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Tips to Help Your Patients File Successful Disability Applications



Your professional, well-documented assessment of a patient's functional limitations is key to a successful disability determination.

Paperwork pertaining to patient disability is a time-consuming, difficult, and often wearisome process for primary care physicians and other providers. The difficulty has its foundation in the multiple disability types, varying documentation requirements, and differences in who serves as the final arbiter of disability. The aim of this article is to review individual cases and, utilizing a step-wise framework,¹ provide examples of how to efficiently, accurately, and confidently complete various types of disability paperwork to aid patients in their disability applications.

OVERVIEW

It is common for patients to come to the primary care office with some sort of disability question or concern. Many people request Family and Medical Leave Act (FMLA) paperwork be completed

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for their employer in order to take some time off of work due to illness or accident, or to take care of a family member.² For long-term and short-term disability, the physician's assessment and supporting documentation can facilitate insurance determinations through processes established by private insurance companies and workers' compensation claims, whereas Social Security disability determination is specifically and only the prerogative of the Social Security Administration judge.

The definition of "disability" is not the same across these legal domains. The Social Security disability definition depends on both medical and vocational aspects related to a person's impairments. Functional limitations that affect an individual's ability to sustain full-time, competitive employment are key. Sustainability, capacity for full-time work, and ability to do competitive work are the three legal components of this definition of "disability." This definition does not contemplate employability, percentage of impairment, or the ability to return to a previous job. However, non-exertional limitations, typically involving mental health signs/symptoms, are far more difficult to corroborate; the medical source statement summarizing the physician's opinion of the patient's physical and mental limitations is crucial and may help determine a finding of "disabled." Primary care clinicians are considered acceptable medical sources, which means that judges, lawyers, and other people reviewing disability applications will use clinicians' statements as evidence of disability or impairment.

Language matters in disability determinations. For example, being specific in describing diagnoses and using

objective measures as much as possible can strengthen supporting documentation. The table on page 21 provides tips for documentation that will increase the likelihood of a successful application.

FOUR STEPS IN DISABILITY EVALUATIONS

All disability evaluations follow the same basic structure, as originally described by Evensen et al:¹

1. Understand the request for evaluation, obtain patient consent, and determine your role in the process. When considering an individual for short-term (generally weeks to months) or long-term (months to years) disability, the paperwork required to complete the claim depends on each specific disability insurance carrier. The top five companies are Cigna, Lincoln Financial Group, Unum, The Hartford, and MetLife.³ Both employer and employee need to fill out forms, which generally end with an evaluation by a physician and completion of a "physician attestation." The required form can be found on the insurance company's website, and patients should fill out what they can before bringing the form with them to the office for a disability evaluation. Short- and long-term disability claims through a private insurance agency are scrutinized to a far greater degree than FMLA paperwork, and it can save you time to first review paperwork instructions, which can be found on the company's website or in the disability documents themselves. While the required paperwork, including the physician's attestation statement, is different across insurers, they all contain common items, questions, and determination requests. The documentation required for worker's compensation cases varies by state, so reference your state's guidelines when evaluating a patient for that.

2. Identify diagnoses and impairments. The requested information includes the specific diagnoses (including ICD-10 codes) and key dates, such as the date the patient was first treated for the condition and dates of the last and next office visits. Comorbidities or secondary diagnoses are also frequently requested, along with specific medications, dosages, and start/stop times, as applicable. Documentation

KEY POINTS

- When reviewing disability applications, insurance representatives, judges, and lawyers rely heavily on the physicians' assessments of functional limitations due to medical conditions.
- Physicians can strengthen their supporting documentation by following certain best practices, such as being specific in describing diagnoses and using objective measures as much as possible.
- The four-step framework cited in the article can help increase the likelihood of a successful application.

TIPS FOR DOCUMENTATION ON DISABILITY FORMS

Tip	Examples
Be as specific as you can about the diagnosis, and add specific diagnosis codes to the problem list for the visit.	Low-back pain with radiculopathy (ICD-10 code M54.16) vs. Low-back pain, unspecified. Consider secondary diagnoses that might be having an impact on the primary disability or the healing process (e.g., depression, post-traumatic stress disorder, or fibromyalgia).
Document symptoms if a person does not have a specific diagnosis.	Headache, nausea, vomiting, fatigue, etc.
Use objective measures as much as possible, and include professional observations.	Vitals. Energy level during the visit. Other patient details (e.g., patient was sitting in the dark due to light sensitivity).
Describe in detail any limitations in activity, which may relate to the patient's specific job functions. State whether the patient can perform key functions, but avoid saying the patient "cannot work." The judge or insurance official will ultimately determine whether a person cannot work.	Patient is able to stand for 20 minutes until pain is unbearable and then will need to sit down for one hour. Patient can look at the computer for 30 minutes before getting a severe headache. Patient can walk around the block once but will then need to rest for 20 minutes to catch their breath.
Encourage patients to optimize health by practicing healthy behaviors.	Instructions such as stop smoking, limit alcohol, exercise if able. Planned follow-up treatments, imaging, or referrals.

of referrals (such as physical therapy or medical specialists) and tests or imaging obtained is also standard. If the disability relates to a behavioral or mental health diagnosis or cognitive impairment, a separate functional impact statement may be requested. Surgical history (with CPT codes) and hospitalization history, as it pertains to the disability, is also frequently requested. Most forms require clinicians to provide a specific return-to-work date, or a range of dates if a specific date is unavailable at the time of the evaluation.

3. Assess activity limitation and participant restrictions. Further information is requested as to the extent of the disability and its impact on lifting/setting restrictions, standing/sitting limitations, bending/stooping limitations, and overall functional impact of the disability. Some forms further define *restrictions* as activities the patient "should not" perform and *limitations* as activities the patient "cannot" perform. Many of the forms also ask what job modifications would allow the patient to return to work.

4. Document the assessment and plan. As with any other assessment and plan, documentation of follow-up treatments, imaging, or referrals are important to help

determine the course of disability and demonstrate that the patient is engaging in a treatment plan to improve their current state of health.

Below, we illustrate these steps using two case studies.

CASE #1: BRIAN

Brian is a 48-year-old male who works as a computer programmer and has a history of traumatic brain injury following a car accident three months ago. He has not been able to return to work because of headaches and inability to maintain focus and concentration long enough to perform the basic requirements of his job. At the time of the accident, he was seen in the emergency department and admitted overnight for observation due to initial loss of consciousness and confusion, but otherwise he has had an uncomplicated initial course. He had a computed tomography scan of his head on initial work-up (normal) and magnetic resonance imaging (MRI) (also normal). Because of his persistent symptoms, a neurologist has evaluated him. He was diagnosed with post-concussive syndrome. He used all of his FMLA leave and now presents to your clinic for short-term disability evaluation. ►

Additionally, he has symptoms consistent with post-traumatic stress disorder (PTSD) and, because of the impact of this disability on his career and life, has been suffering from depression.

Step 1: Understand the request for evaluation, obtain consent, and determine your role in the process. Brian is requesting short-term disability, but the full impact of his disability is not yet known. He comes to clinic today with his

stare at a computer screen for more than 30 minutes without triggering a headache that lasts a couple hours and is “debilitating.” Brian is a computer programmer, and being able to code and work on a computer are vital components of his occupation. He has a normal neurologic exam in clinic. Given his reported symptoms, you state that he currently has a complete disability and cannot perform vital functions related to his job.

Step 4: Document the assessment and plan. Brian is established with neurology and scheduled to see them at least two more times in the next two months. He is completing a headache diary at the neurologist’s request but has not started taking medications beyond ibuprofen and acetaminophen. For depression and PTSD, he will continue previously prescribed escitalopram 20 mg and is going to establish with a behavioral health specialist next week. He requires no further imaging at this time, and you decide to have Brian return to your office in two weeks to see how he is progressing and to follow up on the insomnia. You document that Brian will return for that visit and another in four weeks. In your documentation and on the disability form, you determine that Brian will need at least four weeks before he can return to work activities in any capacity and he may need longer, depending on how he is responding to current therapy and specialist treatments. You also document that, once he is able to return to work, he will likely require a reduced work schedule and slow increase in his responsibilities to avoid further complications from post-concussive syndrome.

CASE #2: DAVID

David’s work involves physical labor at a local warehouse. Recently, he was lifting a 45-pound box off the floor when he felt a sharp pain in his lower back that caused him to drop the box. He was unable to complete his shift and immediately reported the injury to his employer. A worker’s compensation case was opened. You have been his primary care physician for many years, and he presents to your clinic to perform the evaluation for his case.

Step 1: Understand the request for evaluation, obtain consent, and determine your role in the procedure. You review

Include a diagnosis, an anticipated end of healing (approximate), and whether permanent disability has resulted.

consent form completed, and the employer and employee portions of his short-term disability form are also completed. As his primary care physician, you are aware of his history; you ordered the MRI and the neurology evaluation. However, you asked him to come to clinic to review and complete the disability paperwork together.

Step 2: Identify diagnoses and impairments. You go over the paperwork with Brian and review his primary diagnoses (post-concussive syndrome, ICD-10 F07.81; post-traumatic headaches, unspecified, not intractable, G44.309; impaired concentration, R41.840; and insomnia due to medical condition, G47.01). You also discuss secondary diagnoses (major depressive disorder, F32.9; and post-traumatic stress disorder, F43.10) that are likely impacting the primary diagnosis. The insomnia is likely related to post-concussive syndrome but is a new issue; Brian just brought it to your attention at this visit. You recognize that this is an important diagnosis to discuss in greater detail at a future visit but explain that the point of this visit is to complete the disability paperwork.

Step 3: Assess activity limitation and participant restrictions. Brian states that he has been able to walk and watch television, but he is still unable to engage in more vigorous activity, such as recreational running, playing sports, or reading for more than 20 minutes without triggering headaches. He also reports that he cannot

the worker's compensation website for the state of Wisconsin and learn that the injury description should include 1) the cause of injury, 2) the nature of the injury, and 3) the objects/substances/activities involved. In your medical report, you must include a diagnosis, an anticipated end of healing (approximate), and whether permanent disability has resulted.

Step 2: Identify diagnoses and impairments. You observe David as he walks into clinic and notice that he is walking slowly with an antalgic gait. He tells you that he has been off work since the injury one week ago due to pain and weakness. He is having sharp pain, which he ranks as 6/10 at rest, increasing to 8/10 with activity. His pain originates in his lower back and radiates down the front of his right thigh. He has been taking acetaminophen around the clock. He has been spending most of his days laying on a heating pad at home. He denies having any issues with bladder or bowel control and does not have saddle anesthesia.

On physical exam, you note he has tenderness upon palpation of his lumbosacral spine and right paraspinal muscles. He does have decreased pinprick sensation of the right anterior thigh as well as 4/5 hip flexion on the right, but otherwise his physical exam is normal.

You diagnose David with acute lumbosacral radiculopathy due to a lifting injury at work that occurred the prior week.

Step 3: Assess activity limitations and participation instructions. David provides you a summary of his job description and activities he is expected to perform in his work. He is expected to be able to stand for eight hours per day, lift up to 50 pounds, climb ladders, and twist. Given his current injury, you determine that David is unable to perform any of these activities safely.

Step 4: Document the assessment and plan. It is important in worker's compensation documentation to note the mechanism of injury and, when available, the date the injury occurred. Documentation that the injury is work-related will help support your patient's case, but documentation does not need to be lengthy. When giving work restrictions, it is important to reference expected duties.

For David, you do not have an exact

end-of-healing recommendation but outline a plan for reevaluation:

Acute lumbosacral radiculopathy, likely due to disc herniation L2-L4: Patient lifted 45-pound box at work on 2/5/2023 and immediately suffered from low-back pain and was unable to complete his shift. His injury is a direct result of a work action. Based on his job description, he is currently unable to perform his work duties (standing, lifting, climbing, twisting).

Patient is not cleared for work; off work for at least the next 2 weeks. Unknown end-of-healing, anticipate weeks to months.

Naproxen 500 mg BID for 2 weeks.

Re-evaluate in 2 weeks.

When you see David two weeks later, he reports that his pain is unchanged, but he thinks that his weakness is worsening. On exam, strength is now 3+/5 on his flexion, which supports ordering an MRI. You outline a plan that includes a referral and medication, and you continue to recommend time off work due to his injury preventing him from carrying out his job duties:

Acute lumbosacral radiculopathy, likely due to disc herniation L2-L4: Work-related injury suffered on 2/5/2023. Persistent pain and progressive weakness.

Urgent lumbar MRI given progressive neurologic symptom.

If no significant nerve compression, PT referral.

Employers may identify alternative work the employee can perform that complies with your activity restrictions.

Gabapentin titration to help with nerve pain.

Patient should be off work for six more weeks as he is unable to perform job duties (standing, lifting, climbing, twisting). Will re-evaluate in 6 weeks.

Unclear end-of-healing, anticipate 6-12 months.

Employers may identify alternative work the employee can perform that complies with your activity restrictions. The worker's compensation case continues until end-of-healing is reached and the worker

can return to original work or permanent disability is assigned.

When you see David six weeks later, his pain and weakness are unchanged even with consistent physical therapy. His MRI demonstrated L3 and L4 disc herniation with moderate nerve root compression.

It is important for clinicians to understand that the strength of the medical opinion is their medical knowledge, not vocational knowledge.

Patient reports that his job has found desk work for him to do, and he would like to return to work with restrictions.

Your plan reads as follows:

Acute lumbosacral radiculopathy, likely due to disc herniation L2-L4: Work-related injury suffered on 2/5/2023. Persistent pain and weakness despite PT course.

Continue gabapentin.

Referral to orthopedic spine surgeon.

Patient cleared for desk work only.

Patient is not cleared for lifting, twisting, kneeling, standing.

Unclear end-of-healing, anticipate 6-12 months.

David sees a spine surgeon who recommends a discectomy given his persistent symptoms three months post-injury and lack of improvement despite conservative management. The surgery is performed five months after his initial injury. Unfortunately, due to conditions encountered intraoperatively, instead of a simple discectomy, discectomy with spinal fusion at two levels had to be performed. After David has completed his post-operative rehabilitation course, his surgeon advises against repetitively lifting more than 30 pounds.

Most states require a final report documenting permanent disability or end of healing; each state has their own rules for what constitutes a permanent disability. David comes to your clinic for the final

medical report related to his worker's compensation case:

Final report: Acute lumbosacral radiculopathy, likely due to disc herniation L2-L4: Work-related injury suffered on 2/5/2023. Patient now status post discectomy and spinal fusion performed at two levels. He has had good result from the surgery with resolution of his weakness, and he now only suffers from mild pain with activity. His surgeon has recommended that he has a permanent lifting restriction of 30 pounds max. He may return to work activities with the above restriction. This is my final medical report as end of healing has been reached.

Due to the nature of the work injury and performed operation, David qualifies for 20% permanent partial disability as outlined in his state's administrative code.

YOUR ASSESSMENT MATTERS

The ability to perform work activities reliably, 40 hours per week, is the usual test for disability, and any deviation, when well documented, will likely result in a successful claim. It is important for clinicians to understand that the strength of the medical opinion is their medical knowledge, not vocational knowledge. It is not necessary for a physician to understand every nuance a patient's job requirements or to decide whether a patient "cannot work" but to focus on the patient's physical and mental limitations, which may relate to job functions. For Social Security disability, lawyers and representatives rely heavily on medical source statements and assessments to provide the judges information on any and all functional limitations due to medical conditions the clinician observes and documents. **FPM**

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3. Galentine E. The top 25 large-group disability carriers in the U.S. *Employee Benefit News*. June 28, 2018. Accessed Dec. 1, 2023. <https://www.benefitnews.com/advisers/slideshow/top-large-group-disability-insurance-carriers>

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