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Social Security Newsletter

Medical Records Can Make or Break a Claim

To win a claim, properly documenting symptoms in the medical record is paramount.

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It is so frustrating when Social Security denies an application for benefits for someone with disabling medical problems. Clients come to our office angry because "...a guy I know is getting disability checks and he doesn't look like there is anything wrong with him!"

The truth is that most times ap-plications are denied because there is simply not enough "evidence" focused on the issues important in a Social Security decision.

What is Evidence?

Statements such as "I have so much pain," or "I cannot walk a block or sleep through the night," are NOT evidence that can justify a favorable decision. "Evidence" in a disability claim is the clinical charts and the medical records and findings of the treating health specialists.

Remember that social security is not focused only on the diagnosis. Rarely is the diagnosis an issue. Instead, social security battles are all about the symptoms caused by the diagnosis, and how those symptoms impact day to day functioning. Social security evaluates the severity of those symptoms based upon the findings contained in the clinical charts, social workers' notes, psy-

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chological test results, etc. We teach clients at our initial meeting the important symptoms and functional problems that ssa will be looking for with their particular diagnosis so that those can be addressed during ongoing medical treatment.

This turns out to have the benefit of improving physician-client com-munication. Every day we hear from clients that they did not want to tell things to their doctor so as not to upset them. We explain that if they do not communicate the severity of their symptoms the doctor cannot help them! Improved communica¬tion leads to better medical care and more accurate charts.

What is Not Evidence?

Medical reports are important. How-ever, a note from a doctor that says: "My patient is totally disabled and cannot work" is not evidence that will support a claim. SSA wants to know:

- what are the symptoms,
- are they chronic,
- what functional limitations are imposed
- how severe are those limitations.

Without that detail a report is not given much weight. A client's testi-mony, and the testimony of his family members, may support or amplify the medical chart, but it cannot replace a failure of the chart to document the symptoms. We tell our clients: "If it's not in the chart, it doesn't exist."

What Should Be Done?

Patients have to fully communicate to their doctors, therapists and counsel-ors so that they can maximize their medical treatment and document their functional problems. Medical professionals have to be aware of the importance of their medical charts and make sure they document the problems described by patients. Advocates have to gather all of those records, discern what is relevant to the disability claim, and go fight for their clients' benefits. If you have a client that is in need of a case evalu-ation, please call our office. We can help.

Did You Know?

Preservation Of Records Can Be An Issue. Recently, A Case Hinged On An Adult Client's School Records. Schools May Destroy Records, In¬Cluding Special Education Records, Within A Few Years Of Their Creation. Parents Should Get A Full Copy Of Medical Evaluations And 1eps For Safe Keeping. If A Doctor Is Retiring, A Clinic Closing, Or A Client Stops Treatment With A Doctor You Should Also Get A Complete Copy Of Those Records.