

# How to Meet a Listing

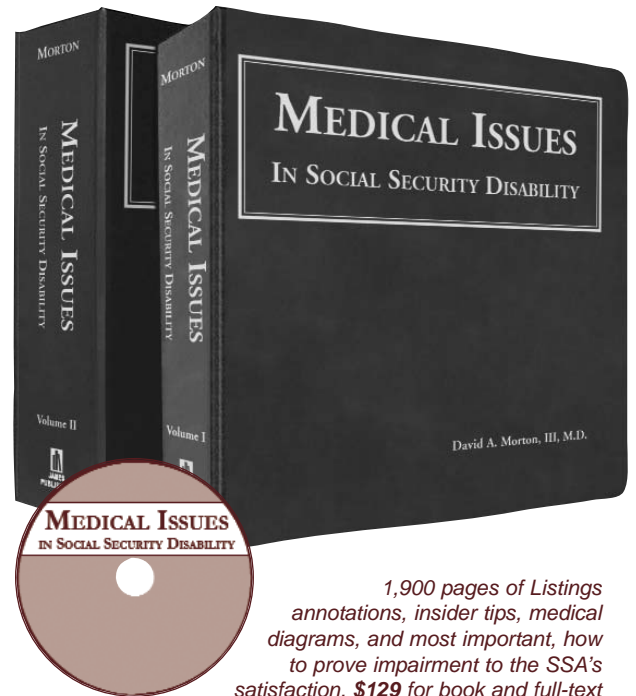
*Inside information from a former Chief Medical Consultant on what it takes to satisfy the SSA's medical proof requirements*

A revealing and practical look inside the SSA's medical evaluation system is now available to claimants' representatives.

Dr. Morton's new *Medical Issues in Social Security Disability* explains how the SSA interprets key Listings:

- What symptoms, physical signs, laboratory test abnormalities, and regimen response are needed to qualify,
- The medical data which should be included in the claimant's file to obtain a favorable decision, and
- Common issues faced by the claimant or the SSA, with a heavy focus on residual functional capacity.

The book is filled with nuggets about shortcomings in submitted medical records, the types of mistakes adjudicators are most likely to make, where generous allowances are provided claimants, ailments and tests frequently overlooked by treating doctors, and much more.



*1,900 pages of Listings annotations, insider tips, medical diagrams, and most important, how to prove impairment to the SSA's satisfaction. \$129 for book and full-text CD.*

These insider tips are extraordinary in both detail and number. For example, the following 12 quotes are taken from just the first 25 pages of the 125-page chapter on the Cardiovascular System and deal with one Listing only:

## **Listing 4.02 Chronic heart failure while on a regimen of prescribed treatment**

1. "The SSA has always had a serious problem with treating physician diagnoses of congestive heart failure, because it is not unusual to find that diagnosis in medical records **with little or even no evidence to support it.** ... The poor longitudinal

quality of many medical records makes it difficult and sometimes impossible for the SSA to determine if heart failure ever occurred in a claimant with that allegation." §4.02.1.a

2. "The SSA should not cite the New York Heart Association or other classification as the fundamental basis for denying or allowing a claim, but such

*Continued inside...*

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## Inside Information *(continued from front page)*

Class should be treated as opinion evidence. It should not be assumed that **improperly trained SSA adjudicators** will not give undue weight to such classification." §4.02.1.a

3. "An SSA adjudicator might try to disregard cardiothoracic ratio findings on a chest x-ray in a case that would otherwise be an allowance, because of echocardiographic findings. Lacking legal regulatory authority, that action would be improper and possibly a **basis for appeal.**" §4.02.1.b

### **Residual functional capacity issues**

4. "Some SSA adjudicators will try to use the objective cardiac performance alone to determine RFC. There is no way an accurate RFC can be determined without close consideration of the claimant's symptoms as well as the objective data." §4.02.2

5. "The claimant should not be considered to have completed 5 METs of exertion unless he or she completes the entire duration of the 5 MET stage of the protocol used, usually 3 minutes and no less than 2 minutes. Careful attention should be given this issue, because it is one in which **an adjudicator with insufficient medical knowledge in this area can easily err.**" §4.02.2

6. "Some cardiologists will not even have considered the

possibility of diastolic dysfunction, but the acknowledgment of that as a possibility can **add credibility to a claimant's alleged symptoms.** It should not be assumed that the SSA adjudicator, even if a medical doctor, will think of diastolic dysfunction when reviewing a cardiac claim." §4.02.2

7. "The SSA does not have cardiologists reviewing most heart impairment claims." §4.02.2

8. "Many claimants with lung disease also have heart disease. The presence of significant lung disease in a claimant who has had an episode of chronic heart failure in the past due to chronic heart disease **should always lower the over-all impairment severity rating by at least one level.** Failure to recognize increased severity as a result of the inter-dependence of cardiac and pulmonary impairments is a major source of error by SSA adjudicators, despite federal regulations requiring consideration of the combined effect of impairments (20 CFR §§404.1522(b), 416.922(b))." §4.02.2

9. "It should be remembered that many activities can be slowly completed that could not be done at a normal pace; that does not mean such functional capacity is an effective work-

related ability. So, **activity completion durations are important** in all forms of heart disease." §4.02.2

10. "Medical conditions are not static in their effects on people; a person might be able to perform at a certain activity level one day but not other days. A person can perform a number of activities such as shopping and cooking but be exhausted for several days afterward. Even the quality of sleep can make a big difference in function the next day; medications and the development of transient pulmonary edema at night can easily ruin a night's rest." §4.02.2

11. "Most claimants do not understand how to complete daily activity forms given to them by the SSA; **the responses are too brief and vague.** Unfortunately, this can get a deserving claimant denied, because critical functional details were not given to the SSA." §4.02.2

### **Other issues**

12. "When trying to understand medical evidence in heart failure or other cardiac impairment cases, it is useful to keep in mind that the treatment given by physicians is **not a reliable indicator** of the nature or severity of the underlying disease." §4.02.3

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RFC issues are directly addressed, complete with suggestions of alternative courses of action

NO GROWTH IMPROVEMENTS \$1.01

and symptoms of pseudoarthrosis, then the SSA should purchase a lumbar CT scan or MRI, if one has not been done. In this report, note that the SSA's wary confirmation of lumbar stenosis on imaging, but provides no guidance regarding what is acceptable as diagnostic of abnormality. Measurements on imaging procedures that are diagnostic of lumbar stenosis have not been established in the medical literature. Therefore, the SSA must be willing to accept this imaging diagnosis as a matter of judgment by the interpreting radiologist, orthopedic surgeon, or neurosurgeon.

"Nonradicular" pain means the pain does not have to follow the pattern of a particular nerve root; it can occur more diffusely in the buttocks, back, or thighs. Inability to have effective ambulation must be documented as per SSA's requirements as specified in §1.006(b). As in other types of back impairments, careful development of the claimant's daily activities and the opinion of the treating physician are critical in deciding whether the listing is satisfied in regard to effective ambulation, once the diagnosis is established.

If the spinal cord is damaged enough to cause significant neurological abnormalities (a possibility in with spinal stenosis), the affected deep tendon reflexes (DTRs) are expected to be abnormally brisk (hyperactive). For example, eliciting the knee-jerk reflex will cause the leg to move with a quicker than normal reaction. Contrast this to damage to a spinal cord nerve root or from a herniated disc, in which the affected DTR will be slower than expected. However, unlike part A of the listing that deals with nerve root compression, part C does not require reflex abnormalities to be present. In spinal stenosis, reflex changes are specific enough to be diagnostic.

**§1.04.2 Residual Functional Capacity**

Since most claimants do not qualify under the listing, there are a large number who must receive a RFC, which may or may not result in a medical vocational allowance. Individuals with spine abnormalities involving the cervical spine (neck) are not as limited as those involving the lumbar spine (lower back). It is instructive to remember that many RFCs for spinal problems, such as arthritis, actually reflect limitations imposed by pain in regard to standing/walking or the amount

of weight that can be lifted or carried. This is particularly true in back impairments. Unless there is some type of structural instability or mechanical weakness (as with osteoporosis), the spine can withstand lifting the 100 lbs required by heavy work. In many cases, it is continued thinking for an adjudicator to reason that a certain degree of standing/walking or lifting limitation is imposed by the spinal disorder and then additional limitation is imposed by pain. Limitation in these instances is rather a function of the degree of functionally limiting credible pain in the context of the individual's pain tolerance.

As noted in the discussion of cervical fusions (see below), the ability to perform overhead work is often considerably limited and can be an important variable in medical-vocational determinations. However, the overhead work restriction is not limited to cervical fusions. An arthritic fusion of the cervical spine would have the same effect, as would any condition of the cervical spine that results in painful movement and stiffness, like the inflammatory spondyloarthropathies (e.g., ankylosing spondylitis) or simply advanced osteoarthritis. The SSA is likely to overlook rotational movement ability in the neck as an important work-related variable; even less regard is given to rotational ability in the lower spine. While these functions are not as important as bending and the ability to look upward, they could be a critical medical vocational consideration in some claims—especially the ability to look right and left without having to turn the whole body. It takes an alert and knowledgeable vocational analyst to apply this kind of information to the ability to perform actual jobs. It is an area that may not have received sufficient consideration vocationally, and many RFCs (improperly) do not address this issue.

**Spondylolisthesis**

Grade I spondylolisthesis is rarely symptomatic and often found incidentally on X-ray. Grade I patients generally do not receive any restrictions from orthopedic surgeons. As a generalization, symptomatic grade II spondylolisthesis can result in restrictions to medium work; grade III restriction to light work; and grade IV can sometimes be limiting to sedentary work. However, this degree of functional severity is unusual and is rare only in those rare cases with significant symptoms. Like degenerative disc disease, spondylolisthesis is a great example of an anatomical abnormality that

Helpful guidance on what symptoms, signs, and laboratory findings are required to meet a Listing

\$1.01 MEDICAL ISSUES IN SOCIAL SECURITY DISABILITY 1-18

does not, by its mere appearance on imaging studies, imply symptoms or functional limitation. For example, some studies cover a period of years showed no symptoms in over a third of patients followed with grades III and IV spondylolisthesis, and only mild symptoms in over half of the cases with grade IV spondylolisthesis. In one study of over 500 children followed into adulthood, only one had significant symptoms regardless of the grade of spondylolisthesis. Of course, all cases must be evaluated in light of the individual claimant's symptoms. (However, it would defy reason to think that someone with a grade I or II spondylolisthesis alone is limited to sedentary work.)

**Laminectomies**

In uncomplicated cases of an L5/S1 and treated with a surgical discectomy and laminectomy, the SSA will generally tend toward giving a medium RFC, with occasional bending. If there are additional problems, such as associated arthritis elsewhere in the spine, surgery at multiple levels, or persistent pain beyond what would be normally expected, then the RFC should be lower. The important point is that the SSA should give no higher than a medium RFC (rating up to 20) if modest pain persists. The most appropriate RFC for an individual claimant may be lower. A completely asymptomatic claimant after a complete laminectomy might receive no restriction in regard to back impairment.

**Cervical or Lumbar Fusion**

In cases of trauma, or the need of stabilization to alleviate chronic pain, the spine may be surgically fused. In these cases, the SSA is likely to give no higher than a medium RFC, with occasional bending even in cases of optimum post-surgical recovery. Those with any significant chronic pain generally receive no higher than a light RFC, with occasional bending.

Fusion of the cervical spine are less symptomatically limiting in regard to lifting and carrying, since they are not in the weight-bearing part of the spine. However, lifting heavy weights can put tension on the cervical spine through the back and neck muscles, with resultant symptoms. In other words, the lack of pain or other symptoms

during resting physical examination does not imply the absence of limitation at heavier workloads. Some claimants who have had a fractured and unstable cervical spine during an accident, may worsen no higher than a sedentary RFC, if there is risk of death or spinal cord injury from heavier work. Also, there may be a residual neurological deficit from spinal cord injury at the time of injury, in the case of the accident. In other instances, a decompressive cervical laminectomy and fusion is necessary to relieve spinal stenosis pressure on the cervical spinal cord. These cases are likely to require more limitation than those with a simple, uncomplicated cervical fusion. If the claimant has had pain lifting during his or her activities of daily living or attempt to return to a new job, it is important that this information be documented in his or her disability file. Furthermore, cervical fusions can make it impossible for a person to perform overhead work, which can be a critical allowance denial variable in some medical-vocational determinations.

**Fractures of Arthritis**

Generally speaking, arthritis occurring in the thoracic spine is not as symptomatic or functional limiting as arthritis in the lumbar or cervical spine. Similarly, cervical spine arthritis is not as limiting as that of the

**Osteoporosis**

Claimants who do have limitations may have frequent, occasional, or occasional vertebrae but do not have the required by the part disability, which requires the statement "indefinite" or "severe" absence of osteoporosis of a 50% component of back pain, that a RFC is not likely to be lower—especially in cases of multiple fractures. But another important point that should not be missed is that some spinal osteoporosis is so severe that, when viewed with even plain X-rays, the vertebral bodies have an obviously thinned-out physalike appearance—paper-thin

Detailed descriptions of documentation challenges faced by both SSA and claimants representatives

Little-known and revealing inside information that helps you take advantage of weaknesses in SSA evaluation and adjudication

# Detailed Coverage of Mental Disorders

Chapter 12, which is over 100 pages long, is devoted to:

- Tips and issues in meeting Parts A-C of the major mental disorder Listings
- Mental impairment factors that determine residual functional capacity
- Additional issues affecting determination of severity
- Cross-references to related discussions

Coverage specific to adults and children is provided for each of the following disorders:

- Organic mental disorders
- Schizophrenic, paranoid and other psychotic disorders
- Affective disorders
- Mental retardation
- Anxiety-related disorders
- Somatoform, eating and tic disorders
- Personality disorders
- Substance addiction disorders
- Autistic and other pervasive developmental disorders
- Attention deficit hyperactivity disorder
- Developmental and emotional disorders of newborn and younger infants

*Weaknesses in the SSA evaluation system ... especially prevalent with mental disorder claims ... are exposed:*

-- "SSA psychologists are not qualified or permitted under federal regulations to evaluate medical disorders. It is quite possible that a significant number of claimants with a medical disorder (organic brain damage) have their claim determined by a SSA psychologist. Claimant representatives would be well-advised to **look out for this kind of SSA**

**adjudicative activity**, especially in State agencies with high case-loads and insufficient psychiatric consultant time." §12.02.1.b

-- "Failure to develop Part B information when it is needed in greater detail probably accounts for a **substantial number of errors in adjudication** of those mental disorders most likely to be disabling: organic mental disorders, schizophrenia and other psychoses, mental retardation, major depression, and autism. Knowing these facts about some of the real dynamics of SSA's internal adjudicative processes, in contrast to theoretical or publicly-alleged realities, is important for claimant representatives to know where to look for problems and Part B development is one such area – a big one." §12.02.1.b

*Tips for exploiting and counteracting these systemic SSA weaknesses are provided:*

-- "The best evidence of functional ability comes from the claimant's family or other caregivers, because they are the one who have actually observed limitations and abilities, rather than having to extrapolate a guess from the claimant's clinical condition – which is what the treating source usually has to do. The daily activity forms that claimants or their caregivers complete are rarely specific enough to be of much use. Often, the SSA adjudicator will try to use daily activity, social information, etc., from a mental status consultative examination. **This information is often lacking** in enough detail for good disability determination." §12.02.1.b

-- "There are many possible ways in which change can satisfy part C.2. For example, the claimant might show increased withdrawal when guests other than family members come to dinner, exhibit emotional outbursts when not permitted to watch a favorite TV show, manifest increased confusion **when some routine of life is interrupted**, show increased irritability when having to travel outside of the house such as a trip to the dentist, or be unduly frustrated and sad when unable to accomplish some new task." §12.02.1.b

Candid assessments of your chances of qualifying your claimant, and what additional factors will help

7-26

methodology in part C.1 and E.0001? The following conditions are examples of contraindications to exercise ABOS-9:

- unstable angina pectoris<sup>94</sup>
- congestive heart failure
- uncontrolled arrhythmias
- uncontrolled severe systemic arterial hypertension
- uncorrected aortic stenosis<sup>95</sup>
- severe pulmonary hypertension
- chronic or disabling acute myocardial infarction<sup>96</sup>
- acute illness
- limiting mechanical or musculoskeletal impairments<sup>97</sup>
- contraindications due to the type of medication(s) prescribed.

How does the SSA decide when purchase of exercise ABOS is relevant to the disability determination? Claimants with RFD values of 41-60% of predicted normal are not eligible with existing ABOS. In any other cases, should be consistent for exercise ABOS. Such a decision is not automatic, most relevant are cases in which the evidence indicates symptomatology significantly worse than would otherwise be expected from the objective findings. In these instances, exercise can expose underlying severity the otherwise not documented.

#### §8.02.2 Residual Functional Capacity

It is important to remember that the intimate physical relationship between the cardio-respiratory and pulmonary systems means an impairment in one of these systems influences the other. Thus, the presence of heart and respiratory impairments in the same claimant can result in much worse functional restriction than either considered alone. A claimant restricted in activities work on the basis of cardiovascular disease and medium work, because of respiratory disease should receive a RFD for no higher than light work. In this regard, it is very common for a claimant with

CHD) secondary to cigarette smoking to also have significant cardiac disease or peripheral vascular disease as separate impairments.

Removal of lung tissue can also limit the RFD. The most frequent type of pulmonary resection is a lobectomy associated with surgery for lung cancer. Sometimes, a pneumonectomy involving the removal of an entire right or left lung is performed. In otherwise healthy lungs, a lobectomy usually results in an essential restriction in activities work when the needs of a normally fit individual in cases of pneumonectomy, an RFD is always required, and even with a healthy remaining lung is usually no higher than light work. As with other pulmonary impairments, environmental restrictions from exposure to excessive dust and fumes would be indicated on the RFD. The fact that a smoking person may say something in his or her medical notes like, "The patient has fully recovered from surgery and has no difficulty breathing," does not mean that symmetry does not have to be performed. When significant amounts of lung tissue are removed, there will be some degree of pulmonary limitation. Minor claimants with pulmonary resection associated with removal of a lung cancer are typical in because they have cancer caused by cigarette smoking. Claimants who have smoked long enough to develop lung cancer always have chronic obstructive pulmonary disease and will have pulmonary deficits worse than would be expected if the remaining lung tissue were normal. This is another reason it would be improper for the SSA to guess about remaining lung function without obtaining appropriate evidence the claim is otherwise allowable. Whether or not a claimant had resection for lung cancer symptoms of absence of health, the SSA has a responsibility to evaluate the extent of breathing impairment.

It is important that claimants with lung diseases (including gas exchange impairment not receive BLD) levels of exertion that could cause them in

Medical opinion forms for 81 impairments – many in both short and long versions – help you efficiently gather medical evidence persuasive to SSA

Practical advice, based on the author's 14 years of making disability determinations for SSA, alert you to common errors by representatives

<sup>94</sup> POMS §§24540.015 (1-10-97).  
<sup>95</sup> Presumably severe aortic stenosis caused by coronary artery disease.  
<sup>96</sup> Narrowing of the aortic valve.  
<sup>97</sup> Exercise could cause rupture of a weak area of the aorta.  
<sup>98</sup> Limiting conditions such as stroke, severe arthritis, etc.

Over 100 pages on 14 categories of mental disorders provide coverage available nowhere else

**CHRONIC PULMONARY INSUFFICIENCY TREATING PHYSICIAN DATA SHEET**

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS	REPRESENTATIVE'S TELEPHONE
	REPRESENTATIVE'S EMAIL
PHYSICIAN'S NAME AND ADDRESS	PHYSICIAN'S TELEPHONE
	PHYSICIAN'S EMAIL
PATIENT'S NAME AND ADDRESS	PATIENT'S TELEPHONE
	PATIENT'S EMAIL
	PATIENT'S SSN
TYPE OF CLAIM	LEVEL OF ADDRESS/AGE
HEAVY <input type="checkbox"/> DISSEMINATED <input type="checkbox"/> CHRONIC	HEAVY DISSEMINATED <input type="checkbox"/> HEAVY DISSEMINATED <input type="checkbox"/>
TYPE 1G <input type="checkbox"/> DR <input type="checkbox"/> DC	HEAVY COR <input type="checkbox"/> HEAVY OFFICER <input type="checkbox"/>
	Administrative Law Judge <input type="checkbox"/> Appeals Council <input type="checkbox"/>
	Internal District Court <input type="checkbox"/> Internal Appeals Court <input type="checkbox"/>

Dear Dr:

We are preparing the Social Security disability claim for the above-named individual (the patient). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical specialty please:

**NOTE 1:** This document will not have legal validity for Social Security disability determination purposes unless completed by a licensed medical doctor or osteopath.

**NOTE 2:** This document only concerns chronic pulmonary insufficiency. Other impairments and limitations resulting from a combination of impairments should be considered separately.

**NOTE 3:** Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

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## About the Book and CD

*Medical Issues in Social Security Disability* contains 1,900 letter-sized pages in two sturdy 3-ring binders. The book covers all common physical and mental impairments evaluated by the SSA, and presents sophisticated inside advice on how to best present your claimant's medical data.

The free, full-text CD may be searched by key word or medical condition, or by using its table of contents and index. No software installation is required – the CD is usable immediately after placing it in your CD drive. Use is 100% intuitive; you need not study any user's manual.

The book and CD cost \$129 new, and are updated annually with change pages and a new CD for \$89. Both the book/CD package and its updates may be returned within 30 days of receipt for a prompt refund if you are dissatisfied. The update service may be cancelled at any time.

## About the Author

**David A. Morton, III, M.D.**, was a consultant for Disability Determination for Social Security Administration in Arkansas for 14 years. He personally made more than 50,000 determinations of both physical and mental disorders in adults and children in every specialty of medicine pertaining to disability.

During the last eight years of his SSA tenure, Dr. Morton was Chief Medical Consultant for the Arkansas State Agency and supervised a large staff of medical specialists. During that time, the Arkansas State Agency received numerous awards of excellence from the Social Security Administration, including the Social Security Commissioner's Award for being the highest ranked agency in the country.

Dr. Morton received his B.A. in psychology from the University of Colorado, and his M.D. from the University of Arkansas Medical School. He has written several highly respected books on social security disability. He has this to say about *Medical Issues in Social Security Disability*:

*"I can objectively say this is the best work I've ever done on the subject, and there's nothing close to it from \_\_\_\_\_ or any other publisher."*

# Abbreviated Contents

## 1. Musculoskeletal System & Growth Impairments

Major Dysfunction of a Joint; Reconstructive Surgery or Arthrodesis of a Major Weight-Bearing Joint; Disorders of the Spine; Amputation; Fracture of Femur, Tibia, Pelvis, Tarsals; Fracture of an Upper Extremity with Non-Union; Soft Tissue Injury, Growth Impairment

## 2. Special Senses & Speech

Impairment of Visual Acuity, Contraction of Peripheral Visual Fields in the Better Eye, Loss of Visual Efficiency, Total Bilateral Ophthalmoplegia, Disturbance of Labyrinthine-Vestibular Function, Hearing Impairments, Organic Loss of Speech

## 3. Respiratory System

Chronic Pulmonary Insufficiency; Asthma; Cystic Fibrosis; Pneumoconiosis; Bronchiectasis; Mycobacterial, Mycotic, and Other Persistent Infections; Cor pulmonale; Sleep-Related Breathing Disorders; Lung Transplant

## 4. Cardiovascular System

Chronic Heart Failure, Hypertensive Cardiovascular Disease, Ischemic Heart Disease, Recurrent Arrhythmias, Symptomatic Congenital Heart Disease, Valvular Heart Disease, Cardiomyopathies, Cardiac Transplantation, Aneurysm of Aorta or Major Branches, Chronic Venous Insufficiency of a Lower Extremity

Children: Chronic Rheumatic Fever or Rheumatic Heart Disease, Hyperlipidemia, Kawasaki Syndrome

## 5. Digestive System

Recurrent Upper Gastrointestinal Hemorrhage, Esophageal Obstruction, Peptic Ulcer Disease, Chronic Liver Disease, Chronic Ulcer-

ative or Granulomatous Colitis, Regional Enteritis, Weight Loss, Liver Transplant

Children: Chronic Inflammatory Bowel Disease, Malnutrition

## 6. Genito-Urinary System

Impairment of Renal Function, Nephrotic Syndrome

## 7. Hemic & Lymphatic System

Chronic Anemia, Sickle Cell Disease, Chronic Thrombocytopenia, Hereditary Telangiectasia, Coagulation Defects, Polycythemia vera, Myelofibrosis, Acute Leukemia, Chronic Leukemia, Lymphomas, Macroglobulinemia or Heavy Chain Disease, Chronic Granulocytopenia, Multiple Myeloma, Aplastic Anemias or Hematologic Malignancies

Children: Chronic Idiopathic Thrombocytopenic Purpura of Childhood, Inherited Coagulation Disorder

## 8. Skin Disorders

Exfoliative Dermatitis, Ichthyosis, Ichthyosiform Erythroderma; Pemphigus, Erythema Multiforme Bullosum, Bullous Pemphigoid, Dermatitis Herpetiformis; Deep Mycotic Infections; Psoriasis, Atopic Dermatitis, Dyshidrosis; Hidradenitis Suppurativa, Acne Conglobata

## 9. Endocrine System

Thyroid Disorders, Hyperparathyroidism, Hypoparathyroidism, Neurohypophyseal Insufficiency, Hyperfunction of the Adrenal Cortex, Diabetes Mellitus

Children: Diabetes Insipidus, Adrenal Cortical Insufficiency, Juvenile Diabetes Mellitus, Iatrogenic Hypercorticotid State, Pituitary Dwarfism, Adrenogenital Syndrome, Hypoglycemia, Gonadal Dysgenesis

## 10. Multiple Body Systems

Children: Down Syn-

drome, Multiple Body Dysfunction, Catastrophic Congenital Abnormalities or Disease

## 11. Neurological Disorders

Convulsive Epilepsy, Non-convulsive Epilepsy, Central Nervous System Vascular Accident, Brain Tumors, Parkinsonian Syndrome, Cerebral Palsy, Spinal Cord or Nerve Root Lesions, Multiple Sclerosis, Anterior Poliomyelitis, Myasthenia Gravis, Muscular Dystrophy, Peripheral Neuropathies, Subacute Combined Cord Degeneration, Degenerative Disease Not Listed Elsewhere, Cerebral Trauma, Syringomyelia

Children: Major Motor Seizure Disorder, Major Dysfunction, Cerebral Palsy, Meningocele, Communication Impairment

## 12. Mental Disorders

Organic Mental Disorders; Schizophrenic, Paranoid and Other Psychotic Disorders; Affective Disorders, Mental Retardation, Anxiety-Related Disorders, Somatoform Disorders, Personality Disorders, Substance Addiction Disorders, Autistic and Other Pervasive Developmental Disorders

Children: Mood Disorders; Eating & Tic Disorders; Attention Deficit Hyperactivity Disorder; Development & Emotional Disorders of Newborn & Younger Infants

## 13. Neoplastic Diseases – Malignant

Head & Neck; Sarcoma of Skin; Sarcoma of Soft Parts; Malignant Melanoma; Lymph Nodes; Salivary Glands; Thyroid Gland; Breast; Skeletal System; Mandible, Maxilla, Orbit, or Temporal Fossa; Brain or Spinal Cord; Lungs; Pleura or Mediastinum

Abdomen; Esophagus or

Stomach; Small Intestine; Large Intestine; Liver or Gallbladder; Pancreas; Kidneys, Adrenal Glands, or Ureters; Urinary Bladder; Prostate Gland; Testicles; Uterus; Ovaries; Leukemia; Uterine Tubes; Penis; Vulva

Children: Lymphoreticular Malignant Neoplasms, Malignant Solid Tumors, Neuroblastoma, Retinoblastoma

## 14. Immune System

Systemic Lupus Erythematosus, Systemic Lupus Erythematosus, Systemic Vasculitis, Systemic Sclerosis & Scleroderma, Polymyositis or Dermatomyositis, Undifferentiated Connective Tissue Disorder, Immunoglobulin Deficiency Syndromes or Deficiencies of Cell-Mediated Immunity, HIV Infection, Inflammatory Arthritis

## Appendices

Combined Stature & Weight Charts for Determining Growth or Weight Percentiles, Tables of Linear Measurement, New Ballard Prematurity Assessment Criteria, Esterman Peripheral Field Grid, Evaluation of Visual Impairments Using Variable Threshold Automated Perimeters, Language Development Checklist, Weight Percentile Chart Showing Example of Malnutrition-Related Weight Loss, Tables of Weight Measurements, Karnofsky Performance Status

Diagnostic Criteria for Alzheimer's Disease, Psychological Tests, Psychiatric Review Technique Form, Mental Residual Functional Capacity Form, Physical Residual Functional Capacity Form, Sample Mental Status Examination Format for CE, Diagnostic Codes for Mental Disorders, Evaluation of Specific Issues – Psychological/Psychometric Testing, Environmental Illness in Disability Determinations

# Prove Disability to the SSA

Yes, send me one copy of Dr. Morton's *Medical Issues in Social Security Disability* and its free CD. Include an invoice for \$129 plus \$8.95 shipping. If I am not satisfied, I may return the book and CD within 30 days for a full refund. Send me the annual updates on the same 30-day review basis. I may cancel the update service at any time.

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Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

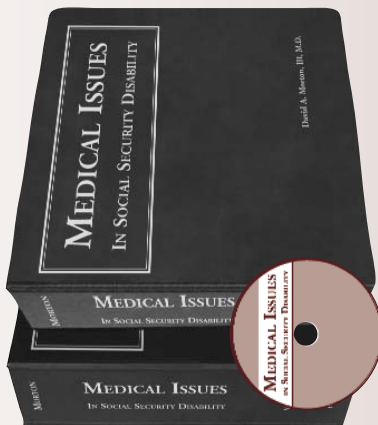
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## An Inside Look at SSA Medical Evaluations

Learn from an insider the SSA's unwritten medical rules and how to best present your claimants' impairments



This affordable book-and-CD package answers the following questions:

- How do I determine severity of impairment?
- Does the claimant's impairment meet or equal a Listing?
- How do I best use the medical findings to obtain a favorable decision?

Author Dr. David Morton has personally made more than 50,000 disability determinations for Social Security administration. As a Chief Medical Consultant, he hired, trained, supervised, and evaluated the work of both medical doctors and clinical psychologists.

Dr. Morton reveals in his newest book how the SSA judges your claimants' medical data. Now you can have at your fingertips reliable guidance on:

- Documenting all essential medical proof elements
- Overcoming frequently-arising claim hurdles
- Guarding against common errors by adjudicators and treating doctors
- Delivering persuasive presentations of impairment

The sophisticated and practical advice in this ground-breaking work is organized by Listing, and all medical terms are defined in lay language.

Most important, the book explains the impairment factors that determine residual functional capacity. Common adjudicator errors in assigning RFCs are highlighted.

The knowledgeable Dr. Morton also provides innovative approaches for avoiding denials like his MET Connector Equation and Multimodal RFC.

Sample pages, table of contents, and author biography inside

Details inside...