

## Your Doctor and Disability Support Letters

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Treating physicians will often help their patients' claims for private insurance and Social Security Disability benefits. While both the claims examiners will want a complete copy of the physician's medical records, office notes are often abbreviated and sometimes difficult to read. Many physicians will draft a letter to supplement the medical records with a narrative of your treatment. Unfortunately, too many letters are not as helpful as they could be.

Too often a physician will dash off a paragraph or two that says only that he or she considers you to be disabled. Your doctor's opinion of disability will not help your claim at all. Social Security and private disability insurance contracts have specific definitions of disability that must be met in order to qualify for benefits, so rather than want the doctor's opinion about disability, they want to see, from the medical record as well as a letter, what symptoms and treatment are present that limit your ability to work. It's not the doctor's conclusion they want, but the facts that led to the doctor's conclusion.

To be of benefit to the disability claimant, the doctor's letter needs to be several pages long. Because of the time required to review the file and draft such a thorough letter, many physicians will charge. While it may cost \$50 to \$100 or even more, a well-written narrative from the physician can be well worth the cost.

Because of the personal nature of each person's medical issues, it is impossible to provide a valid "sample" letter or template that your physician can use. However, there are certain things that should be included in such letters:

**Expertise and History.** There should be a brief statement of how long you have been a patient and a brief summary of his or her expertise with your specific condition. If your physician is particularly noted for treating HBV or HCV, your doctor may want to include a copy of the doctor's Curriculum Vitae (CV), or resumé.

**Summary of Care.** In addition to listing the diagnoses, the letter should include a narrative of your symptoms and treatment, including noting any hospital confinements and the reasons for them. The letter should also include a list of all current medications as well as prior medications tried and eliminated. Any referrals to specialists and their results and treatment, whether they were to rule-out a diagnosis or to treat a specific issue should also be included.

**Objective Confirmation.** Be sure that any results of tests that "objectively" support the diagnoses and symptoms are mentioned with reference to their presence in the medical record.

**Subjective Symptoms.** Subjective symptoms such as fatigue, malaise, pain, or lethargy, should be noted more extensively as there are no ways to “objectively” confirm them. Relate any reported subjective symptoms to being typical for the diagnoses and cite your complaints as reported to him.

**Clinical Observations.** The doctor should note personal observation during visits of symptoms or results of symptoms, including noting the patient’s posture, gait, mood attentiveness, and other factors observed, especially those that support the claimed subjective symptoms.

**Restrictions and Limitation.** The letter should spell out what tasks or activities should be limited or prohibited. Specific limits and the justification for them should be itemized.

In addition, letters for a Social Security Disability claim should also note any of the Social Security Listings and document the medical evidence that supports the Listings.

Social Security Listings are found in a book published by Social Security called, *Disability Evaluation Under Social Security*. This book contains a Listing of Impairments which describes, by medical condition, the severity level required to be considered disabled under any of Social Security’s disability programs including SSDI and SSI, as well as Medi-Cal (Medicaid).

The Listing of Impairments is designed to help the state offices contracted to determine disability eligibility. In addition to listing severity levels of medical conditions, it provides information on how medical files should be documented for various medical conditions.

According to Social Security rules, if your medical records show that your medical condition and its symptoms meet or equal one of the Listings, you are to be considered disabled for Social Security purposes. People applying for disability benefits are well advised to rely on the listings and make sure their physicians have a copy of them when drafting a letter.

The Listings for HBV and HCV disabilities are listed under **Chronic Liver Disease** at:

<http://www.ssa.gov/disability/professionals/bluebook/5.00-Digestive-Adult.htm> - [top](#)

**5.05 Chronic liver disease, with:**

**A.** Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy, demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability

as defined in 5.00D5, and requiring hospitalization for transfusion of at least 2 units of blood. Consider under disability for 1 year following the last documented transfusion; thereafter, evaluate the residual impairment(s).

OR

**B.** Ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period. Each evaluation must be documented by:

1. Paracentesis or thoracentesis; or  
2. Appropriate medically acceptable imaging or physical examination and one of the following:

- a. Serum albumin of 3.0 g/dL or less; or
- b. International Normalized Ratio (INR) of at least 1.5.

OR

**C.** Spontaneous bacterial peritonitis with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm<sup>3</sup>.

OR

**D.** Hepatorenal syndrome as described in 5.00D8, with on of the following:

1. Serum creatinine elevation of at least 2 mg/dL; or
2. Oliguria with 24-hour urine output less than 500 mL; or
3. Sodium retention with urine sodium less than 10 mEq per liter.

OR

**E.** Hepatopulmonary syndrome as described in 5.00D9, with:

1. Arterial oxygenation (PaO<sub>2</sub>) on room air of:
  - a. 60 mm Hg or less, at test sites less than 3000 feet above sea level, or
  - b. 55 mm Hg or less, at test sites from 3000 to 6000 feet, or
  - c. 50 mm Hg or less, at test sites above 6000 feet; or
2. Documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

**F.** Hepatic encephalopathy as described in 5.00D10, with 1 and either 2 or 3:

1. Documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on at least two evaluations at least 60 days apart within a consecutive 6-month period; and
2. History of transjugular intrahepatic portosystemic shunt (TIPS) or any surgical portosystemic shunt; or
3. One of the following occurring on at least two evaluations at least 60 days apart within the same consecutive 6-month period as in F1:
  - a. Asterixis or other fluctuating physical neurological abnormalities; or
  - b. Electroencephalogram (EEG) demonstrating triphasic slow wave activity; or
  - c. Serum albumin of 3.0 g/dL or less; or
  - d. International Normalized Ratio (INR) of 1.5 or greater.

OR

**G.** End stage liver disease with SSA CLD scores of 22 or greater calculated as described in 5.00D11. Consider under a disability from at least the date of the first score.