to all of these characteristics.

In order to consider chest pain to be of cardiac origin, the precipitating factor should be primarily effort that is a physical exertion. At times after meals, or due to extremes of emotional upset, chest pain of cardiac origin may arise. In the case of preinfarction or unstable angina, chest pain of cardiac origin can arise with little provocation or even at rest. When the diagnosis is Prinzmetal angina the pain is experienced usually at rest, often at night, at times during usual activity.

The location of the pain is always substernal.

The character of the pain is pressure-like, heavy, constrictive or oppressive, aching, or burning sensation.

The duration of the pain is somewhat unreliable, yet, it is most often between several and 15 minutes.

The pain might radiate in the arms and hands or the neck, lower jaw, epigastrium, or the back.

The pain is generally relieved by nitroglycerin, often times by rest.

The frequency of the pain is always intermittent and it is often associated by diaphoresis, apprehension, and fear of death.

On tests and medications the claimant is likely to report that he is receiving various nitroglycerin preparations, beta-blocker, calcium antagonists. The claimant is also likely to report to have undergone resting EKG, treadmill exercise test, various blood tests (enzyme tests), and possibly coronary arteriogram (angiogram).

For disability purposes, the preferred assessment of ischemic heart disease is a functional evaluation. The technique is that of a treadmill exercise test which combines constant electrocardiographic monitoring of the claimant while he is progressing from the resting state through a gradually increasing exercise load by walking on a treadmill. This is a non-invasive and reasonably safe way of quantitating the functional state of the coronary arteries with a relative high degree of accuracy. The workload on the treadmill is defined in units called METS. Depending on the speed of the treadmill, the grade of the slope against which the patient walks, and the duration of the exercise, various protocols have been developed which are correlated with various levels of workload (various MET levels). One of the most widely used protocols is the Bruce Protocol.

BRUCE PROTOCOL

STAGE	SPEED (MPH)	GRADE (%)	MINUTES	METS

I	1.7	10	3	4.9
II	2.5	12	6	7.1
III	3.4	14	9	9.7
IV	4.2	16	12	12.6
V	5.0	18	15	16*

* Permits heavy labor

A positive test at the level of 5 METS or less is generally considered to indicate impairment severity precluding any substantial gainful activity on a sustained basis. Positive tests at higher MET levels may be used ot define the claimant's residual functional capacity, that is the type of work which the claimant might be able to do.

Since the graded treadmill exercise test is a reasonably safe procedure, it can be ordered by the Railroad Retirement Board to be performed at a competent facility as a consultative examination. It is essential to leave the judgment as to indication or contraindication of the treadmill exercise test to the consulting physician.

NOTE: A decision as to the possible contraindication to the test should never be made by the Railroad Retirement Board, the Board's medical staff or any other individual who is not directly examining the patient immediately prior to the scheduled test.

There are alternative types of documentation which may be applicable in the absence of acceptable treadmill exercise test, or if the treadmill test is contraindicated. In fact, if the treadmill test is not available as evidence of record the examiner should not order treadmill test as a consultative examination if the claim can be adjudicated on some other basis. Such basis could be EKG abnormalities which establish that the claimant any time in the past experienced a transmural myocardial infarction. To document this fact, acute tracings of the infarction from the time when it occurred (as evidence of record) is the preferred evidence. Considering that most myocardial infarctions are treated in hospitals, as a rule these records should be available. In case the acute tracings are not available, remote tracings should be secured which are consistent with a history of past myocardial infarction. These remote tracings are EKG signs present on a current resting EKG consistent with past myocardial injury.

The resting EKG findings may show ischemic type changes which would constitute alternative documentation to graded exercise treadmill testing.

1. Master's two step exercise testing constitutes an alternative to graded exercise treadmill test. This test is less accurately standardized than the treadmill; therefore, clinicians prefer the latter. Before treadmill technology became widely available in the United States (in the 1970's) the Master's test was the test of choice.

2. If angiographic evidence (coronary arteriogram) is available as evidence of record indicating severe narrowing of main coronary arteries, this evidence constitutes an alternative to graded exercise treadmill test, as well.

A left bundle branch block generally prevents application of the graded exercise treadmill testing and the block itself commonly results from coronary artery disease. Accordingly, the presence of left bundle branch block may be considered indicative of coronary artery disease, per se, unless it is negated by a negative coronary arteriogram available as evidence of record.

Ejection fraction studies, if available as evidence of record, could also constitute an alternative to graded exercise treadmill test in documenting coronary artery disease.

4. CONDUCTION DISTURBANCES, ARRHYTHMIAS

Generally, the irregular heart beat must be objectively confirmed by Electrocardiogram either by ordinary resting EKG or the ambulatory tape recording (Holter monitoring), which device will monitor the rhythm of the heart over a multi-hour time span during customary activities.

Particular caution is to be used in assessing arrhythmias of the claimants who take digitalis because the medicine itself commonly produces arrhythmias.

Many arrhythmias are treated with pacemakers. The examiner should be conscious of the fact that the implantation of a pacemaker in not considered a major heart surgery and it does not automatically mean that the claimant is completely disabled. The degree of severity is to be assessed by documentation of the underlying condition and the extent of control achieved by the pacemaker and/or medication. Nevertheless, the presence of permanent pacemakers will restrict an individual's functional capacity to a considerable degree.

5. MISCELLANEOUS OTHER CARDIOVASCULAR CONDITIONS

A. Hypertensive Vascular Disease - High blood pressure produces impairment by its damaging action on major organs such as the

heart. If symptoms are generated due to high blood pressure they should be evaluated according t the nature of the symptoms. In evaluating these symptoms the examiner should be conscious of the fact that some of these symptoms are subject to significant improvement once the high blood pressure has been brought under control.

B. Aneurysms - This bulging out of the blood vessel generally arises from either the aorta or one of its major branches. The presence of the condition is to be documented by x-ray studies as objective evidence. Severity evaluation then is base on various complications caused by the aneurysm. These complications maybe unique to the condition or may fall under previously described categories, such as congestive heart failure. Occasionally, the aneurysm causes recurrent attacks of sudden temporary loss of consciousness. The claims of recurrent syncopal attacks due to aneurysm should be documented by x-ray findings of the presence of the aneurysm. Also, documentation should include a description of the interference these syncopal episodes represent with respect to normal daily activities.

C. Chronic Venous Insufficiency of the Lower Extremity

1. Arteriosclerosis Obliterans and Thrombo-angiitis - The first of these two entities is the common chronic arterio occlusive disease of the extremities, usually the lower extremities. The second condition in this group is a rare affliction call Buerger's disease. Unlike arteriosclerosis obliterans this condition is an inflammatory disorder involving both the arteries and the veins. It is peculiar to young male smokers.

   There must be a detailed history and physical examination demonstrating two key points:

   a. Malfunction of the deep venous return of the limb, and

   b. Persistent or recurrent ulceration of the skin which is resistant to therapy. Laboratory evidence of record such as Doppler studies or venograms are useful in assisting the adjudication.

   The cardinal requirement of documentation of these conditions is the clinical presence of intermittent claudication which must be established by history. The symptom complex is characterized by pain in the muscles f the extremity which is brought on by use of the limb and relieved by rest. Objective documentation may be provided by

arteriography showing obstruction of the common femoral or the deep femoral artery.

As in other situations of invasive procedures it is to be noted that the Railroad Retirement Board must not order such arteriograms as consultative examination but when it is available as evidence of record it is always to be secured.

An alternate form of documentation which is absolutely noninvasive, (thus, it could be ordered as consultative examination) is the Doppler's ultrasound blood flow study. This noninvasive technique offers confirmation of arterial obstruction by showing impaired pulsation. This study is a simple means of measuring the blood pressure in specified arteries with great precision thus demonstrating obstruction.

Plethysmography is a more cumbersome means toward the same end utilizing an electrical impedance technique.

2. Transient Ischemic Attacks - Transient ischemic attack are transient episodes of ischemia of the brain, the area of involvement in turn producing symptoms depending on the function of the involved area. Symptoms range from weakness of one extremity through unilateral blindness homonymous hemianopsia, weakness in face, arms, or legs, or simply a sensation of numbness or tingling in certain areas of the body. Recent studies indicate that these attacks are linked almost exclusively to arteriosclerotic thrombosis. This is the first stage of developing stroke which may progress to a completed stroke or regress without any permanent damage.

   In documenting transient ischemic attacks, arteriograms are of great value. As in other invasive techniques, such arteriograms are to be obtained if they are available as evidence of record but never ordered as a consultative examination by the Railroad Retirement Board. In assessing impairment severity resultant of transient ischemic attacks, one should document the actual functional impairment caused by the condition. Because of the variety of symptoms produced by this condition, a highly individualized approach is recommended. In addition to the nature of the symptoms, their precipitating factors and frequency, longitudinal evidence relative to their progression is also to be developed.

6. GLOSSARY OF CARDIOVASCULAR TERMS, SYNONYMS, ABBREVIATIONS

AG	Angiogram
AI	Aortic insufficiency
AMI	Acute myocardial infarction
A/S	Aortic stenosis
ASCVD	Arteriosclerotic cardiovascular disease
ASD	Atrio-septal defect
ASHD	Arteriosclerotic heart disease
AF	Atrial fibrillation
A/V	Atrioventricular
BBB	Bundle branch block
CAD	Coronary artery disease
CHF	Congestive heart failure
CV	Cardiovascular
ECG	Electrocardiogram
EKG	Electrocardiogram
HCM	Hypertrophic cardiomyopathy
HCVD	Hypertensive cardiovascular disease
HHD	Hypertensive heart disease
HOCM	Hypertrophic obstructive cardiomyopathy
IHD	Ischemic heart disease
IHSS	Idiopathic hypertrophic subaortic stenosis
LBBB	Left bundle branch block

LVH	Left ventricular hypertrophy
MI	Myocardial infarction
NSR	Normal sinus rhythm
NTG	Nitroglycerine
PAC	Premature atrial contraction
PAT	Paroxysmal atrial tachycardia
PSVT	Paroxysmal supraventricular tachycardia
SVT	Supraventricular tachycardia
TIA	Transient ischemic attack
V.FIB	Ventricular fibrillation
VSD	Ventricular septal defect

D. SENSORY SYSTEM IMPAIRMENTS

1. BASIC CONSIDERATIONS

In determining impairment severity of visual or hearing deficit, remaining vision or hearing in the better eye or ear after best correction is taken into consideration.

2. VISUAL DISORDERS

History should include the onset of visual loss, the cause and diagnosis, if known, the treatment received and the therapeutic response. If surgery has been done, date of surgery and therapeutic results are all parts of adequate documentation.

Physical examination should describe the eye findings in detail, including funduscopic examination.

Central visual acuity is measured by a Snellen's test for far vision and by a Jaeger's test for near vision. In assessing impairment severity, one should always utilize the best corrected vision (with eye glasses or contact lenses) in the better eye.

Visual field examinations should be carried out via a parametric device utilizing a 3 millimeter white objective disc target at a distance of 330 millimeter. The illumination during the examinations should not be less

than 7 foot candles. The hand held arc perimeter and the Goldmann perimeter are also acceptable as an alternative to the preferred arc perimeter.

Tangent screen perimeters and various automated perimeters while helpful in clinical practice are not desirable instruments for disability determination purposes. This is mainly due to the fact that many of these devices record an erroneously more constricted visual field than the arc perimeter or the Goldmann perimeter.

In cases where visual field loss is a component of the impairment severity assessment, a copy of the appropriately labeled visual field chart must be included in file.

3. HEARING DISORDERS

Generally, in clinical practices, a distinction is made between conductive and sensori-neural hearing loss.

When the hearing loss is due to external canal or middle ear abnormalities, it is conductive. Hearings loss due to the inner ear and/or the eighth cranial nerve is classified as sensori-neural.

Conductive hearing loss in the majority of cases is not expected to last for 12 months, as opposed to sensori-neural losses which, as a rule, fulfill durational criteria.

A special condition relative to hearing impairments is Meniere's disease. It is characterized by recurrent, severe vertigo, sensori-neural hearing loss and tinnitus. These attacks are associated with nausea and vomiting. Occasionally, recurrent feelings of fullness or pressure in the affected ear is part of the clinical picture. The hearing loss is usually progressive although in the initial stages it is often fluctuating.

History should include the cause of the hearing loss if it is known, along with the diagnosis and the development of symptoms. If Meniere's disease is the working diagnosis, detailed history as to vertigo, tinnitus and fluctuating hearing loss should be elicited.

Physical examination of the ear should be done and results recorded in file. The standard tuning fork tests (Rinne and Weber's) are often helpful in documentation of a hearing impairment. The presence of an audiometric examination by an audiologist does not eliminate the need for a physical examination, as the audiometry concerns itself with measurements of hearing but not with etiological abnormalities which are necessary to document in order to establish a medically determinable impairment along with data relative to durational requirements. In sensori-

neural hearing loss, often a detailed neurological examination is necessary.

Audiometry is the standard measurement used to document the degree of hearing loss. As it is primarily a measurement, the audiometer used must meet the standards of the American National Standards Institute.

The hearing in the better ear is the value used for proper determination of impairment severity.

If medical evidence suggests hearing is restorable by hearing aid, the pure tone testing and speech discrimination testing are to be done with simultaneous use of a hearing aid.

Results of the audiometric examination along with a copy of the actual chart should be included in the file for adequate documentation. A complete audiometric exam should include the results of:

a. Air conduction test,

b. Bone conduction test,

c. Speech discrimination test.

In vestibular-labyrinthine disorders (i.e. Meniere's disease), additional special studies (such as caloric test, electronystagmography, polytomograms and x-rays of the skull and temporal bone) are needed for proper documentation.

4. GLOSSARY OF SENSORY TERMS, SYNONYMS, ABBREVIATIONS

AD	Right ear
AS	Left ear
AU	Both ears
Aur	Ear auricle
bilat.	Bilateral
DB	Decibels
EENT	Eye, ear, nose and throat
OD	Right eye

OPH	Ophthalmology
OS	Left eye
OU	Both eyes
PERLA	Pupils equally reactive to light and accommodation
SRT	Speech reception threshold
VA	Visual acuity

E. RESPIRATORY IMPAIRMENTS

1. BASIC CONSIDERATIONS

Generally, documentation of respiratory impairments of any kind consists of medical evidence relative to:

a. Adequate history,

b. Physical examination,

c. X-ray findings,

d. Other special studies of the respiratory system.

In the presence of chronic respiratory failure, claimants invariably complain of shortness of breath. This allegation alone is not sufficient for documenting a respiratory impairment, but it is essential as the initial step toward establishing the diagnosis of chronic pulmonary disease. In evaluating respiratory impairments, a distinction generally is made between obstructive and restrictive pulmonary conditions.

2. OBSTRUCTIVE DISORDERS

Obstructive disorders are characterized by an increased resistance in the airways (blockage) which results in a prolongation of air passage during expiration (exhaling). This condition often includes the loss of lung elasticity, bronchospasm, edema of the bronchial mucosa and thick bronchial secretion.

A mechanical example illustrating the condition is a balloon pump with the function of pumping air in and out a tube system. Bronchospasm would be corresponding with sudden narrowing of the tubing system permitting less room for air to pass through. Edema and bronchial secretion further aggravates the same problem. The loss of lung elasticity would be

analogous with the pump's inability to pump out all the air it sucked in with a resultant residual of air. The end result is that the absolute efficiency of the pump decreased while resistance of the tubing increased. These two factors in combination result in a grossly deficient air exchange.

Accordingly, the major symptom of all obstructive disorders is dyspnea (shortness of breath), even at rest. The term obstructive lung disease is often combined with the term "chronic" denoting long term disorder, largely involving irreversible changes in the respiratory system's structure and function, ultimately producing a clinical picture called chronic respiratory failure.

The most frequently occurring chronic obstructive pulmonary diseases are:

a. Emphysema,

b. Bronchial asthma.

Since many asthmatics at a later stage of their condition develop emphysema as well, the distinction between the two conditions is not always easy or clear. Both conditions have the common characteristic of episodic nature and, in the end stage, they both can lead to chronic respiratory failure.

Claimants with these conditions usually present a history of dyspnea (shortness of breath), which is the number one item in the required documentation. In addition, a common complaint is chronic coughing with or without expectoration (sputum).

Upon physical examination, the physician is likely to find an increased AP (anteroposterior) diameter of the chest wall, often referred to as "barrel chest" in case of emphysema. The same finding is somewhat unreliable and it is not present at the early stages of bronchial asthma, only at the stage where chronic respiratory failure and sequential emphysema complicates the clinical picture. Use of the accessory muscles of respiration with ordinary breathing might be noted as well as flaring of the nostrils. When the patient is in chronic respiratory failure, signs of cyanosis may be observed.

On percussion, the examining physician may find increased resonance or tympanitic chest. Again, these findings are present in emphysema only and early stages of asthma may present with a completely normal physical examinations with the exception of an examination performed during an acute asthmatic attack when the findings are primarily present on auscultation.

During an acute asthmatic attack, prolonged expiration (exhaling), coarse rhonchi, rales and expiratory wheezing can be present.

In emphysema, the auscultation is of limited value. If any findings are mentioned, they are likely to be decreased breath sounds.

These are some general system findings relative to chronic obstructive pulmonary disease such as clubbing of the fingernails, cyanosis and dyspnea.

It is to be emphasized that not all these findings are present at the same time in all patients. Individual judgment is to be used, but the preponderance of these findings should be present in order to establish the presence of a chronic obstructive pulmonary disease.

On chest x-ray the most common findings are:

a. Hyperaeration of the lungs (increased transparency of the lung tissue to x-ray),

b. Flattening of the diaphragm or tenting of the diaphragm at it's rib insertion,

c. Occasionally, large bullae may be seen.

Pulmonary function studies measure the lung's capacity for moving and containing air, that is, ventilation. With some exceptions, generally, pulmonary function studies are used in the evaluation of obstructive disorders whereas in the evaluation of restrictive disorders, arterial blood gas studies are of greater value.

Pulmonary function studies are to be obtained only when clinically a pulmonary impairment is clearly established based upon history, physical examination and chest x-ray findings. A mere complaint of dyspnea without corroborating objective evidence is not sufficient indication to purchase a pulmonary function study.

The documentation requirements for pulmonary function studies are as follows:

a. Identification of the spirometer by manufacturer and model number,

b. Properly labeled spirogram showing distance per second on the abscissa and distance per liter on the ordinate,

c. Calibration of volume units through mechanical means if the spirogram is generated by means other than direct pen linkage to a mechanical displacement type spirometer (giant syringe),

d. FVC (FEV-1) recorded at a paper speed of at least 20 mm. per second.

3. RESTRICTIVE DISORDERS

Restrictive disorders are another group of respiratory tract diseases which are also characterized by limitation or reduction of the volume of air which can be moved in and out of the lungs. As opposed to obstructive disorders, the problem here appears to be that our example pump is quasi-encapsulated in a hard shell, not permitting the pump to expand adequately, that is, the lung's capacity to expand and to contact is reduced. The result is again inadequate air exchange. The shortness of breath is more prominent on exertion.

Two conditions are particularly known to produce such a restrictive disorder:

a. Mechanical restrictions - This involves the loss of ventilatory volume due rib cage, thoracic skeletal abnormalities such as kyphosis and scoliosis as well as paralysis of the diaphragm.

b. Fibrotic degeneration of the lungs (pulmonary fibrosis) - This involves decreasing lung tissue elasticity.

Frequently, both obstructive and restrictive pulmonary diseases are present in the same individual.

History should establish the complaint of dyspnea, (that is, shortness of breath) particularly on exertion.

On physical examination, various findings might be present. If the restrictive condition is a result of mechanical restrictions, physical examination should reveal the reason for the disruption of the anatomical mechanisms of ventilation (such as the fixation of the rib cage, paralysis of the diaphragm, thoracic or other skeletal abnormalities such as kyphosis or scoliosis.)

If the restrictive condition is a result of fibrotic lung conditions, the only physical finding might be markedly diminished breath sounds or some dullness on percussion.

The chest x-ray in fibrotic conditions may be normal, or might e characteristic of conditions known to cause fibrotic restriction (such as, sarcoidosis, diffuse pulmonary fibrosis, etc.)

Arterial blood gas studies are used to analyze the concentration and percentage of oxygen and carbon dioxide in the arterial blood coming from the lungs (that is, to measure respiration.)

The testing procedure is somewhat invasive and painful. It involves an arterial puncture, often times combined with exercise testing of the claimant. The technique is to determine the acid base balance in the blood, the arterial carbon dioxide and the oxygen partial pressure in the blood, drawn from arteries leaving the lungs.

These test are reflective of the efficiency of oxygen/carbon dioxide transfer in the lungs and are most useful in the evaluation of pulmonary disorders in which there is lung tissue damage, scarring or fibrosis.

The diagnosis of fibrotic pulmonary condition may be established by biopsy. A biopsy should never be purchased as a consultative examination. If it is available as evidence of record it establishes the diagnosis but does not establish the degree of impairment severity.

s evidence of record, carbon dioxide diffusion capacity may be available. This test is subject to a high degree of technical error and should not be purchased as a consultative examination but if available it should be considered as any other medical evidence.

In the usual case, arterial blood gas studies would not be substituted for pulmonary function studies in chronic obstructive pulmonary diseases. The ideal documentation of the severity of chronic obstructive lung disease is, as discussed previously, the pulmonary function study.

However, there are some chronic obstructive pulmonary conditions in which the main process involved is shunting. Such impairment could be reflected by blood gas studies establish a disabling pulmonary condition in the wake of a chronic primarily obstructive pulmonary disease, the blood gas values are acceptable in lieu of pulmonary function studies only if the claimant is clinically clearly in chronic respiratory failure.

For instance, an individual who has chronic obstructive pulmonary disease which is now acutely superimposed by bronchitis or pneumonia, may be producing blood gas values of disabling severity. This is due to the fact that his or her ability to compensate for the obstruction is temporarily compromised. However, after resolution of the acute superimposition, (recovery from bronchitis or pneumonia) the ventilatory function may significantly improve. Accordingly, when the pulmonary disease is primarily obstructive in nature and evidence of record blood gas studies are available indicating a disabling pulmonary condition, particular attention is to be paid to determine that the claimant is indeed in chronic and not acute (temporary) respiratory failure.

Less often the converse might occur when a claimant has a condition which is primarily restrictive in nature and pulmonary function studies are indicating a disabling degree of restrictive pulmonary condition. If chronic

respiratory failure is clinically established, the pulmonary function study results could suffice in documenting primarily restrictive pulmonary disorder.

If pulmonary function studies are used in evaluating restrictive pulmonary diseases, the value to be considered is the vital capacity.

Lung scan results may be available in file. As with lung biopsy it should not be purchased as a consultative examination. If it is available, it should be used in the establishment of diagnosis and overall assessment.

4. PULMONARY TUBERCULOSIS

The reason for pulmonary tuberculosis not having been given as an example or categorized under obstructive or restrictive conditions, is that it may produce various clinical pictures depending on the stage of the disease and the extent of the lung involvement. It is very rare, in this day and age, that treated tuberculosis per se would reach disabling severity. However, in certain cases when the disease involves an extensive area of lung parenchyma, significant loss of respiratory function may result. In such case, documentation with either a pulmonary function study and/or arterial blood gas studies could be used for determining severity. In the usual case, the presence of an active lesion as documented by a positive sputum test would not be a determinant of severity.

5. PULMONARY MALIGNANCY

This condition will be discussed under MALIGNANCIES.

6. AUTOIMMUNE DISEASES

These diseases involving the lungs will be discussed under MULTIPLE BODY SYSTEMS.

7. COR PULMONALE

This condition involves both the lungs and the heart. The causative factor is the heart condition. It will be discussed under CARDIOVASCULAR IMPAIRMENTS.

8. DISEASES OF THE LARYNX

Since the larynx is part of the respiratory system it will be discussed here.

The most common potentially disabling condition affecting the larynx is cancer. In most cases, a laryngectomy is performed resulting in partial or total loss of ability to speak. The degree of speech loss would determine

the claimant's ability to perform work related activities. Impairment severity would be determined by two factors:

a. The degree to which the claimant's natural ability to speak is compromised, and

b. The degree to which the patient's speech is restored by using various electronic assisting devices.

In evaluating speech one should consider it's:

a. Intelligibility,

b. Volume

c. Sustainability,

d. Speech structure.

9. OTHER INFECTIOUS DISEASES OF THE LUNGS (MYCOTIC INFECTION, ETC.)

These types of lung disorders are usually both obstructive and restrictive. They can be evaluated either on the basis of the impairing impact on the claimant's pulmonary function or in some cases, on the basis of other systemic involvements (brain, heart, etc.).

When pulmonary function is the determinant of severity, pulmonary function studies or arterial blood gas studies may be used for evaluation.

10. OCCUPATIONAL LUNG DISEASES (SILICOSIS, ASBESTOSIS, PNEUMOCONIOSIS, BERYLLOSIS, ETC.)

These diseases can cause nodular or diffuse fibrous degeneration, as well as generalized granulomatous disease with resultant impairment of pulmonary function. For determination of the impairment's severity, both pulmonary function studies (vital capacity) and/or arterial blood gas studies can be useful.

11. GLOSSARY OF RESPIRATORY TERMS, SYNONYMS, ABBREVIATIONS

COPD	Chronic obstructive pulmonary disease
COLD	Chronic obstructive lung disease emphysema
CDAL	Workers pneumoconiosis

CWP	Black lung disease
FEV-1	Forced expiratory volume in one second
FVC	Force vital capacity
MVV	Maximal voluntary ventilation
PA Co2	Arterial partial pressure of Co2 (mm Hg.)
PAL,	Chest x-ray (Postero-anterior and Lateral)
PA 02	Arterial partial pressure of 02 (mm Hg.)
	Pulmonary In- sufficiency Respiratory failure
SOB	Shortness of breath, dyspnea
TB	Tuberculosis
WNL	Within normal limits

F. GASTROINTESTINAL IMPAIRMENTS

1. BASIC CONSIDERATIONS

Disorders of the gastrointestinal system that are found to be disabling, are disabling either because of resultant malnutrition or due to complications of the impairment. Since therapeutic response is considered in the overall severity assessment, documentation of therapy and response is often essential for adequate documentation of the claim.

The more common gastrointestinal problems include recurrent upper gastrointestinal hemorrhage, stricture, stenosis or obstruction of the esophagus, peptic ulcer disease, chronic liver disease, chronic ulcerative or granulomatous colitis and regional enteritis. Significant weight loss due to miscellaneous gastrointestinal disorders also often occurs.

Most of these, as well as other less common gastrointestinal disorders, require documentation in terms of the claimant's past medical history, physical examination findings, as well as findings by means of special studies (e.g. x-ray examination, endoscopic examination, biochemistry findings, etc.)

2. RECURRENT UPPER GASTROINTESTINAL HEMORRHAGE

Documentation of this condition requires that the claimant's past history evidence hematemesis, preferably confirmed by medical personnel. The latter is desirable because lay observers tend to mistake any bleeding through the mouth for hematemesis. Bona fide hematemesis involves a large amount of bright or dark red material proven to be blood on chemical testing.

Generally massive hematemesis results in immediate hospitalization, thus on physical examination aided by special studies it is easily confirmed. By use of nasogastric tube placed in claimant's stomach and suctioning, generally a large amount of blood is obtained.

An alternative means of documentation consists of use of esophagi-gastroscopy through which the hemorrhage can be directly observed. In order to consider upper gastrointestinal bleeding as "recurrent", by definition, it has to occur at least twice sufficiently far apart to assure the reviewer that indeed the bleeding is recurrent and not one occurrence being interrupted by temporary remission. Exact time frame cannot be given but it is desirable that at least several weeks elapse between the episodes to qualify for the term "recurrent."

"Hemorrhage" refers to brisk bleeding, not simply oozing. Accordingly systemic symptoms are expected to accompany through hemorrhage. These systemic findings include decreased hemoglobin level, faintness, dizziness, tachycardia, in more severe cases loss of consciousness. Documentation should be secured whenever possible relative to the source of bleeding since many of the causative conditions are correctable by surgery.

Optimal documentation also includes evidence to the fact that claimant's coagulation system is intact.

3. STRICTURE, STENOSIS OR OBSTRUCTION OF THE ESOPHAGUS

Documentation of these disorders must evidence substantial weight loss caused by the disorder.

Documentation of the specific disorder requires demonstration of the condition by both esophagoscope and x-ray studies.

Biopsy and cytology studies of the strictured area are often valuable to determine the etiology and the stricture. The most frequent causative conditions are neoplasm and fungal diseases. While neoplastic diseases are rarely reversible, fungal diseases are often treatable and reversible. Accordingly, whenever these studies are available as evidence of record they should be secured.

NOTE: Cytology studies or biopsies should never be ordered as consultative examinations by the Railroad Retirement Board.

If stricture is not neoplastic in origin, it is desirable that documentation evidence that dilations of esophagus has been tried, since the majority of benign esophageal strictures are treatable enabling claimant to maintain adequate nutritional status.

4. PEPTIC ULCER DISEASE

Claimant's medical history includes epigastric pain, at times accompanied by vomiting.

In bleeding ulcers, history of hematemesis may be obtained.

If the claimant underwent surgery for the ulcer, recurrence of the disease is significant information. Documentation of recurrence goes beyond history; it is to be demonstrated by special studies.

X-ray evidence of recurrent ulcer is often difficult following definitive surgery, due to the fact that typically there is a great deal of distortion of the area of previous ulcer by the surgery. As a result, recurrence of ulcer is more often suspected than actually proven by x-ray. Consequently, unless the recurring ulcer is unusually large, proper documentation relies upon gastroscopic findings.

An infrequent but potentially disabling complication of peptic ulcer disease is fistula formation.

Inoperable fistulas are usually complications of ulcer surgery. As a result of the fistula, a large volume of fluid is being continuously lost. The claimant who is unable to compensate for the loss of a large amount of fluid gradually becomes malnourished.

Documentation of fistula formation should demonstrate accordingly:

a. X-ray evidence of fistula,

b. Measurement of daily fluid loss,

c. Signs of malnutrition.

Physical examination findings are not characteristic in uncomplicated ulcer. There may be vague abdominal tenderness and/or distention. If obstruction occurred, severe abdominal distention is a common finding. Because of the impact peptic ulcer disease might have on the claimant's nutritional status, a report of the claimant's height and weight is always an inherent part of the physical examination report. Whenever the claimant's

poor nutritional status is considered as a significant factor in finding of disability, documentation should be secured to evidence that the claimant has none of the remedial causes of peptic ulcer complications (such as obstruction.)

To satisfy this aspect of documentation repeat upper GI x-ray series are desirable along with statement from the treating physician regarding claimant's compliance in following diet and medication.

5. CHRONIC LIVER DISEASE

Symptoms vary depending on the stage of the disease. Anorexia, fatigue, nausea and weakness are common elements of history which also might be positive for habitual excessive drinking and/or hepatitis.

During history taking, special attention is being paid to previous episodes of hematemesis to elicit the possibility of esophageal varices. It is to be noted that past history of hematemesis is not tantamount to having esophageal varices, as a host of other conditions can cause hematemesis.

History of massive hematemesis, supported by direct endoscopic observation by a physician of bleeding varices, is considered sufficient documentation of the severity of chronic liver disease.

An alternative to this direct endoscopic observation is x-ray evidence of varices enabling the professional reviewer to attribute the hematemesis to the varices.

A palliative therapy performed to alleviate the problems caused by esophageal varices is shunt operation. Documentation of this operation requires the operative report describing the procedure. The term "shunt operation" refers to porto-caval shunting procedures. Shunt procedures performed to manage otherwise intractable ascites (Le Veen shunt) are not to be considered as a shunt operation for esophageal varices.

Physical examinations findings in chronic liver insufficiency are varied and numerous. Jaundice, hepatomegaly, ascites are the most common findings. When the claimant's consciousness is impaired due to hepatic insufficiency in the wake of established chronic liver disease, the diagnosis of hepatic encephalopathy should be considered. The initial symptoms include drowsiness, sluggish movements and speech disturbances, which symptoms eventually progress to confusion, stupor and frank coma.

Some claimants with chronic liver disease develop skin and/or endocrine abnormalities. Spider nevi, palmar erythema and gynecomastia are some examples.

Routine laboratory evaluation of claimants with chronic liver disease shows several significant abnormalities.

Blood chemistry studies will demonstrate low serum albumin and elevated serum globulin values. One of the most widely used blood chemistry studies in documenting chronic liver disease is serum bilirubin. In order to utilize serum bilirubin values as evidence of chronic liver disease, they must be fractionated. Fractionated bilirubin studies divide the bilirubin by chemical means into total and direct bilirubin. Claimants with hemolytic jaundice will have constant elevated bilirubin without liver disease but the bilirubin is almost all total bilirubin. This is in contract with claimants with genuine liver disease whose bilirubin values are elevated in the total and the direct fraction.

Several serum enzyme values, if significantly elevated, are indicative of hepatic dysfunction. It is to be noted that the abnormal enzyme value must be at least three to four times greater than normal to document significant functional impairment. Enzymes most often elevated are SGOT, SGPT, LDH and alkaline phosphatase.

The most valuable special study in establishing the presence and severity of chronic liver disease is liver biopsy. Documentation requires a detailed pathological report of liver biopsy, for the term "cirrhosis" is used too liberally in clinical practice. Fibrosis and disorganization of the liver structure must be reported to substantiate the diagnosis of cirrhosis of the liver.

If ascites is present, it has to be documented not only as a physical finding but also needle aspiration of abnormal cavity should evidence the presence of fluid. Ultrasound examination of the abdominal cavity constitutes an acceptable alternative documentation to needle aspiration.

6. CHRONIC ULCERATIVE COLITIS

Usual history of these claimants consists of a series of episodes of bloody diarrhea with minimal or no symptoms between attacks. Recurrent bloody stools should be demonstrated by proctoscopic or colonoscopic evidence of active colitis by direct visualization. X-ray evidence is not a requirement and it is frequently not done; however, if barium enema results are available as evidence of record substantiating the condition, they should be secured.

Occasional blood in passed stool is not evidence that colitis has recurred or that it is active.

One of the most significant complications of this condition is anemia due to blood loss as a result of recurrent bloody stools. Anemia, when present, should be documented by repeated hematocrit determinations.

Since another potential sequela of this disease is significant weight loss, height and weight values are an inherent part of the documentation of chronic ulcerative colitis.

In some cases, chronic ulcerative colitis is not limited to the gastrointestinal system, but it may involve other organs or body systems. The most often affected areas include the joints (arthritis), the eyes (iritis) and the liver. Proper documentation of systemic manifestations requires an accurate clinical description of the organ involved.

When the condition is complicated by fistula formation, intractable abscess or stenosis, intermittent obstruction might be the result. Proper documentation of intermittent obstruction requires not only an accurate description of clinical findings of obstruction, but also corroboration by abdominal x-rays.

7. REGIONAL ENTERITIS

Due to the vagueness of symptoms, this condition is not only difficult to diagnose but it is equally difficult to identify past history and/or chief complaints characteristic of regional enteritis. Systemic symptoms such as anorexia and weight loss, often accompany the initial episodes of diarrhea. Visual complaints due to iritis and joint pains due to arthritis are found as complications of this condition.

On physical examination, elevated temperature might be found. Abdominal pain, distention or mass on palpation, perianal fistula and/or abscess formation, are not infrequently present. Abnormal funduscopic findings, joint swelling and jaundice indicate systemic manifestations.

Laboratory findings are not specific, thus the presence of the condition can only be proven by x-ray description of findings or macroscopic observation during surgery. In the latter instance, detailed and specific description of macroscopic findings is required. It is to be noted that biopsy of the lesion is not diagnostic of regional enteritis.

Persistent or recurrent intestinal obstruction must be documented by repeated x-ray finding of obstruction. Physical findings of abdomen are important, but x-ray evidence takes precedence.

Although, in general documenting the presence and severity of an impairment, by accurate description of findings is more important than establishment of an exact diagnosis, it is important for proper documentation of gastrointestinal disorders that an exact gastrointestinal diagnosis be made to account for the gastrointestinal findings. This is a requirement because many emotional conditions can cause gastrointestinal symptoms such as loss of appetite, nausea, vomiting, diarrhea and weight loss.

8. GLOSSARY OF GASTROINTESTINAL TERMS, SYNONYMS, ABBREVIATIONS

BILI T&D	bilirubin total and direct
BS	Bowel sounds
G	Gastrointestinal
HAA	Hepatitis associated antigen
IJ BYPASS	Ileo-jejunal bypass
JAUND	Jaundice
LGI	Lower gastrointestinal
NG	Nasogastric
PR	Per rectum
RDA	Recommended dietary allowance
RECT.	Rectal
RLQ	Right lower quadrant, abdomen
RUQ	Right upper quadrant, abdomen
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SMB	Small intestine
TPN	Total parenteral nutrition
TWE	Tap water enema

UGI	Upper gastrointestinal
WN	Well nourished

G. GENITO-URINARY IMPAIRMENTS

1. BASIC CONSIDERATIONS

Impairments of this body system include various conditions, involving organs of the genito-urinary apparatus. As with other body systems documentation includes adequate history physical examination and special studies confirming the presence of a genito-urinary system disease. With few exceptions, disability resulting from these disorders is determined by the resultant renal failure. In addition, treatments for renal failure (such as hemodialysis, peritoneal dialysis, kidney transplantation) may also have an impact on the impairment severity.

One of the conditions representing an exception from the previously described group of genito-urinary disorders is nephrotic syndrome. This condition can cause disability even if bone fide renal failure is not present. Nephrotic syndrome is a collection of low serum albumin, increased fats (cholesterol and triglycerides) and edema. These manifestations reflect the essence of the syndrome, that is, excessive protein loss due to kidney damage.

Documentation requirements of genito-urinary disorders are similar in all cases, regardless of the underlying condition if chronic renal failure ensued. They will be outlined next. The somewhat different documentation standards of the nephrotic syndrome will follow.

2. CHRONIC RENAL FAILURE

Since the long-term prognosis of chronic renal failure is principally different from that of acute renal failure, documentation of the chronic nature of claimant's renal disorder and the subsequent renal failure is an essential part of claims development. Medical evidence fulfilling this requirement (that is, providing longitudinal perspective over claimant's condition) include hospital records and/or outpatient records. Considering the debilitating nature of chronic renal failure, patients are almost invariably under continuous medical care, thus ample medical evidence should be available as evidence of record in most cases.

Systemic manifestations (such as anorexia, weight loss, weakness, fatigue and lassitude of chronic renal failure) along with symptoms of associated anemia, glucose intolerance, peripheral neuropathy or

osteodystrophy are all non-specific. They are results of retention of various metabolic by-products under normal circumstances excreted by the kidneys (urea, creatinine, potassium, etc.).

Physical examination findings vary, as well. Neuromuscular manifestations seen on physical examination include muscular twitching as well as peripheral neuropathy affecting sensory or motor functions or both.

Malnutrition, leading to severe weight loss and muscular wasting, is common. Accordingly, documentation of the claimant's height and weight in the physical examination report are always desirable.

Further complications of chronic renal failure have to be documented. For instance, the common and uncomfortable symptom of intractable pruritus can reach disabling proportions. Hypertension, edema and heart failure are frequent sequelae of persistent fluid overload. Pericardial irritation or inflammation (pericarditis) may be the cause of substernal chest pain which is often confirmed by ECG or echocardiograph findings.

Documentation of the need for chronic dialysis (either peritoneal or hemodialysis) is essential in the determination of the severity of chronic renal failure.

In case of renal transplant, documentation should secure medical evidence pertaining not only to the fact that is has been performed but also relative to the period of convalescence (that is, adequacy of renal function twelve months following surgery.)

Complications, if any, should be documented, as well. Renal infections, rejection, systemic complications and side effects of steroid and/or immunal suppressive therapy are not uncommon postsurgically.

Primary diagnostic confirmation of chronic renal failure is by special studies. Laboratory testing of blood and urine (that is, serum creatinine and creatinine clearance in a pooled 24-hour urine collection) are the most basic studies.

In addition to these primary studies, adjunct laboratory results are often desirable. Results of blood gases, electrolytes, serum calcium and phosphorous are often available as evidence of record. Complete blood count often documents low hematocrit indicating anemia. A bone x-ray may show osteoporosis, osteitis fibrosa and/or pathological fractures. A chest x-ray and ECG will show congestive heart failure, when present.

3. <u>NEPHROTIC SYNDROME</u>

Abnormalities in serum and urinary protein characterize this genito-urinary system impairment.

Documentation of this condition relies heavily upon evidence of record as these claimants are invariably under continuous medical supervision. History is best obtained from hospital or outpatient records.

Confirmation of the impairment is obtained through serum albumin determination and urinary protein determination in a 24-hour interval. Serum cholesterol is another adjunctive laboratory evidence in establishing the presence of this renal disorder.

In addition to these special studies, adequate documentation should reveal appropriate physical findings.

Physical findings should include descriptions of the extent and location of tissue edema, the presence of absence of ascites, pleural and/or pericardial effusion, hydrarthrosis, etc.

If renal biopsy was performed, results of the biopsy should be secured.

NOTE: Due to the invasive nature of the procedure a renal biopsy should never be ordered as consultative examination by the Railroad Retirement Board.

The determination of impairment severity of the nephrotic syndrome depends on the level of serum albumin and urinary protein. These parameters should be viewed in light of the claimant's therapeutic response.

4. GLOSSARY OF GENITO-URINARY TERMS, SYNONYMS, ABBREVIATIONS

A/G	Albumin globulin ratio
Alb	Albumin
BUN	Blood urea nitrogen
Ca	Calcium
Creat	Creatinine
GFR	Glomerular filtration rate
GU	Genito-urinary

IVP	Intravenous pyelography
KUB	Kidney, ureter and bladder x-ray
	Retro Pyelo Retrograde Pyelography
	Sod Bicarb Sodium bicarbonate
TP	Total protein
TUR	Transurethral resection
UA	Routine urinalysis
UTI	Urinary tract infection

H. HEMIC-LYMPHATIC IMPAIRMENTS

1. BASIC CONSIDERATIONS

This group of disorders include disorders of the different blood cells (red blood cells, white blood cells and platelets), as well as the factors involved in the coagulation process.

Red blood cell disorders are often manifested by anemia which results in pallor and weakness. Diseases affecting white blood cells are usually characterized by frequent bacterial infections since these cells play a predominant role in the body's immune defense mechanism. Platelet disorders, along with vascular disorders and clotting factor deficiencies, result in hemorrhagic tendencies.

The more common red cell disorders are due to deficient red blood cells. However, polycythemia vera is characterized by an increase in red blood cells. As a result of this increase in the red blood cells, the blood becomes thick (hyperviscosity) and the resultant impaired blood flow is responsible for most of the clinical signs and symptoms.

The most common red blood cell disorders result in anemia. There are varied causes of anemia, due to deficient red cell production because of lack of component substances (e.g. iron deficiency, folic acid deficiency) or because of bone marrow failure (hypoplastic and aplastic anemia). Some anemias are due to excessive red cell destruction (e.g. hemolytic anemias, such as sickle cell anemia), and some are a result of a combination of both decreased production and increased destruction (chronic disease malignancy, renal disease.)

The white blood cell disorders are also characterized by either reduction in their number (granulocytopenia) or an abnormal accumulation of abnormal white cells (leukemia).

Plasma cell disorders are characterized by the proliferation of a group of cells normally involved in immunoglobulin synthesis. Multiple myeloma is a neoplastic disease characterized by the over-production of abnormal immunoglobulins. The presence of abnormal cells results in pathologic fractures, bone pain and recurrent infections.

MACROGLOBULINEMIA is another plasma cell disorder which involves IgM synthesis and results in hyperviscosity (thickening of the blood) symptoms and recurrent bacterial infections. Diagnosis is made by serum or urine protein electrophoresis and/or immunoelectrophoresis.

A finding of disability due to these disorders is based on the recurrent systemic infections and/or bone abnormalities. They should be documented accordingly.

Coagulation disorders may be classified into three groups based on the stages of clotting:

a. Vascular phase (e.g. anaphylactoid purpura, hereditary telangiectasia,)

b. Platelet phase (e.g. idiopathic thrombocytopenic purpura, congenital platelet defects such as wiskott-aldrich syndrome,) and,

c. Coagulation phase (e.g. Hemophilia.)

These groups of disorders may result in a finding of disability, because of the recurrent bleeding tendencies requiring frequent blood transfusions. In addition, bleeding into major organs (e.g. the brain) can cause irreversible resultant changes.

Many of the hemiolymphatic disorders are classified as neoplasms because of the presence of abnormal cells that tend to proliferate and take over the normal cells in the blood and the bone marrow. The most common of these are the lymphomas, foremost of which is Hodgkin's disease. A finding of disability occurs when the disease is uncontrolled by prescribed therapy or if there is a metastasis, to distant organs.

The documentation of hemic-lymphatic disorders preferably include more than a one-time consultative examination (internist) and appropriate laboratory test. Hospitalization and/or out-patient records to document the longitudinal course of the alleged disorder is also always desirable.

Since these conditions require ongoing medical monitoring, as a rule hospital records should be available.

2. DISORDERS OF THE RED BLOOD CELLS

These diseases are characterized by the anemia caused by either excessive blood loss, deficient red cell production and/or excessive red cell destruction.

Regardless of the cause, the documentation should include a history of the symptoms (e.g. weakness, lassitude, excessive bleeding, etc.) and the diagnosis, if already established.

Physical examination findings should include pallor, noted not only on the skin but also in the mucous membranes (e.g. conjunctiva, buccal mucosa). In some cases where there is excessive red cell destruction, splenomegaly may be noted.

Laboratory findings to establish the diagnosis include, the red blood cell count, hemoglobin and/or hematocrit.

The following discussion of sickle cell anemia reflects the special features of this disease not seen in other anemias. History should include the episodes of sickle cell crisis, its frequency, severity and the type of therapy received (i.e. blood transfusions, prolonged hospitalizations, etc.) Inquiry as to the involvement of major organs (such as the lungs, brain and heart) is needed since it is not uncommon for sickle cell disease to cause organ damage. Frequent hospitalizations due to repeated sickle cell crisis may be significant in the process of finding the degree of severity of disability. Medical records from previous hospitalizations generally provide optional documentation of this order.

Physical examination findings in sickle cell disease include joint swelling and/or deformity, which may be marked, especially during a crisis. Splenomegaly is also a common finding.

Laboratory examination to document the diagnosis of sickle cell anemia include hemoglobin electrophoresis, red blood cell count (decreased and a peripheral smear (typically showing sickle cells).

3. DISORDERS OF THE WHITE BLOOD CELLS

The most common disease of this group is leukemia, acute and chronic.

History usually consists of an apparently infectious process with acute onset, although it may have an insidious onset with progressive weakness and pallor.

The less common, granulocytopenia (a reduction in white cells) may present with the same history.

Leukemia is usually treated with chemotherapy. It is important to elicit a history of drug side effects since these may cause symptoms, affecting the impairment severity assessment.

Physical examination findings seen in this group of disorders include, pallor, splenomegaly and lymphadenopathy.

Special studies confirming the diagnosis are complete blood count, peripheral blood smear examination and/or bone marrow puncture examination showing the abnormal white blood cells. The latter test (bone marrow puncture) is an invasive and painful procedure and should not be ordered as a consultative examination by the Railroad Retirement Board.

4. HEMORRHAGIC DISORDERS

These are diseases which are characterized in hemorrhagic tendencies. This may be due to a defect in the vascular system, the platelets or coagulation factors.

Regardless of etiology, bleeding tendency is the predominant symptom elicited in the history. Many of these disorders (e.g. hemophilia) are hereditary; thus, the family history is an important aspect of documentation.

There are no characteristic findings in this group of disorders, on physical examination, however, hematomas and ecchymoses are common findings. In addition, in hemophiliacs with repeated bleeding in their joints (hemarthrosis) there may be joint swelling and effusion which, if chronic, may result in permanent joint deformity. Hospital records usually include all the required documentation.

Special studies to document the diagnosis include coagulation studies (platelet count, bleeding time, prothrombin time, specific assays for factors V-XIII, etc.)

5. LYMPHOMAS

The two major types are Hodgkin's disease and non-Hodgkin lymphoma.

History consists of varied systemic symptoms ranging from fever, nights sweats, weight loss to bone pain.

Physical findings include lymphadenopathy which should be differentiated from other diseases causing lymph node enlargement.

Special studies include lymph node biopsy and/or bone marrow examination documenting the characteristic cells. Because they are invasive, they should not be purchased as a consultative exam.

6. PLASMA CELL DISORDER

The most common of these disorders is multiple myeloma which is a progressive and neoplastic disease.

History includes persistent, bone pain and/or pathologic fracture. Recurrent bacterial infection is also common. It is not unusual for renal failure to be the presenting symptom.

Physical examination findings are usually not characteristic or prominent except for pallor.

Special studies include laboratory findings (such as anemia seen in a complete blood count, proteinuria and an abnormal serum protein electrophoresis.) Occasionally, x-ray of the bones may show characteristic punched-out lesions or osteoporosis.

Another plasma cell disorder is macroglobulinemia. History should include fatigue, weakness, bleeding, visual disturbances and headache. Physical examination reveals generalized lymphadenopathy and hepatosplenomegaly. The confirmatory special studies include laboratory diagnosis made by serum protein electrophoresis and/or immunoelectrophoresis.

7. GLOSSARY OF HEMIC-LYMPHATIC TERMS, SYNONYMS, ABBREVIATIONS

ALL	Acute Lymphocytic leukemia
Aniso	Anisocytosis
CBC	Complete blood count
CLL	Chronic lymphocytic leukemia
CML	Chronic myelocytic leukemia
CGL	Chronic granulocytic leukemia
Coag	Coagulation
EBL	Estimated blood loss

Fe	Iron
G-6-PD	Glucose-6-phosphate dehydrogenase
HB or Hgb	Hemoglobin
Hct	Hematocrit
ITP	Idiopathic thrombocytopenic purpura
PTT	Partial thromboplastin purpura
PT/Quick	
Time	One stage prothrombin time
RBC	Red blood cell
Retic	Reticulocyte
Rh	Rhesus factor
SS or SC	Sickle cell
T & C	Type and cross match
TIBC	Total iron binding capacity
WBC	White blood cell

I SKIN IMPAIRMENTS

1. BASIC CONSIDERATIONS

Finding of disability on the basis of a skin disorder may result when the skin lesion involve extensive body surface or areas (such as the hands and feet) which are crucial for job-related activities and/or normal daily functioning. In many instances, the response of the disease to therapy is taken into consideration, as certain skin disorders resist therapy.

As with other impairments, skin impairments must be shown to have persisted or to be expected to persist at disabling severity for at least 12 months following onset.

Certain systemic diseases may include skin abnormalities as one of the systemic manifestations (systemic lupus erythematosus, dermatomyositis,

scleroderma). In these cases, along with other body systems involved, the extent of the skin lesion and resultant functional restriction must be documented.

Malignant tumors of the skin require documentation, as outlined in the chapter for malignant tumors.

Some skin disorders result in severe physical disfigurement. Documentation of impairment of this nature is done separately below.

Certain diseases (such as psoriasis) manifest not only skin involvement but also joint swelling (arthritis). Documentation of the body system involved is an inherent part of claims development in these cases. Standards for documentation are outlined in the chapter for musculoskeletal impairments.

3. DOCUMENTATION STANDARDS OF COMMON SKIN DISORDERS

History of the skin condition has to be sufficiently detailed to assist determination of diagnosis as well as prognosis. Onset date of the disorder, description of the symptoms, their location and severity are all elements of adequate documentation. This type of data is usually part of outpatient follow-up records. The same medical evidence also often contains data as to the nature of therapy as well as the therapeutic response. Adverse side effects of therapy should be documented if they occurred.

Physical examination findings are varied however, the majority of skin diseases are diagnosed by characteristic skin lesions. The findings vary from papules, nodules and vesicles to scales, crusts and ulcers. The oral mucosa, the axillary area, the anogenital areas, scalp and nails may be involved in the disease process, thus findings in these areas should be noted.

In cases where contractures occur secondary to burns, it is important to document the areas affected since they may cause significant limitation of motion (i.e. burns involving the chest and the axilla may restrict abduction and/or elevation of the shoulder).

There are no specific laboratory diagnostic tests for skin disorders, however, skin biopsy results may give an indication of the exact nature and etiology of the condition.

NOTE: Biopsy should never be ordered as a consultative examination by the Railroad Retirement Board, but when available as evidence of record it is always desirable to obtain this valuable medical evidence.

If the skin disease is a manifestation of a systemic disorder, the appropriate laboratory tests to document the underlying condition are a relevant part of the required medical evidence.

3. PHYSICAL DISFIGUREMENT

Although physical disfigurement without functional loss is rarely a basis for finding of disability, severe disfigurement due to any cause (skin disease, burns, etc.) may preclude the claimant from job activities requiring extensive person to person contact or dealing with the public in general.

When disfigurement is found to be a significant factor in impairment severity assessment, the following documentation is necessary:

a. Detailed physical examination results, describing the physical defect and therapy received along with the side effects of therapy and the therapeutic response.

b. Description of claimant's daily activities, potential constriction of interest, reclusiveness and relationship with others, in general. This data is necessary to determine the functional limitations the claimant's disfigurement causes not only in a physical but also in a psychosocial sense. Information relative to repeated denial of employment due to claimant's appearance may be considered as adjunctive evidence of a non-medical nature.

c. Current photographs of the claimant along with close up view of the affected areas are often helpful evidence aiding the impairment severity assessment process. If use of prosthesis has been recommended pictures should be taken while prosthesis is in use.

Frequently, claimants with disfiguring impairments develop secondary psychiatric conditions (e.g. depression) which should be documented and evaluated in addition to the disfigurement caused by the skin lesion itself. Documentation standards for the additional psychiatric impairment, if present, are outlined in chapter for mental impairments.

4. GLOSSARY OF TERMS, SYNONYMS, ABBREVIATIONS

derm	Dermatology, dermis
epith	Epithelium (skin)
SC	Subcutaneous
SMR	Submucous resection

STSG	Split thickness skin graft
UVL	Ultraviolet light

J. ENDOCRINE SYSTEM IMPAIRMENTS

1. BASIC CONSIDERATIONS

Disability resulting from endocrine disorders is caused by either an excess or deficiency of hormones secreted by endocrine glands. Since hormones enter the blood, rather than ducts, they can impact upon any or all organs through the circulatory system. Accordingly, abnormalities in endocrine function may affect other body systems. Hormones play a major role in metabolism and are crucial for normal physical and mental development, reproduction and homeostasis. If endocrine disorders occur during the early stages in life affecting development, permanent pathological conditions may be the result.

2. THYROID DISORDERS

This group of diseases is a result of either excessive or underproduction of hormone. The diagnosis is established by characteristic symptomatology resulting from the hormonal imbalance. Laboratory findings substantiate the level of glandular functioning; thus, thyroid function tests are an inherent part of adequate documentation.

Complete physical examination findings should document any other organ involvement resulting from the thyroid disorder. It is common to find exophthalmos (protrusion of the eyeballs) along with goiter. Chronic exposure of the eyeballs can result in the drying out of membranes covering the eyes. Significant impairment severity can be found on that basis alone. Establishment of severity depends on the ophthalmological findings; specifically, that of exophthalmometry.

In summary, documentation of thyroid disorders should include:

a. History of the disorder, corresponding symptoms,

b. Physical examination findings describing involvement of other body systems, if any;

c. Laboratory tests should include thyroid function studies and,

d. If exophthalmos is present an ophthalmological examination to document the extent of exophthalmos.

3. DIABETES MELLITUS

The diagnosis of diabetes mellitus is customarily established by findings of persistently elevated blood sugar, family history and symptomatology initially characterized by a triad of polyuria, polydipsia and polyphagia.

The degree of elevation of blood sugar level, per se, does not determine the severity of the condition. Complications (that is, end-organ damage resulting from diabetes) are the determining factor of severity.

Acidosis occurring frequently, requiring repeated hospitalizations, should be factored into the impairment severity assessment. Records of repeated hospitalizations are to be secured for review.

Documentation of end-organ damage consists of careful history to identify the organs involved. Commonly, complaints of blurred vision indicate involvement of the retinal blood vessels. Numbness and tingling in the extremities may reflect peripheral neuropathy. In cases where peripheral vascular disease complicates the clinical picture history may vary from intermittent claudication to amputation due to non-healing wound which eventually resulted in gangrene. In cases with ocular (retinal) involvement ophthalmological examination results should be included in file. If renal complications are at issue, signs and symptoms of the renal involvement along with renal function tests are necessary for adequate documentation.

Documentation of diabetes mellitus includes not only a comprehensive history and system review documenting symptomatology, but also a comprehensive physical examination to explore potential end-organ damages. Hospitalization and outpatient records are valuable evidence in determining the course of the disease and the resultant complications.

4. DIABETES INSIPIDUS

Abnormalities of the posterior pituitary gland may cause this condition. Diagnosis is usually easily established by history, which also includes the course of the disease.

Laboratory documentation includes an urinalysis indicating low specific gravity. Hospital records generally indicate electrolyte abnormalities upon admission due to recurrent dehydration, a frequent complication of this condition.

5. HYPERPARATHYROIDISM

In addition to history describing the claimant's symptoms, laboratory evidence establishing this condition is elevated parathyroid hormone level. Other laboratory findings include serum calcium and serum phosphorous level. The former is pathologically elevated while the latter is depressed.

Finding of severity is generally commensurate with the manifest bone disorder that is secondary to generalized decalcification of bones.

The x-ray of the bones indicates various abnormalities ranging from signs of decalcification to pathological fractures.

If other body systems are involved physical examination and systems review should document the severity of impairment of corresponding body system. For documentation standards of each body system, the reviewer is cross-referred to the appropriate chapter of this appendix.

6. HYPOPARATHYROIDISM

This condition is the opposite of the pathological condition described above.

Documentation standards for the condition are similar to those of hyperparathyroidism; of course, the findings will be different. Generally, the characteristic mineral abnormality (that is, pathologically low serum calcium level supported by parathyroid hormone assay) is sufficient to establish the diagnosis.

As a sequelae to the hormone and mineral imbalance, neuromuscular irritability is found in these claimants. Clinically, this irritability is manifested in severe and recurrent episodes of tetany. The same underlying pathology can expand to the extent that generalized seizures occur. The history of episodes of tetany and/or convulsions are best obtained from hospitalization or outpatient records. A one-time consultative examination is usually inadequate to establish this particular facet of the disorder.

Parathyroid hormone deficiency is known to cause cataracts. If visual complications accompany Hypoparathyroidism, apply the documentation standards outlined in the chapter for visual impairments in this appendix.

7. GLOSSARY OF ENDOCRINE TERMS, SYNONYMS, ABBREVIATIONS

ACTH	Adrenocorticotrophic hormone
ADH	Anti-diuretic hormone
DM	Diabetes mellitus
DI	Diabetes insipidus
DOCA	Deoxycorticosterone acetate

FBS	Fasting blood sugar
FTI	Free thyroxine index
Glu	Glucose
GTT	Glucose tolerance test
17-OH	17 hydroxysteroids
I131	Iodine 131 (radioactive iodine)
17-KS	17 ketosteroid
PBI	Protein binding iodine
PPBS	Post-prandial blood sugar
PTH	Parathyroid hormone
PZI	Protamine zinc insulin
RIA	Radio-immuno assay
TSH	Thyroid stimulating hormone
T3 Uptake	Triiodothyronine uptake

K. NEUROLOGICAL IMPAIRMENTS

1. BASIC CONSIDERATIONS

A neurological examination usually includes the following:

a. Mental Status Examination - This part of the neurological examination provides documentation relative to the claimant's level of consciousness (alert, comatose, stuporous, confused, etc.); orientation to time, person, and place and intellectual deterioration. Memory is tested along with the claimant's reality testing. Abnormal behavior patterns, if present, should also be noted here.

b. Speech - Claimant's ability to communicate by verbal means should be documented. The presence of aphasia, or other speech impairment, along with any other significant interference of communication should be noted.

c. Cranial Nerve Examination - This should include findings of the testing of cranial nerves, such as ability to swallow, etc. Any hearing or visual defects should be noted as well in this portion of the neurological examination.

d. Cerebellar Function Tests - This portion of the neurological examination is concerned with the claimant's stand or station, gait and coordination in the upper and lower extremities. If ataxia, hemiparesis, limping, or abnormal ambulation is present, a description of the claimant's ability to walk and stand with and without ambulatory devices should be included in the report. Common tests used in this area are: Romberg's test, finger to nose test, rapid alternating movements, etc.

e. Motor Function Examination - This essential portion of the examination includes the presence or absence of rigidity, tremors, weakness, etc. Any abnormalities of muscle groups should be quantified (that is, graded from normal to complete paralysis.)

f. Sensory System Examination - The senses of touch, pain, temperature (hot or cold), vibration and muscle joint position sense are tested. Sensation may be normal, decreased, absent or heightened. Stereognosis (recognition of shapes by touch with eyes closed) is also tested.

g. Reflex Examination - A reflex, by definition, is a response evoked by a stimulus; it may or may not be conscious. A set of reflexes is usually tested. Examples of the upper extremity reflexes are, the biceps and triceps reflex. Examples of superficial reflexes in the face include the corneal reflex. In the lower extremities, the knee jerk or patellar reflex and the ankle jerk or Achille's reflex is tested as well as some pathological ones (such as the Babinski reflex). Superficial reflex in the abdomen is the abdominal reflex and the cremasteric reflex.

2. EPILEPSY (SEIZURES)

Epilepsy is a syndrome as opposed to uniform disease entity. The epilepsy syndrome may be divided into two general categories of its clinical manifestations.

a. Major Motor Seizures (Grand Mal or Generalized) - This type of seizure is characterized by momentary feeling of strangeness (aura) followed by unconsciousness and convulsive movements of the arms and the legs. These events are followed by complete relaxation of the muscles to such an extent that there might be

incontinence of urine and sometimes feces. This phase is often followed by sleep or gradual regaining of consciousness.

1) Documentation Requirements

a) History - Include the following essential items:

Onset of seizures,

Description of seizures.

This portion of the documentation can be obtained several ways, emergency room and/or hospitalization records may have a detailed description of the seizures observed by a doctor, a nurse, or hospital personnel. If these are not available, the claimant's attending physician could be contacted for description, if he himself has observed an alleged seizure. More frequently, the friends or relatives of the claimant have observed a seizure. Therefore, in the absence of medical evidence documenting a detailed seizure description, lay evidence may be used to document an alleged seizure. The claimant's description of his own seizure, is however, unacceptable, since he is supposed to be unconscious during a seizure and thus would not be aware of what actually happens during an episode. This portion of the documentation is crucial for documentation of a seizure disorder since the objective findings are usually negative. A seizure patient commonly has a normal neurological examination and many seizure disorders will manifest with a normal EEG.

b) Frequency of Seizures - This information may be obtained from the claimant's treating physician and/or relatives who live with the claimant. This information may also be found in out-patient progress notes and/or follow-up notes (clinic records).

If the claimant alleges daytime and/or nighttime seizures, the frequency of each one must be clearly documented. In addition, if seizures occur only at night, information as to the presence of any residuals occurring the day after a seizure, is essential. This is to provide information as to how these residuals would affect the claimant's ability to function during

the day. The frequency of seizures usually imposes considerable difficulty in verification.

Actual frequency is subject to a great deal of variability. Certain patients may experience no seizures for many months, then suddenly may have several attacks within a brief period of time.

The following information in c), d), and e) must be obtained in detail when seizures occur in such a manner.

c) Prescribed Therapy - This should include the names and dosages of the medications the claimant is taking to control his seizures. Statements relative to the claimant's compliance to prescribed therapy is needed, since most seizures are controlled by anti-convulsive therapy. The determination of blood levels of Dilantin or other anticonvulsive drugs are useful in determining whether treatment is being followed. On cases adjudicated after 1980, this type of evidence is desirable to secure.

d) Physical Examination - Physical examination findings should include the complete neurologic examination. While a completely normal neurological examination is often present in a substantial number of claimants with genuine seizure disorder, this portion of the documentation is an indispensable part of the documentary process. If the examination is not normal, the abnormal findings may include injury secondary to a seizure episode (such as bruises, lacerations, tongue bite, etc.).

e) Laboratory - An EEG (Electroencephalogram) should also be in the record substantiating the presence of convulsive disorder. A positive EEG does not necessarily mean that the impairment is severe; however, it serves to confirm the diagnosis of epilepsy. On the other hand, a normal EEG does not necessarily rule out a seizure disorder or imply that the impairment is not severe. Fifteen percent of epileptics have a normal EEG. Due to the statistically significant number of individuals who have a genuine seizure disorder with concomitant normal EEG, an allowance can be made in the presence of normal EEG if the preponderance of evidence indicates a

disabling seizure disorder. Nevertheless, this provision is not intended to eliminate the need for documentation of EEG as when it is present and it is positive it increases the likelihood significantly as to the presence of a genuine seizure disorder.

The anticonvulsant serum level is an essential documentation requirement in seizure disorders, since the most important factor in determining the severity of seizure disorders is the response to therapy (that is, whether frequency and intensity of the seizures will occur in spite of adherence to prescribed therapy). The serum level of each prescribed medication should be obtained.

An acceptability of an EEG is unlimited, except when secondary changes occurred in the clinical manifestations of the seizure disorder.

b. Minor Motor Seizures - This category may be further divided into:

1) Petit Mal - This consists of a brief interruption of consciousness, sometimes accompanied by rhythmical blinking of the eyelids. Recovery usually immediately follows and the entire episode usually occurs within seconds. A classic petit mal may be developed by getting a detailed description of a seizure in the same manner as obtained in a seizure description in major motor seizures. A petite mal seizure is usually very brief in its episode. The seizure episode itself is not determinant of severity. It is the postictum manifestation, if any, which interferes with the claimant's ability to perform work related functions; therefore, the documentation of postictal manifestations in petite mal (as well as the other less common types of minor motor seizures) is essential in the documentation of these types of seizure disorders. Such postictal manifestations, which are usually behavioral, as well as their duration, should be documented in the file. Unlike the previously described major motor seizure disorder which does not have a characteristic EEG pattern or doesn't necessarily have positive EEG finding whatsoever, this type of seizure disorder has a very specific EEG abnormality without which pattern the diagnosis of petite mal is considered unsubstantiated and undocumented. This absolutely necessary positive EEG finding is 3 per second, spike and a wave EEG pattern.

There are two less common types of minor motor seizures that are sometimes classified as petit mal. The EEG findings for classic petit mal are not necessarily characteristic of the two less common types of minor motor seizures.

The first one is myoclonic jerks. This is sudden and involuntary contraction of the muscles of the trunk or extremities. They may e slight, or they may become so violent that the claimant may drop an object held in the hand. The seizure should be adjudicated under the minor motor seizure disorder.

The other type of minor motor seizure is akinetic seizure (drop attacks). This is characterized by a sudden loss of tone in all the muscles resulting in the patient's fall to the ground. If there is any loss of consciousness, it is usually very brief. Again the documentation of this is the same as the documentation of petit mal and the adjudication would also be done under minor motor seizures.

2) Focal Seizures - During an attack of focal seizure, the claimant remains conscious. The seizure itself consists of clonic movements in localized groups of muscles such as the hand or the forearm. There may be momentary weakness of the muscles involved (Todd's paralysis). These are classified under minor motor seizures. Focal seizures very rarely have postictal manifestations.

Certain focal seizures may cause a spread of epilepsy discharge causing clonic movement throughout the body (Jacksonian seizure). In such cases, consciousness is lost. Further manifestation of the Jacksonian seizures are similar to those of a Grand Mal type. Documentation of this type of seizure disorder should involve very careful detailed description of the seizure to enable an independent reviewer to determine whether adjudication should be done under major motor seizures or minor motor seizures. The predominant manifestations should be the guide to be used in this determination. Nevertheless, previously outlined documentation requirements apply to whichever type of seizure is more predominant, whether it be the major motor seizure or the minor motor seizure.

A special type of focal (or partial) seizure is the psychomotor or temporal lobe seizure. This is the complex disorder of sensation ranging from sensory hallucination (sight, sound, taste or smell) to highly organized psychic disturbances.

Occasional chewing movement and smacking of the lips are accompanying symptoms. Frequently, this type of seizure disorder results in the alteration of consciousness (dreamy and confused state) as opposed to loss of consciousness. These phenomenon are followed by repetitive, usually stereotype, automatism which involve only partially purposeful or totally inappropriate bizarre behavior. There is complete amnesia of these events after the attack. In these types of seizure disorders, documentation should include, as in other seizures, a detailed description of the seizures.

3. CEREBROVASCULAR ACCIDENT (STROKE) - This condition often occurs without any forewarning signs, but even if some forewarning signs have been present for some time the event is usually dramatic. In a matter of several minutes, the claimant develops a wide scale of neurological symptoms, the specifics of which depend on the area affected by the accident. Functional loss directly after the occurrence of the CVA tends to be much greater than the residuals after the stormy, dramatic event settles. Accordingly, the functional loss observed immediately after the stroke, tends to be much more exaggerated and affects greater neurological functions than the residuals will be once the accident takes a more chronic and less precipitous course.

   Proper documentation of this condition consists of documentation of the time the cerebrovascular accident occurred, possible forewarning signs (transient ischemic attacks), description of the functional loss (symptoms, signs and findings), as well as documentation of a waiting period of approximately three months to permit the individual to regain all the functions that were only temporary lost and to assess the residual symptoms which are unlikely to improve with time. Results of detailed neurological examinations, three months after the alleged episode of CVA, are crucial to the determination of severity. This should include the same detailed findings as detailed under basic considerations of the complete neurological examination. If any motor dysfunction is present due to the episode, this should be documented by detailed description of the motor system (that is, if there is any weakness, spasticity and/or cerebellar abnormalities such as ataxia, incoordination, tremor). The neurologic findings should be completed and detailed to enable an independent reviewer to determine the degree of interference the neurologic abnormalities would impose on the claimant's remaining ability do fine and/or gross

movements as well as the degree of interference that it could impose on the patient's ability to stand and walk.

4. CEREBRAL PALSY - The term cerebral palsy embraces s group of disorders of the motor system present at birth. This is true even if at times all signs of the disease may not be immediately apparent at birth. The most common clinical feature is spastic paraplegia with brisk tendon reflexes and extensor plantar responses. There is a spasm of the muscles at that time. Sometimes, only the upper extremities are involved, but, more commonly, one upper and one lower extremity is involved. Accompanying intellectual disability and epilepsy are often present in cerebral palsy. As with any other neurologic disorders, the diagnosis of cerebral palsy should be established and this can be made by obtaining records from the claimant's attending physician or past medical records of hospitalization documenting the neurologic dysfunctions which led to the diagnosis of cerebral palsy. If the claimant is seen as an adult, it is more difficult to obtain birth records which document the possible cause or the cerebral palsy. However, previous medical records, hospital records or outpatient follow-up would also document the neurologic dysfunctions which would have been the basis for documenting cerebral palsy.

   By definition, cerebral palsy is a static condition, that is, progression or improvement of the condition is not expected throughout life. When the diagnosis of cerebral palsy is definitely established, the neurologic findings need not be very recent. Nevertheless, they should contain a complete documentation of the neurologic findings (that is, including the motor, sensory and reflex findings as well as cerebellar examination).

   In cerebral palsy, there are various degrees of severity of the neurologic dysfunction. In many cases, cerebral palsy may result in motor dysfunction that would be so severe as to interfere with the claimant's ability to walk, stand and/or to perform fine and gross motor manipulations. However, in certain cases where there is less severe neurologic dysfunction, a finding of severity may be made when it is combined with other disorders (such as seizure disorder, Intellectual Disability, significant behavioral or emotional disorder and/or significant speech, hearing or visual problems). In the latter type of cases, documentation should include not only the establishment of the diagnosis of cerebral palsy and the corresponding neurologic findings,

but should also include an IQ testing; when Intellectual Disability is present, or if any mental impairment is present such as autism and/or emotional disorders, a detailed psychiatric examination report should be in the file. When there is evidence of a significant defect in speech, hearing or vision, the documentation of this additional impairment should also be made accordingly.

5. HEAD INJURY - Compound fractures and depressed fractures of the skull often result in cerebral trauma. The most severe forms of brain damage with gross traumatization usually result in unconsciousness and there is a danger of intercranial bleeding. Persistent eurologic deficits after recovery are often found. The resulting neurologic manifestations of head injuries are similar to that seen in cerebrovascular accidents; therefore, the documentation of head injury is the establishment of the diagnosis, the chronology of events leading to the head injury and the resulting neurologic residuals.

   In addition to normal neurologic findings, a head injury may also result in a seizure disorder which should then be documented just like any seizure case. Likewise, the head injury may result in chronic organic brain syndrome which would be documented as outlined under mental impairment.

6. INTRACRANIAL TUMOR - The usual symptoms of intracranial tumors are caused by irritation and destruction of the nerve tissue as well as intracranial pressure. Deficits arising as a result of a brain tumor depend on which area of the brain is affected. Brain tumors vary from the most common (which is the benign gliomas) to the malignant brain tumors. It is crucial in the documentation of brain tumors to obtain the pathology report documenting what type of brain tumor is present since there are certain forms of malignant gliomas (such as glioblastoma multiform). Other types of brain tumors should be documented not only by the pathological classification of type of brain tumor present, but also the resulting neurologic dysfunction. Therefore, the crucial evidence needed for these types of tumors is the neurologic examination findings. It is also crucial to establish if there is any evidence of metastasis anywhere else secondary to the brain tumor.

7. PARKINSONISM - Parkinsonism is a syndrome which includes generalized poverty of movement, tremor and rigidity. It is a progressive degenerative disorder affecting the

basal ganglia. Documentation needed in Parkinsonism is the history of the disease (that is, the signs and symptoms) which must support the diagnosis. Disease is fairly characteristic (that is, the first and most prominent symptom is tremor). Rigidity usually follows the same distribution as the tremor. Eventually, bradykinesia may also be noted. With progression of symptoms, there is significant neurologic dysfunction resulting in disturbance in the patient's ability to perform fine and gross as well as dexterous movements and his ability to walk and stand is also markedly affected. The crucial documentation for parkinsonism includes not only the characteristic history and the course of the disease, but also the response to therapy as well as the detailed neurologic examination findings.

8. CHOREA - This condition is characterized by sudden jerking movement of the limbs which, although not fully coordinated, may have the appearance of poor manners. The two most common types are the Huntington's chorea and sydenham chorea. Sydenham chorea is a benign disorder of childhood and is usually one of the manifestations of rheumatic fever. On the other hand Huntington's chorea is a progressive disorder consisting of dementia and bizarre involuntary movements. It is a hereditary disorder and mental deterioration usually occurs sooner or later. The latter type of chorea (Huntington's) is the most serious one, since it is a degenerative disease and usually results in very severe neurologic dysfunction. Documentation of the resulting motor dysfunction could be done with a comprehensive neurologic examination. In addition, there is mental deterioration, and possibility of development of chronic brain syndrome occurs eventually. Documentation of this resulting impairment could be done as in the documentation for chronic brain syndrome outlined under the mental impairments category (that is, with detailed mental status as well as the description of daily activities).

9. MULTIPLE SCLEROSIS - This is a chronic disease which is caused by the absence of the covering of the nerve cells and is clinically manifested by a variety of neurologic symptoms and signs which have a tendency toward remission and exacerbation. The chief character of the symptoms is the multiplicity and the tendency to varied nature as well as severity with passage of time. Documentation of this disorder includes the history, which is crucial to determine the course of the disease and the response to therapy. Change of the symptoms occurs frequently; therefore, it is

important that current neurological findings be in the file to allow determination of current severity. There are no characteristic laboratory findings of multiple sclerosis, therefore, laboratory evidence may be helpful when positive but does not negate the presence of the disease when it is negative (example CAT scan).

10. DISEASES OF THE SPINAL CORD - This includes diseases such as compression of the spinal cord by tumor or cervical spondylosis, subacute combined degeneration of the cord and syringomyelia. The careful establishment of the diagnosis and the history, the course of the disease, the supporting laboratory findings (such as the results from a myelogram, a CAT scan and/or EMG) should be secured if available. When the diagnosis is established, the resulting neurologic dysfunction should be documented with a comprehensive neurologic examination. If there is any persistent disorganization of motor function that would result in the inability of the patient to use his upper extremities for manual manipulation or the use of his lower extremities for standing and/or walking, such a finding should be described in detail as it can limit the claimant's residual functional capacity. In certain spinal cord disorders where there is involvement of the cranial nerves, the cranial nerve examination (part of the comprehensive neurologic examination) should allow the evaluation of the presence of significant bulbar signs, if any. In certain cases (such as poliomyelitis), certain residuals result, in addition to significant motor dysfunction involving one or two extremities. There may be difficulty with swallowing or breathing or with the patient's ability to speak intelligibly; therefore, in addition to the complete neurologic examination, comprehensive physical examination with general observations should document if any of the above abnormalities are present.

11. DISORDERS OF MUSCLES - This includes the classic muscular dystrophy and myasthenia gravis. Types of these disorders involve not only the muscle itself but the innervation of these muscles. Significant muscle weakness with resulting atrophy is a common finding. In myasthenia gravis there may also be difficulty with speaking, breathing, and swallowing, which findings should be taken into consideration when evaluating the overall physical examination findings.

Response to therapy should also be documented in the file. Overall, however, disorders of muscles would result in finding of severity when there is significant motor dysfunction resulting from muscular weakness. The comprehensive neurologic examination which should be in file would include, among other things, the description of the muscles, and the presence or absence of atrophy. The muscle strength of the affected muscle group should be quantitated. It is not sufficient that the report would only say mild, moderate, or severe weakness, but this should be illustrated in more detail by a description of how the muscle group would respond to resistance and gravity.

12. PERIPHERAL NEUROPATHY - This type of impairment may be the result of end-organ damage by diseases such as diabetes mellitus. The diagnosis is established by the symptoms (that is, numbness and tingling of extremities) and by the neurologic findings (that is sensory deficits). In severe cases, there are motor deficits documented by muscle weakness and/or atrophy. Again, documentation of this type of disorder is adequate with a comprehensive neurologic examination.

13. GLOSSARY OF NEUROLOGICAL TERMS, SYNONYMS, ABBREVIATIONS

ALS	Amyotrophic lateral sclerosis
ANS	Autonomic nervous system
CAT scan	Computerized axial tomography
CNS	Central nervous system
CP	Cerebral palsy
CSF	Cerebro-spinal fluid
CVA	Cerebro-vascular accident
DT	Delirium tremens
DTR	Deep tendon reflex
EEG	Electroencephalogram

EMG	Electromyography
EOM	Extraocular movements
GM	Grand mal
HNP	Herniated nucleus pulposus
KJ	Knee jerk
LP	Lumbar puncture
MS	Multiple sclerosis
MD	Muscular dystrophy
Phenobarb	Phenobarbital
TIA	Transient ischemic attack

L. MENTAL IMPAIRMENTS

1. BASIC CONSIDERATIONS

For disability evaluation purposes, four different categories of mental impairments should be distinguished:

a. Intellectual Disability,

b. Chronic organic brain syndrome,

c. Functional psychotic disorders,

d. Functional nonpsychotic disorders.

2. INTELLECTUAL DISABILITY

Among these four types of mental impairments, Intellectual Disability is the most objectively, numerically assessed. Intellectual Disability is a lifelong condition characterized by below-average intelligence with resultant impairment in learning, maturity, and social adjustment. This assessment is carried out by the use of standardized measurements of intelligence often referred to as psychometric testing. Psychometric testing is professionally administered by psychologists. Accordingly, while organic brain syndromes, functional psychotic disorders, and functional non-psychotic disorders are best assessed by physicians, the optimal

assessment of Intellectual Disability lies in the field of psychology. In some instances of organic brain syndrome, where the impairment primarily affects the intelligence, psychometric testing is also useful to establish an objective measure of intellectual deterioration.

There are several types of psychometric testing that yield a numerical measurement of intelligence (IQ). It is generally agreed that the Wechsler Intelligence Scale (revised) is the most reliable intelligence testing. This scale provides three different IQ values: the full scale IQ (computed by utilizing two subtest scores); the performance score (performance IQ); and, the verbal score (verbal IQ).

NOTE: In assessing the impairment severity of the claimant the lowest of the three subtest scores always prevails.

The second most popular psychometric testing provides only one IQ score. This test is the Stanford-Binet Intelligence Test. There are several other acceptable intelligence tests, (Leiter, McCarthy, Cattel, Raven); however, either the Wechsler or the Stanford-Binet is always desirable.

Several tests are often erroneously used for assessment of intelligence and they are unacceptable as they either measure something other than intelligence or they are not well standardized. The most often mistakenly used tests are:

a. Peabody Picture Vocabulary Test,

b. Vineland Social Maturity Test,

c. The Denver Developmental Achievement Test,

d. The Slosson Intelligence Test.

Intellectual Disability is a lifelong condition which is not subject to significant improvement once the intelligence level has reached its final plateau. Nevertheless, during the early years of development, it is subject to change, particularly depending on the degree of Intellectual Disability. Accordingly, when assessing the acceptability of psychological testing one should consider the claimant's age at the time of the testing as well as the date of testing as it relates to the date adjudication.

TIMELINESS OF PSYCHOMETRIC TEST RESULTS

IQ Score	Age at testing	Time Limit
Below 40	Before 7 Years	2 Years

Over 40	Before 7 Years	1 Year
Below 40	Before 7 Years	4 Years
Over 40	Before 7 Years	2 Years
Any IQ	At 16 or Older	No Limit

Medical evidence is always desirable to verify that the claimant's IQ is consistent with his daily activities, scope of interest, ability to relate to others, and general behavior.

In assessing the medical evidence one should be conscious of the fact that an IQ of 59 or below is characteristic of the lowest two percent of the general population.

There are some special circumstances, particularly in the profoundly intellectually disabled range, where, due to the claimant's condition, a well standardized IQ testing cannot be performed. In these instances, psychological or medical reports (specifically describing the claimant's behavior with attention to the obvious intellectual, social, and physical impairment) should be secured.

3. ORGANIC BRAIN SYNDROME, FUNCTIONAL NONPSYCHOTIC DISORDERS, AND FUNCTIONAL PSYCHOTIC DISORDERS

These disorders are best evidenced by a psychiatrist's report.

Psychiatric judgment in clinical practice relies heavily on observations of the interviewer (that is, the psychiatrist draws inference from what he sees as the patient's behavior) as to the nature of the patient's mental functions.

Two salient features of this have particular significance for disability assessments:

The clinician observes and describes behavior. This is the type of objective evidence required for independent assessment.

Although there are varied schools of thought in the field of psychiatry which may affect the diagnosis, treatment, approach, etc., in a clinical setting, these variances have little impact on the required documentation. It is so, because it is the actual observation and descriptions which are central to the disability assessment. The definition of disability requires that the individual have a medically determinable impairment substantiated by signs, symptoms, and ancillary findings.

The evidence should contain three basic characteristics: it should be current, complete, and objective, requiring a minimum amount of extrapolation relative to the claimant's functioning. The timeliness of this evidence is required for both determining current severity and duration.

Obtaining detailed objective evidence (as opposed to subjective judgments) is very important and often difficult.

For example, if the psychiatrist just sates that the claimant "appears paranoid," this is inadequate documentation as it represents a conclusion only and does not relay how that conclusion was reached. On the other hand, if the physician states that "the claimant appears paranoid as he glanced around the room after entering, stating that he just wants to make sure the office is not electronically bugged", then we have objective data. In the latter example, the psychiatrist clearly demonstrated why he concluded that the person was paranoid.

Another example concerns cognitive functioning. The psychiatrist might state "the memory and concentration are o.k." This is inadequate evidence, as the data used to come to this conclusion is not presented. Instead, the report should disclose the procedure and response (such as, "the claimant's immediate memory is good as measured by his ability to repeat five items after two minutes waiting").

Proper documentation should include medical evidence relative to the following four elements of claimant's condition.

a. Medical History - Every well documented file should contain a medical history. In Mental disorder claims, longitudinal information is often more important than it is in other body systems. A report of past psychiatric hospitalizations might be helpful in documenting the continuing nature of the mental disorder. It can also aid in determining whether a particular behavior is in response to an acute stress or is part of a long-term process.

   For example, sudden severe paranoia may be a newly emerged problem but it might have been present in low grade form for a number of years. It might also be an acute response to drug ingestion from the streets (such as, PCP, LSD, etc.) or prescribed medications (such as, corticosteroid). The first instances would be more consistent with a psychosis such as schizophrenia, while the latter are limited to the duration of the affect of the drug with only a few or no postpsychotic residuals. Historical data can also be used to determine whether longitudinally significant deterioration has taken place.

The perspective that a well-documented psychiatric history provides is especially useful when the only current medical data in file for the mental disorder is a one-time evaluation by a consultative examination. This may or may not be representative of the claimant's usual functioning. A medical history provides the background with which the current medical information can be correlated. This is similar to a strip of movie film comprised of many individual still pictures none of which alone portrays the whole story. Only by observing each still picture in a series and in proper sequence does a coherent progression of events emerge. More than one individual piece of medical evidence is needed in order to portray the development, current status, and potential duration of a mental disorder.

b. Mental Status - A vital part of psychiatric evidence is the mental status examination. This can be defined as a systematized description of the psychiatrist's observations and impressions of the claimant. There are several parts of the mental status examination and each one is an important component in assembling the total picture of claimant's functioning. The following are several important sections:

1) There should be a description of the claimant's appearance noting areas such as dressing, personal hygiene, type of distress and motor activity.

2) A description of the claimant's attitude toward the interviewer is helpful in trying to draw conclusions about the claimant's behavior in a work situation. For example, if the claimant establishes a profile of hostility when facing questions posed to him, difficulty might be anticipated in the person's relationship to coworkers and supervisors.

3) The manner in which the claimant expresses himself gives an indication of possible underlying psychopathology. Such phenomena is pressured speech, loosened associations, disturbances in perception (hallucinations), disturbances in content of thought (delusions), or disturbances in form of thought (loosening of associations, incoherence, flight of ideas, ideas of reference, etc.), along with some "soft signs" of thought disturbances (poverty of thought, thought blocking, circumstantiality, tangentiality), are potentially incapacitating. Being aware of these disorders is important because they influence work and school behavior.

4) Speech content gives us an idea of what the claimant's main concerns are. The previously mentioned perceptual

disturbances, disturbances in content and form of thought, somatic preoccupations, suicidal and homicidal ideations, phobias and obsessions are examples of significant findings.

5) A description of claimant's emotional state, both from the interviewer's and the claimant's point of view, is valuable information about the claimant's mental life. Mood disorders (such as, mania and depression) can be impairing; especially, as they affect energy level and concentration. Thus, it is necessary to see if they are present.

6) An assessment of the claimant's appropriate level of cognitive functioning is important in determining the extent that the claimant can learn new tasks and cope with the changing requirements of a work situation. A person's orientation, memory, attention, concentration, ability to abstract, fund of general information and level of judgment need to be tested.

Assessment of the claimant's insight into his mental condition will permit better prognostication regarding treatment compliance.

c. POST MORBID FUNCTIONING - Residuals of a psychiatric illness affect post morbid functioning and, therefore, it is necessary to have an account of the individual's daily activities after some of the acute symptoms have subsided. For example, after an acute schizophrenic episode there often is a prolonged postpsychotic depression during which the psychotic symptoms (delusions, hallucinations, incoherence) are no longer evident. Nevertheless, there might be a series of residuals present (such as, pronounced lack of energy, disturbance in eating or sleeping, feeling of hopelessness and helplessness, at times suicidal ideations, suicidal attempts, etc.). Although these symptoms might not be described as schizophrenic by nature they do interfere with normal functioning.

A contrasting example would be manic depressive illness where the person's behavior can e quite disturbed during the manic episode but with treatment, his ability to function may be remarkably good after a few weeks. Due to the fluctuations of symptoms of psychiatric conditions, a single current examination may not always sufficiently describe an individual's sustained ability to function. The claimant's level of functioning may vary considerably over a period to time depending on the claimant's ego strength, stability of condition, regression potential, stress tolerance and other factors. The level of functioning at any particular point in time may appear

relatively efficient or very poor. Proper evaluation the claimant's sustained customary functioning is best obtained by longitudinal evidence.

d. DAILY ACTIVITIES - The task of disability documentation does not end by simply confirming the claimant's allegations by clinical findings. The process involves a second step of documenting the impact the verified psychiatric impairment has on the individual's ability to function. Documentation of the claimant's activities, which is representative of the individual's customary daily psychological functioning, is a vital part of the documentation of mental claims. The documentation should cover the description of the claimant's typical daily activities, scope of interest and ability to relate to others. In cases where the claimant's condition is not psychotic, his ability to attend to personal hygiene should be documented as well. Often, it is necessary to obtain documentation relative to the claimant's sleep pattern, appetite, energy level, relationships with others, nature of these relationships, ability to engage in hobbies and other discretional activities and to take care of household chores.

A description of these activities can be deceptively optimistic, particularly in cases of psychiatric claimants with supporting families or claimants who live in various highly structured settings such as halfway houses, day care centers, nursing homes, etc. In assessing the claimant's daily activities, scope of interest and ability to relate to others (that is, the claimant's quality of life) one should be cognizant of the independence with which the claimant participates in these described activities, the frequency and appropriateness of the activities and the general quality of the claimant's daily living.

For instance, if it is stated that the claimant watches television all day it should not be automatically assumed that the claimant watches television as a choice as opposed to other recreational activities, that claimant selects the programs that he enjoys, or even that the program, per se, registers while the claimant is sitting in front of the television set. In some instances the family puts the claimant in front of the television set, turns it on, and the claimant, removed from reality, sits in front of the television not as a result of free choice but rather as a sign of withdrawal, indecisiveness, and diminished motivations

Similar individual judgment should be applied in assessing each and every aspect of the claimant's daily activities, scope of interest, ability to relate to others and (in nonpsychotic disorders) ability to attend to person hygiene.

Many mental disorders have a common feature; that is, the disorder is characterized by one or more psychotic episodes interrupted by intervals with different degrees of recovery. This recovery is typically varied and uncertain. Documentation of the claimant's daily functioning should be comprehensive, pertaining to as large a portion of the claimant's daily living as possible. Certainly, the documentation should describe usual daily functioning for a greater length of time than, for instance, a period of acute hospitalization.

It should be clear that the documentation must enable the examiner to form an objective opinion, free of assumptions and predictions about claimant's current functioning.

Due to the nature of mental impairments, it is often desirable to obtain a statement from the examining physician/psychologist regarding the claimant's ability to handle his own finances.

In summary, the medical documentation of psychiatric claims is multiple. The first step is to substantiate the presence of a medically determinable impairment; the second is to document the historical background and longitudinal aspect of the mental disorder. This is followed by the description of a comprehensive mental status. The fourth element is to secure documentation relative to the claimant's customary daily living, which should be current, typical, and representative of the claimant's usual daily functioning. This documentation should be thorough and detailed to enable the independent reviewer to assess the claimant's impairment severity, residual functional capacity, and competence to manage their own affairs.

4. GLOSSARY OF MENTAL TERMS, SYNONYMS, ABBREVIATIONS

CBS	Chronic organic brain syndrome
CPZ	Chlorpromazine (a type of neuroleptic medication)
CNS	Central nervous system
CVA	Cerebrovascular accident
DT	Delirium therapy
ECT	Electroconvulsive Tremens
EST	Electrosh ck therapy

FSIQ	Full scale IQ
IQ	Intelligence quotient
MAIO	Monoamine oxidase inhibitor (A type of antidepressant medication)
MSW	Master of Social Work
OBS	Organic brain syndrome
OT	Occupational therapy
PIQ	Performance IQ
SH	Social history
VIQ	Verbal IQ

The following section briefly defines the specific behavior manifested in frequently seen psychiatric symptoms. This indicates the kind of information needed to determine how the disease process is manifesting itself, possibly causing disability.

Agitation

This is a manifestation of restlessness with hyperactivity (such as, handwriting, pacing, etc.) and general perturbation. In essence, the behavior can't keep up with the thought processes and results in inappropriate behavior.

Autistic or Other Regressive Behavior

Regression refers to the act of returning to some earlier level of adaption (e.g., a shift from mature behavior to less mature behavior, either mental or physical).

Autistic behavior is manifested by the individual's total absorption with himself. He responds only to internal stimuli, daydreams, fantasies, delusions, hallucinations, etc. External stimuli is either ignored or interpreted only in terms of the individual.1/

Delusions

"A belief engendered without appropriate external stimuli and maintained by one in spite of what to normal beings constitutes incontrovertible and

'plain-as-day' proof or evidence to the contrary. Further, the belief held is not one which is ordinarily accepted by other members of the patient's culture or subculture....Delusions are misjudgment of reality based on projection."2/

1/ Psychiatric Dictionary Fourth Edition; Leland E. Hinsie, M.D. and Robert Jean Campbell, M.D.; Oxford University Press, New York, London, Toronto, 1974, p.78.

2/ Ibid, p. 191.

A delusion is a belief that is obviously contrary to demonstrable facts 3/ as opposed to a hallucination which is a sense perception to which there is no external stimulus.

Phantasy/fantasy is a conscious or unconscious product of imagination, consisting of a group of symbols synthesized into a unified story by a secondary process. 4/ Phantasies are not psychotic symptoms and are not necessarily pathological, either.

Depression

"A pathological state of conscious psychic suffering and guilt, accompanied by a marked reduction in the sense of personal values, and a diminution of mental, psycho-motor, and even organic activity, unrelated to actual deficiency....."5/

Depression is generally thought of as a lowering of mood-tone, synonymous with dejection, sadness, gloominess, despair, despondency, etc. Claimants with depression will also exhibit a change in their activity levels, usually with a marked reduction, although there may be a restlessness and increased psycho-motor activity. There will also be demonstrated difficulty in thinking (e.g., forgetfulness, obsessive thinking, anxieties, worries, inability to complete thoughts, etc.).

3/ Ibid, p. 333.

4/ Ibid, p. 564.

5/ Ibid, p. 200.

Elation

"An affect consisting of feelings of euphoria, triumph, intense self-satisfaction, optimism, etc." 6/

Hallucinations

"An apparent audio-visual perception of an external object when no such object is present. The auditory and visual stimuli have no source in the environment; rather, they are sensations arising within the individual himself." 7/

Illogical Association of Ideas

Associations are the innumerable related threads which guide thinking. In some psychotic conditions, the associations are interrupted and lose their continuity. As a result, thinking becomes haphazard, seemingly purposeless, illogical, confused, incoherent, abrupt and bizarre. Among the many possible association disturbances are clang associations association based on similarity of sound, without regard for differences in (meaning), indirect associations, thought-deprivation (blocking), inappropriate application of cliches, impoverishment of thought, replacement of thinking proper by a senseless compulsion to associate 8/ and ideas of reference (a morbid impression that the conversation, smiling, or other actions of other persons have reference to oneself.). 9/

6/ Ibid, p. 258-9.

7/ Ibid, p. 333.

8/ Ibid, p. 69.

9/ Ibid, p. 372.

Inappropriateness of Affect

Affect is the nonverbal aspect of communication or qualification of the verbal communication. It is the feeling-tone, emotion, or mood accompaniment of an idea or mental representation. To some extent, it is culturally/sub-culturally determined. Typical disturbances include indifference, blunted affect, shallowness, flatness and constriction of the affect.

Mood is often inconsistent or exaggerated with a lack of adaptability and capacity for appropriate modulation of mood tone. There may be an incongruity between the affect displayed at the verbal productions of the individual. 8/ Affect may be behavior manifestations of intrapsychic pathology (e.g., response to hallucinations or delusions.)

Psycho-motor Disturbances

Normal activity is controlled or disturbed by movement which is psychically determined. This could be manifested by either a reduction or an increase in psycho-motor activity (such as, psycho-motor retardation; stereotypes,

(which are constant repetitions of any motion, catatonia; dysarthria, which is difficulty with articulation; stammering and tremors).

M. MALIGNANT TUMORS

1. BASIC CONSIDERATIONS

Although medical science has taken giant steps in treating many malignancies, the diagnosis of cancer is still an ominous one which is recognized by most physicians. Accordingly, malignant tumors represent a special group of impairments. The special nature of these impairments is manifested in the fact that while impairment severity assessment in other categories of impairments is primarily an evaluation of function (with only secondary emphasis on diagnosis) with respect to malignancies the opposite is true.

The well established diagnosis of malignancy, with very few exceptions, represents at least a significant impairment. Most malignancies are not only considered significant but, if some other provisions are met, they are also considered for a time period automatically disabling.

These provisions can be divided into three categories:

a. Some malignancies are considered disabling by simply establishing the diagnosis, (e.g., oatcell carcinoma of the lung). This group of malignancies carry the worst prognosis; that is, an individual having been diagnosed as such would have an extremely short life expectancy.

b. The second group of malignancies is less invasive; thus, in order to find a claimant disabled with these malignancies, usually the presence of a metastasis is required (e.g., carcinoma of the kidneys). In some instances the required metastasis qualifies for the finding of disability only if it is located beyond the region of the primary tumor, indicating wide spread neoplastic pathology (e.g., arcinoma or sarcoma of the large intestine).

c. The third group of malignancies will be found disabling if they show resistance to therapy; either surgery (unrespectable tumors) or chemotherapy (e.g., inoperable carcinoma of the stomach or carcinoma of the prostate gland not controlled by prescribed therapy).

Whichever classification a given claimant's malignancy falls under, if the medical criteria are fulfilled the finding of disability is warranted for a time period regardless of the momentary functional impairment manifested by the claimant.

Again, the underlying principle is that if an individual meets the specified criteria, death is expected to follow in a short period of time, even if momentarily the individual is in remission.

The logical question follows: How long is the assumption valid? At what point in time should the reviewer concern himself with the actual functional limitations caused by the malignancy? At what point should residual functional capacity be assessed, thus focus be shifted from diagnosis to function?

Although the answer to this question is somewhat arbitrary, most physicians agree that three years after onset usually a more or less stable functional assessment of impairment severity can be carried out.

Accordingly, as a rule, documentation of malignancies needs to develop specific diagnostic and in some instances therapy-resistance criteria only for three years, after which period documentation should be secured as to current impairment severity and resultant residual functional capacity. The only exception is acute leukemia where, the time limit is two and a half years after the diagnosis was established.

2. DOCUMENTATION

The operative report and the pathological report are generally the most desirable evidence supporting the diagnosis of malignancies. As a rule, efforts should be made to secure this valuable evidence. Because of the nature of malignancies claimants require hospitalization during the diagnostic work-up and often during therapy as well. Accordingly, the desired documentation should be available as evidence of record. The reports and/or summaries should contain sufficient details establishing the diagnosis with which clinical signs and symptoms of the disease, along with other available laboratory evidence, should be consistent.

The site of primary lesion and any recurrence of metastasis must be specified in all malignancy claims.

The operative report should be comprehensive. Detailed and definitive findings of gross and microscopic examination of available surgical specimen should be in file.

The presence of local or regional recurrences, if any, should be included in the report along with a description of metastases.

Post-therapeutic residuals must be described in detail, as well as the side effects of therapy. Frequently, the therapy applied to control the malignancy causes functional limitations due to its side effects.

Chemotherapy, radiation therapy and surgery are the most common forms of treatment for malignancies. Often times, these modalities are used in combination. Therapeutic regimen and therapeutic response to chemotherapy vary widely. Hence, a description of therapy as well as the long-term therapeutic plan is always desirable evidence. Side effects of therapy may change in the course of administration. Effectiveness of therapy can be adequately assessed only if sufficient time (usually several months) elapsed since initiation of therapy to allow full therapeutic effects and side effects show significant individual differences. The most frequently encountered side effects of chemotherapy include: gastrointestinal side effects, skin reactions and central nervous system symptoms. It is not uncommon for individuals not to experience any significant side effects at all or only a mild degree in the course of chemotherapy.

Chemotherapy is frequently administered in 6 to 12 month cycles and the response to therapy usually can be determined during this period. Severe reactions to therapy may last 5 to 7 days following administration. Severe reactions may occur as often as once a month. Documentation during this period should include signs and/or symptoms indicating recurrence or metastasis, if present.

Radiation therapy can cause skin or other soft tissue damage (e.g. scarring) as a side effect. Not infrequently, the radiation affects the bone marrow as well, with a resultant decrease in the cellular elements of the blood manifesting as anemia, leukopenia and/or thrombocytopenia. In the presence of these side effects adequate documentation should include evidence relative to these findings.

Radical surgery as a therapeutic modality frequently causes functional limitations. Most often these limitations are appropriately evaluated under the musculosketal system, and at times under other corresponding body systems. When the musculosketal system is most affected, documentation should include description of range of motion in degrees, status of musculature as well as a description of abilities to perform fine and gross manipulations.

In general, a good functional description of the affected body system is always desirable and often essential. The following is an example of the diverse descriptions necessary for adequate documentation:

1. Cancer of the larynx often/requires laryngectomy. Documentation should include the effects of surgery on claimant's speech, such as:

    a. Intelligibility,

    b. Volume,

c. Sustainability,

d. Speech structure.

In addition, documentation should be developed regarding the claimant's ability to lift and carry, since the ability to close the glottis is lost.

2. Cancer of the tongue and/or mandible often affects the claimant's abilities to speak as well. Adequate documentation should cover not only this function but facial disfigurements should be documented as well.

3. GLOSSARY OF MALIGNANT TUMOR TERMS, SYNONYMS, ABBREVIATIONS

Alk Phos	Alkaline phosphatase
Bx	Biopsy
BSO	Bilateral salphingo-oophorectomy
Ca or CA	Carcinoma
D & C	Dilatation and curretage
DUB	Dysfunctional uterine bleeding
FS	Frozen section
Metas.	Metastases
TAH	Total abdominal hysterectomy
TUR	Transurethral resection

N. MULTIPLE ORGAN SYSTEM IMPAIRMENTS

1. BASIC CONSIDERATIONS

This section includes diseases manifested by abnormalities involving more than one body system. This may be a result of their nature; that is, they are not confined to one single organ. In some other instances, the disorder may start out in one body system but later may affect other organs.

Foremost of this type of disorder are the so-called rheumatic diseases which are manifested mainly by involvement of the joints.

Further examples are the connective tissue disorders (such as, systemic lupus erythematosus; scleroderma, dermatomyositis, polyarteritis nodosa, sarcoidosis, ulcerative colitis and regional enteritis). Sarcoidosis is discussed more at length under pulmonary Impairments. Ulcerative colitis and regional enteritis are discussed under gastrointestinal impairments.

2. SYSTEMIC LUPUS ERYTHEMATOSUS

This inflammatory disorder of unknown origin affects the connective tissues. The majority of cases occur in females; symptoms may affect any organ system.

The diagnosis is made by the clinical findings which are varied. Characteristic butterfly rash in the face is often present. In some instances, alopecia (loss of hair) may occur. Some patients complain of photosensitivity. Lung involvement is manifested as recurrent pleurisy or pneumonia. The covering membrane of the heart may also be affected (pericarditis).

Since the small blood vessels may be involved, purpura (small hemorrhages under the skin) is a common finding. Kidney involvement occurs in many patients, although this may be asymptomatic for a long time. A nephrotic syndrome-like clinical picture may be the initial manifestation of the disease.

When the central nervous system is involved, manifestations range from mild personality changes to frank psychosis, organic brain syndrome and epilepsy. Permanent joint deformity (such as, ankylosis or subluxation) may occur, when joints are chronically swollen after extended duration of the condition.

The LE cell test is most correlated with SLE but it is not pathognonmic.

The antinuclear antibody test (ANA) is also useful for establishing the diagnosis, although this is usually done by correlating all available medical evidence including history, physical findings and other laboratory tests.

The course of systemic lupus erythematosus is commonly chronic. Relapses and long periods of remission are also seen. Those patients with heart and kidney involvement have a less favorable prognosis than those with only skin and joint involvements.

Documentation of systemic lupus erythematosus claims require obtaining hospital and/or outpatient records which usually contain either positive ANA test or positive LE preparations test. In some instances, as evidence

of record, results of skin and/or other organ biopsy are available documenting the diagnosis.

NOTE: Biopsy should never be ordered as a consultative examination by the Railroad Retirement Board, but when available as evidence of record, this valuable medical evidence is always desirable.

Since a significant component in the assessment of the impairment severity is the resultant end organ damage, adequate documentation includes evidence relative to organ/system involvement and damage. Documentation standards for various systemic involvements are cross-referred to the corresponding organs or systems.

3. OBESITY

Chronic obesity is associated with problems affecting musculosketal, cardiovascular, pulmonary and vascular systems. Impairments resulting from this end organ involvement is the determining factor for findings of severity in massive obesity.

Documentation of the body system involved is crucial in addition to documenting the severity of obesity. Documentation of obesity itself includes measurements of height and weight. The height and weight of the claimant should be measured without shoes.

In obese patients with hypertension, it is important to document the blood pressure measured with the appropriate size cuff since blood pressures of obese patients taken with the regular cuff may show falsely high readings.

When the claimant alleges a past history of heart disease with the possibility of congestive heart failure, reasonable efforts should be exerted to document such episodes by obtaining hospital and/or outpatient records to determine if the claimant indeed has signs and symptoms of congestive heart failure.

If musculosketal impairment (i.e. osteoarthritis) is alleged in addition to obesity, the appropriate documentation will include the condition of the alleged joint problems (range of motion of the affected joint as well as the corresponding x-ray evidence).

In claims involving obesity, the limitations of functions must be determined by objective medical evidence documenting the individual's ability to perform functions of everyday living, such as walking, sitting, bending, arising and standing. Documentation of this is important, since an obese individual may be found disabled on the basis of obesity alone due to resultant gross reduction of function.

It is also necessary to document, if possible, the etiology of obesity to determine if the condition may be expected to improve within twelve months following alleged onset date.

4. GLOSSARY OF MULTIPLE ORGAN SYSTEM TERMS, SYNONYMS, ABBREVIATIONS

BP	Blood pressure
CHF	Congestive heart failure
Ht.	Height
HPN	Hypertension
LE	Lupus erythematosus
SLE	Systemic lupus erythematosus
Wt.	Weight

Appendix B Field Guide

MEDICAL EVIDENCE DEVELOPMENT AND EVALUATION

See FOM1 Article 13, Appendix B

Appendix C Medical Exam Reference Chart

See FOM1 Article 13, Appendix C