3.1 Introduction

3.1.1 General Information

Information concerning Railroad Retirement Act requirements for a disability annuity is contained in the Code of Federal Regulations (CFR) Title 20, Chapter 2. Information concerning Social Security Act requirements for a disability benefit is contained in CFR Title 20, Chapter 3. Click on CFR on-line to get to the website containing the CFR.

Four types of disability annuities are expressly created by the Railroad Retirement Act (RR Act). They are occupational disabilities 2(a)(1)(iv), total and permanent disabilities 2(a)(1)(v), Widow or Widower's disability annuities 2(d)(1)(i)(B), and child's disabilities 2(d)(1)(iii)(C). The RR Act also created the disability overall-minimum benefit and benefits for disabled children included in an age and service overall minimum benefit. These annuities are governed by the RR Act and the regulations and procedures which emanate from the Act. In addition, a spouse who is under FRA can qualify for an unreduced annuity based on having a disabled child over age 18 in his/her care. The criterion for which an “in care” determination is made is described in RCM 4.7.95 through 4.7.100.

In addition to its authority to decide whether a claimant is disabled under the RR Act, the Board has authority, in certain instances, to decide whether a claimant is disabled under the Social Security Act (SS Act). In making these decisions the Board must apply the regulations of the Social Security Administration in the same manner as does the Secretary of Health and Human Services.

The SS Act governs benefits allowed under Title II of the Act. These benefits include the disability insurance benefit, the disability freeze, and Medicare eligibility.

3.2 Disability Annuities Under The RR Act

3.2.1 Requirements for Annuity Entitlement

A. Occupational disability annuity - To be entitled to an occupational disability annuity, an employee must have

1. A current connection.
2. Filed an application for disability annuity.
3. Acquired 240 service months (234 service months if application filed before April 1, 1982), or 120 service months and attained age sixty.
4. Been rated permanently disabled for work in his regular occupation.
5. Stopped compensated service to an employer under the Railroad Retirement Act.

B. Total and permanent disability annuity - To be entitled to a total and permanent disability annuity, an employee must have

1. Filed an application for disability annuity.

2. Acquired 120 service months,

   or

   60-119 service months, and at least 60 months are after 1995, and his ABD is 1-2-2002 or later; however:

   - Tier 1 is not payable unless the applicant has enough quarters of coverage (based on RR and SS earnings) to have an insured status under the SS Act. If under age 62, the applicant must have 20 QC's in the 10 years immediately preceding the onset of disability.

   - Tier 2 is not payable until age 62.

   - If the applicant is under age 62 and does not have enough QC's to be insured under the SS Act, nothing is payable and the application must be denied.

3. Been rated permanently disabled for all work;

4. Stopped compensated service to an employer under the Railroad Retirement Act.

3.2.2 Definition of Work Under The RR Act

A. Regular railroad occupation - For the purpose of receiving an occupational disability annuity, an employee's regular railroad occupation is one in which

1. He has been engaged in railroad service for hire in more calendar months than he has been engaged in service for hire in any other occupation during the last preceding five calendar years (not necessarily consecutive), or

2. he has been engaged in railroad service for hire in not less than one-half of all the months in which he has been engaged in service for hire during the last preceding 15 consecutive calendar years.

B. Regular employment - Regular employment is defined as any substantial gainful activity (SGA). Substantial work activity being work that involves doing significant physical or mental activities regardless if it is done on a part-time basis or if the pay is less than when the claimant worked before. Gainful activity is work that the claimant does for pay or profit whether pay or profit is realized.

3.2.3 Definition of Disability Under The RR Act

A. Permanent Physical or Mental Condition - A physical or mental impairment that has lasted, or can be expected to last, for 12 consecutive calendar months or result in death.

Disability Benefits Division (DBD) interprets whether or not such a condition exists or has existed and will or has already prevented work. The reason for the existence of the condition is not considered.

Some conditions by their very nature can be expected to improve at some time in the future. However, this does not affect whether or not disability is established; it only affects the date annuity payments, periods of disability or Medicare coverage terminate. Further, there are conditions that can be controlled by prescribed treatment to a level considered not disabling. Whether or not an employee is availing themselves of medical treatment to correct or control their condition will be evaluated in each case by DBD in accordance with and. 20 CFR 220.12 and 20 CFR 220.115.

B. Occupational Disability - An employee is deemed permanently disabled for work in his/her regular railroad occupation if the employee has a permanent physical or mental condition that prevents him/her from performing the duties of his/her regular railroad occupation. The employee may have been disqualified from service in his/her regular railroad occupation because of disability by his/her employer, or been rated disabled for work in his/her regular railroad occupation by DBD according to established standards for his/her or a similar occupation.

If the employee's last occupation was as an officer or employee of a railway labor organization, including a subordinate unit "employer," and continuance in that occupation is unavailable to the employee, the disability standards used in an occupational disability annuity decision are those that apply to the position to which the employee holds seniority rights or from which he/she left to assume a position with the labor organization.

If the employee is found medically disqualified from his/her union work and is told by the union that he/she may no longer perform that job then the job is no longer available to the employee. However, if the employee is medically disqualified from the railway labor organization job, but is not told by the union that he/she must give up the job, then the job remains available to the employee. A railway labor organization position would be considered to be no longer available where:

- The employee is not reappointed to the position,
- The employee does not run for reelection,
- The employee loses the election, or

- The position is abolished.

The railway labor organization position remains available if the employee quits during his/her term.

If the employee is removed for cause from his/her railway labor organization job, the employee has no option to remain in that job and it therefore is no longer available to the employee. Therefore the employee's regular railroad occupation would then be the position to which the employee holds seniority rights or the position that the employee left to work for a railway labor organization.

It is also possible for an employee to work in self-employment and retain their current connection. In some instances a significant lapse of time may expire between when the employee last worked for the railroad and when the employee files for an application for a disability annuity. In cases such as these disability claims examiners need to carefully review the employee's vocational history and determine whether or not the employee has a regular railroad occupation based on the 5 or 15 year rule (See FOM I 1305.10.1).

Disability claims examiners are to use the information provided on Forms G-251, *Vocational Report*, and the G-251A, *Railroad Job Information* in determining the job duties performed.

EXAMPLE 1: An employee worked for CSX railroad as a conductor from 1979 through July 1995. The employee then works as a locomotive engineer from August 1995 through July 2001. In August 2001, the employee then starts his/her own business. In January 2017, this employee files a disability application with the RRB. It is determined that the work done for this business is self-employment and allows the employee to keep his/her current connection. Based on the information provided, the employee cannot be found to have a regular railroad occupation under the 5 or 15 year rule due to having worked in self-employment for at least 16 years following his DLW-RR. As a result of not having a regular railroad occupation, this annuitant is not entitled to an occupational disability annuity under the Railroad Retirement Act (RRA). Disability examiners will therefore need to review and determine whether the annuitant qualifies for a Total and Permanent Disability annuity under the RRA.

According to Legal Opinion L-2013-08, dated March 11, 2013, an individual will not lose his/her current connection if his/her only employment after leaving railroad employment is with a non-covered railroad employer (i.e., any railroad that is not covered by the Railroad Retirement Act) or with certain governmental agencies listed below:

- Department of Transportation;
- Interstate Commerce Commission;

- National Mediation Board;
- Railroad Retirement Board;
- National Transportation Safety Board;
- Surface Transportation Board.

(See FOM1 225.35 Regular Employment Exceptions).

Legal Opinion L-2013-08 also makes clear that although work with these employers does not break the employee’s current connection, work in these occupations **is** to be considered the same as work for any other non-covered employer when making a determination for regular railroad occupation.

EXAMPLE2: An employee files for an occupational disability annuity on October 20, 2008. The employee last worked for a railroad employer on July 30, 1988 as a locomotive engineer. The employee then worked as a safety inspector for the Federal Railroad Administration (FRA), a government agency, from March 1, 1990 through August 31, 2007. Since the employee worked for a governmental agency he/she would still maintain his/her current connection, however in determining his/her regular railroad occupation it would be necessary to consider his/her work for the FRA. In this example the employee would not have a regular railroad occupation as he/she has not worked in the railroad industry for over 20 years. Thus the employee would not be entitled to an occupational disability at the RRB.

Example 3: An employee worked for the BNSF railroad (covered employer) as a Carman from January 21, 1985 through December 22, 2005. The employee then worked for Alaska Railroad (non-covered railroad employer) as a locomotive engineer from January 2, 2006 through December 31, 2011. The employee files an occupational disability application on January 5, 2012. The work for the non-covered railroad employer would not break the employee’s current connection. The employee’s regular railroad occupation would be as a Carman based on the 15 year rule. .

C. Total and Permanent Disability - An employee is deemed permanently disabled for work in any regular employment if he/she has a permanent physical or mental condition that prevents him/her from performing in the usual and customary manner the substantial and material duties of any regular and gainful employment.

A condition substantiated by medical evidence that meets the standards listed in the SS regulation (20 CFR Part 220, Appendix 1, "List of Impairments"), or combination of such conditions, is considered disabling for all regular employment for annuity purposes.

NOTE: See DCM 6.3.3 for "Disability Definition Under SS Act."

3.2.4 Annuity Beginning Date

When an employee meets the disability annuity requirements, the annuity can begin on the latest of the following dates:

A. The earliest date permitted by law, or

B. The day designated by the employee.

To determine the correct ABD see the instruction in RCM 1.7.

If the employee is subject to a disability waiting period (see DCM 3.2.5), the beginning date of a disability annuity cannot be earlier than the first day of the sixth month after railroad retirement disability onset. If the employee is not subject to a disability waiting period, the beginning date of a disability annuity cannot be earlier than the first day of the month of railroad retirement disability onset.

Reconciliation of any work in service for hire performed by the applicant within one month after the effective date of disability shown on Form G-325 will not be required. When the applicant worked later than one month after the effective date of disability, a decision should be made as to whether the employment can be reconciled with the disability should be made.

3.2.5 Disability Waiting Period

The 1983 Railroad Retirement Amendments provide a five month waiting period for employee disability annuity applicants before their annuity may begin. The waiting period applies to employee disability annuity applications filed September 1, 1983 and later. The railroad retirement disability waiting period is used only to determine the disability annuity beginning date.

The waiting period does not apply to employee disability annuity termination. If an employee is re-entitled (new onset) within sixty months of previous disability annuity termination, no waiting period must be served. This is true whether or not a waiting period was fulfilled before the previous disability annuity began. If an employee does not become re-entitled before the expiration of the prescribed period, a five month waiting period must be fulfilled before the disability annuity may begin.

The waiting period begins with the month after the month in which railroad retirement disability onset occurs, and continues for five calendar months. The duration of the railroad retirement waiting period will differ from the social security waiting period when the onset date is the first day of the month.

EXAMPLE: The railroad retirement and social security disability onset date is January 1, 1984. The railroad retirement waiting period begins February 1, 1984 and continues

through June 30, 1984. The social security waiting period begins January 1, 1984 and continues for five full calendar months through May 31, 1984.

3.2.6 Employee in Compensated Service Filing a Disability Application

In most cases under the Railroad Retirement Act, an employee who is actively working for a railroad employer at the time of filing is, by definition, not disabled. The fact that they are working any railroad job shows that they are able to work. However, the definition of compensated service includes not only compensation with respect to active service performed by an employee for an employer, but also includes pay for time lost, wage continuation payments, certain employee protection payments, and any other payment for which the employee will receive additional creditable service.

For applications filed on or after January 1, 2006

An employee is allowed to still be in compensated service while filing a disability application provided that the compensated service terminates within 90 days from the date of filing and the compensated service is not active service. When an employee files a disability application while in compensated service, it is necessary for the employee to provide an identifiable ending date of the compensation. In cases where the compensated service exceeds 90 days the disability application will be denied. Any request for reconsideration or appeal from such a denial is to be limited to the issue of whether the employee was in compensated service to an employer within 90 days of the filing date. Under these circumstances, a disability application may be filed under the same rules and procedures used for advanced Age and Service applications. On APPLE, the field representative will enter the expected ending date of the compensation, as provided by the applicant, in the Employment Ended field. The field representative will code the application for manual review and indicate in Remarks that the disability application is being filed in advance. It will also be noted in Remarks if the case is being submitted for denial based on the employee filing while in active service or if the employee is filing more than 90 days from the date of last compensated service. The DLW (or in this case, the date creditable compensation ended) will be verified by the appropriate retirement unit through the monthly G-88a.1 listings sent to individual employers.

In addition, when a case is received in DBD that the field has coded for manual review due to advanced filing, DBD claims examiners can begin their development action and can render a decision immediately, even if it is before the projected date of the last compensated service. If the case was submitted for denial or before a decision is rendered and it is determined that the last day of compensated service is after 90 days, DBD is responsible for taking the necessary denial actions.

3.3 Evidence Requirements

3.3.1 Evidence Requirements For An Employee Disability Annuity

- Application (AA-1): Always.

- Application (AA-1d): Always.
- Field Office Personal Observation Record (G-626A): Always.
- Age: Always; however, a D/A may be awarded before establishment of DOB when age is not a factor of eligibility.
- Job information: Always from employee; for occupational disability job information will be requested from the railroad employer.
- Service and Compensation Reported After 1936: Always. Request a DEQY from SSA. (See DCM 3.4.205)
- Cessation of RR Service: For Occupational disability (2(a)(1)(iv)).
- Cessation of all Service: For Total and Permanent disability (2(a)(1)(v)).
- Disability (Medical Evidence): Always.
- Service and Compensation Before 1937: If claimed and employee has less than 360 months of S/S.
- Current Connection: In all Occupational disability (2(a)(1)(iv)).
- Military Service: If M/S is to be included in the years of service.
- SSA Benefit Data: If employee worked under SS Act or has filed for SS Benefits.
- Joint and Survivor Annuity: Only if joint and survivor election made before 7-31-46 is operative.
- Capability to Manage Payments (G-478): If incompetency is alleged or employee is in mental institution.
- Guardianship (AA-5): If guardian or other legal representative is selected as representative payee.
- Marriage: If joint and survivor election is operative.

NOTE: For evidence required in order to increase the Disability Annuity (D/A) under the overall-minimum (O/M), see evidence requirements as shown in appropriate RCM Chapters 1.1, 1.3, or 1.5.

3.4 Initial Development and Processing Of Claims

Procedure in DCM 3.4 is presented in the following general categories:

3.4.1 to 3.4.99 - General Processing Information

3.4.100 to 3.4.199 - Medical-Related Information

3.4.200 to 3.4.299 - Earnings-Related Information

Beginning at 3.4.300 - Claim Authorization-Related Information

3.4.1 Development of A Disability Application And Evidence

The normal development of a disability claim and evidence is summarized in this section. (For detailed information on the development of medical evidence, see DCM 4 .)

A. Initial Development of an Employee Disability Application

A disability claim will be developed by the field if all of the following conditions exist:

- The applicant claims to be disabled, and
- a determination of disability within the meaning of the RR Act would cause an annuity to be payable that otherwise would not, or would cause an annuity to be payable at a higher rate, and
- all other eligibility requirements are met.

NOTE 1: The employee who is eligible for an age and service annuity (60/30) is normally encouraged to apply for an annuity based on age and service rather than disability. This encouragement is based mainly on the advantage for the employee in receiving more prompt benefit award and the reduction of reporting and follow-up responsibilities. For most employees, there is also an immediate financial advantage in the calculation of Tier 1 of the annuity. In addition, the employee can still file an application for a period of disability ("Disability Freeze") and early Medicare coverage.

NOTE 2: When Form AA-1d is completed, signed and filed by an employee who dies without filing an AA-1, the AA-1d meets the application filing requirement. The employee’s survivors, as listed in FOM1 615.5.2, may file an AA-1 so that a disability determination may be made. Use the date the AA-1d is received as the official filing date for the application. If the employee is found to be disabled prior to death and death did not occur during the waiting period or the first month after the waiting period, annuity entitlement is established. Survivors may then file Form AA-21 for annuities due but unpaid at death, as outlined in FOM1 615.5.5.

B. Initial Development of Medical and Non-Medical Evidence

The field offices will develop medical and non-medical evidence for all disability applicants, which includes ordering independent medical examinations, if needed. If exams are deferred by the field staff, a notation must be made in the remarks

section of Form G-180D that is associated with the application. The notation in remarks must read “IME Deferred” and include an explanation as to why the exams were not ordered. Please see FOM 1 1330.5 for additional information.

1. Medical evidence consists of such items of a clinical nature as reports of medical examination, x-ray, or laboratory tests; hospital records; psychiatric or psychological tests; personal physician records; etc. Some acceptable medical sources include the following:

   - Licensed doctors of medicine and osteopathy,
   - Licensed optometrists,
   - Licensed or certified clinical psychologists,
   - Hospital or clinical records, and
   - Social Security medical records or other government agency medical records.

2. Non-medical factors are items which are not purely medical in nature, but which can assist in determination or disability. Examples of non-medical factors are:

   - Job duties,
   - Personal observations of the applicant,
   - Work Experience,
   - Education achievement, and
   - Special training.

3.4.2 Examiner Handling Of an Occupational Disability Annuity Filed Prior To 1-1-1998

DBD usually considers an employee disabled for work in his or her regular railroad occupation if the employer does not allow the employee to continue working in that occupation for a medically documented reason and DBD has evidence that supports the conclusion that the employee is unable to perform the duties of his or her regular occupation because of a permanent physical or mental impairment. DBD uses the following evaluation process in determining disability for work in the regular railroad occupation:

A. DBD evaluates the employee's medically documented physical and mental impairment(s) to determine if the employee has an impairment which is listed in the Listing of Impairments. That listing describes impairments which are

considered severe enough to prevent a person from doing any substantial gainful activity. If the Board finds that an employee has an impairment which is listed or is equal to one which is listed, it will find the employee disabled for work in his or her regular railroad occupation without considering the duties of his or her regular railroad occupation.

B. If DBD finds that the employee does not have an impairment described in A above, it will:

1. Review the occupation which the employee has held in the last 5-15 calendar years in which he or she was employed, to determine his or her regular railroad occupation (see DCM 3.2.2); and

2. Determine if the employee has an impairment that is listed or equal to one that is listed in the Provisional Occupational Disability Rating Schedule (PODRS). If the impairment is listed, DBD will find the employee disabled for work in his or her regular railroad occupation. If the impairment is not listed in the PODRS, DBD will do the following:

3. Determine what the physical and mental demands of the employee's regular railroad occupation are. In making this determination, DBD will consider the employee's own description of his or her regular railroad occupation and all information obtained from his or her employer(s). DBD may also take administrative notice of reliable job information available from various governmental and other publications; and

4. Evaluate the employee's physical and mental impairment to determine what limitations these impairments cause. DBD may consider the effect of all of the employee's medically documented impairments to determine whether he or she retains the capacity to meet the physical and mental commands of this or her regular railroad occupation.

3.4.3 Examiner Handling Of an Occupational Disability Annuity Filed After 1-1-1998

Occupational disability claims filed after January 1, 1998, are handled in accordance with the Disability Manual for Assessment of Occupational Disability Claims (DM). Refer to chapter 13 for the DM.

The DM contains information on how to adjudicate claims according to Federal Regulations. The DM contains the steps of sequential evaluation followed for occupational disabilities, how to evaluate claims with employer disqualification, and test descriptions and protocols.

3.4.4 Evaluating Disability Cases Under Section 2(A)5

DBD will rate a disability case under section 2(a)5 if annuitant does not meet the eligibility requirements for an annuity under section 2(a)4. This occurs when the

applicant is less than 60 years of age and would have less than 20 years of service. The sequential evaluation process should be used for this evaluation.

3.4.5 RR Act (Annuity) And SS Act (Disability Freeze/Early Medicare) Decisions

Whenever possible, simultaneous ratings under the RR and SS Acts should be made on current disability claims. However, claims examiners should not defer the processing and certification of claims for award of an annuity under the RR Act for determinations under the SS Act. If the RR Act and SS Act (disability freeze) determinations are made simultaneously, a determination of the medical improvement classification must be made. In most instances, a diary must be set for a continuing disability review. Refer to DCM 8.5.4 for further information.

The annuitant has the right to request that a disability freeze not be granted. This could occur for a number of reasons (e.g. employee and spouse would get better coverage under private insurance than under Medicare.) In such cases, have the field obtain a signed statement from the employee that all of the advantages of the disability freeze (early Medicare, O/M, possible tier 1 increase, tax advantage, possible survivor benefit increase) have been explained to him and he still does not want to be granted a disability freeze. Once the statement is received, prepare a technical denial of the disability freeze even if there is sufficient medical evidence to warrant a favorable decision. Make a notation in the remarks section of OLDDS that the DF was denied per employee's request. Use RL-260c as a notification letter. This can be done even if the case would ordinarily be a joint freeze decision.

3.4.6 Awarding A Disability Annuity Prior To Establishing DOB

A. Initial Action - A D/A can be certified for payment even though the DOB has not been established provided the applicant:

   1. Is rated disabled under section 2(a)(1)(iv) of the Act, and has at least 234 months of service, a C/C, and is otherwise entitled; or

   2. Is rated disabled under section 2(a)(1)(v) of the Act and is otherwise entitled.

   If POA has not been requested prior to placing the case in payment channels, take appropriate action to request POA.

   Use the claimed DOB on the award form. Code a "14-01" call-up on Form G-662 for two months from the current date to trace POA development.

B. Subsequent Actions When Different DOB Established After D/A Award - When a D/A was certified without establishing a DOB, and the POA that is later submitted establishes a different date than was originally claimed, notify BIS-DSS by Form G-59 of the change (even if it is only one day if an award form will not be prepared because no adjustment in the annuity is required.

3.4.7 Handling Cases Previously Denied

A. If Rating Is Changed - As a result of a new evidence or correspondence, determine whether a new application is required in accordance with RCM 5.1, "Applications." If a new application is required, DBD will initiate development through the D/O and control for a 30 day call-up.

B. If Rating Is Not Changed - When Form AC-1 is not in file, DB will release an informal letter to the applicant indicating his case has been reconsidered and he is still not shown disabled. Include Code Paragraph 189 if applicant's appeals rights have not expired. If such rights have expired, advise applicant that if he feels his condition is not adequately described by medical evidence submitted, he should file additional medical evidence, and a new application at the nearest Board office (a formal denial is not made unless a new application is filed).

3.4.8 Applicant Dies During Waiting Period Or Month After Waiting Period Ends

When a waiting period is applicable, the annuity beginning date cannot be earlier than the first day of the sixth month after the month of the railroad retirement disability onset date. An application for disability benefits must be denied if the applicant dies during the waiting period or the first month after the waiting period (the month in which the annuity would have begun) since benefits are not payable for the month of death.

3.4.8.1 Action To Be Taken By The Disability Rating Examiner

If notice of death is matched with the folder, have the application dumped from RASI, if necessary.

If the disability rating can immediately be completed take the following actions:

1. Develop for the cause of death and death certificate if that information is not already in file.

2. If the folder contains a previous OLDDS printout on which the applicant was rated disabled before notice of death was received, mark that OLDDS printout "superseded" and review the onset date determination.

   a. If the actual onset date can be revised to a date early enough to fulfill the waiting period and allow payment for a period before the month of death, complete OLDDS and G-325.1 in the usual manner.

   b. If the actual onset date cannot be revised to a date early enough to fulfill the waiting period and allow payment for a period before the month of death, complete OLDDS and the G-325.1.

      On OLDDS, complete items 1 through 16 as usual; enter the "not disabled" code in both item 17, 18, 19, or 20 and item 24, 25, or 26. In the "Remarks" section on the first screen enter the actual onset date and date

of death, indicate that this OLDDS printout supersedes the previous OLDDS printout and provide the date of the previous OLDDS printout. Complete item 22a by entering a "2" and item 28 by entering "7"; item 27 should be blank. The examiner should then enter "Y" for submitted and then submit the case for authorization.

NOTE: If the previous OLDDS printout was a denial, check to ensure the denial letter has been released and the G-661 completed and the claim coded out. Then forward the folder to the appropriate survivor section if necessary.

3. If a rating was not previously done, make the disability determination on D-BRIEF and complete OLDDS and G-325B as usual. If death occurred during the waiting period or the month following the waiting period, entries should be completed in the same manner as for cases in which the applicant is not disabled, except that the actual onset date and the date of death must be entered in remarks section of the OLDDS screen. The examiner should then enter "Y" for SUBMIT, the date and a "Y" for REVIEW.

   If the disability rating cannot be done immediately, route the folder to the appropriate survivor section for any survivor benefit payments. Enter the date of death in the "Remarks" section of the route slip and remind the survivor unit that the disability determination is pending and the file must be returned to DBD when the survivor actions are complete. When the file is returned, complete steps 1 through 4 above.

3.4.9 Setting Disability Onset Dates

Medical evidence and other factors need to be analyzed to determine the appropriate onset date. Examiners need to use sound judgment and completely explain their reasons for determining a disability onset date in their rationale. When the onset date is different from that alleged, the reasons must also be explained on the Form RL-121f, Notification of Rating.

3.4.9.1 Development For Possible Earlier Onset Date

When more development is needed to establish an earlier onset date, but there is sufficient medical evidence in file to allow a restricted onset date, it is DBD policy to make a favorable decision with the information in file. Request the additional information for a subsequent rating. For example, the claimant alleges an onset date of March 1, 2003, but the earliest medical evidence in file that supports a finding of disability is from November of 2003. Rate the case using an onset date in November, 2003 and request additional medical evidence for the period March through October. Explain the reasons for the restricted onset date and that additional medical evidence is being requested in the RL-121f. When an earlier onset date cannot be allowed after the request for additional evidence, either because no further medical evidence was submitted, or because the medical evidence submitted did not support an earlier onset

date, an RL-121f must be sent with an explanation of the reasons for not allowing the earlier onset date.

3.4.9.2 Onset Date Different From The Date Alleged

The disability onset date is determined by medical evidence, DLW and other factors. The applicant cannot designate the disability onset date. Allow the claim and base the onset date on the evidence in file, whether it is earlier or later than the alleged onset date. If there is any indication in the file that an earlier onset date may be possible, but more development is needed, contact the field office for further development. If the claimant chooses not to submit additional evidence, an earlier onset date cannot be allowed.

3.4.9.3 Setting An Onset Date That Is Earlier Than The DLW

For occupational disability annuities, there are certain situations in which an onset date can be set prior to the DLW. The most common situations would be those in which ·

- the person was unable to perform full job duties and performed light duties because of the impairment; or
- the person was assisted by another to perform duties that would normally be performed alone; or
- the person had frequent absences because of the impairment; or
- the person returned to work, but had to stop after a very short period because of the impairment.

In most cases, information from the employee is sufficient documentation to set the onset date earlier than the DLW. The information needed is as follows:

- Items 7 through 11 of the AA-1d should be complete in order to determine that an onset date prior to the DLW can be established. These items must make it clear whether the claimant worked or if their condition caused a change in job duties, hours of work, attendance, etc. If you cannot determine the impairment caused any changes to work, then additional development is necessary.
- If the person alleges a period of light duty, a detailed description of the light duty must be obtained and compared to the regular duties. The employee's description is sufficient for both types of job duties. Verification with the employer is not necessary. Note, however, that if a G-251a or G-251b is received from the railroad employer with a description of duties that differs substantially from the employee’s description of regular duties on the G-251, that discrepancy must be resolved.
- If an applicant claims someone is helping perform job duties, a detailed description should be provided of any assistance.

- If there is an indication of frequent absences, the employee needs to provide more information rather than just indicate a lot of time was missed. The employee should provide the number of days absent and the reasons (i.e., due to the impairment or being laid off). The reason for the absence must be related to the impairment in order to support an earlier onset date. The employee may provide copies of time cards or pay stubs that show the days not worked. This information does not need to be verified by the employer.

EXAMPLE 1: A track laborer suffers a heart attack. After time off to recover he attempts to return to work on light duty. After a month back on the job he still is experiencing fatigue and shortness of breath regularly doing light duty. Rather than try to return to his regular job duties as a track laborer he files for an occupational disability. The employee's description of the difference between his regular job duties and the light duty is sufficient to allow the onset date to go back to the heart attack. Verification is not required from the employer.

EXAMPLE 2: An employee is injured on the job June 1, 2000. He returns to work July 7, 2000, but he can only work 2 days and has to stop because of the injury. The employee's claim that he only worked 2 days is sufficient to give an onset date of June 1, 2000.

EXAMPLE 3: A claimant states on the AA-1d that he was injured on February 1, 2000 and returned to work on June 28, 2000. He worked until July 5, 2000 when he had to stop because of the injury and filed for a disability. In the doctor's notes it mentions that the claimant returned to work February 8, 2000 and worked until the time of filing. Further development will be necessary to resolve the discrepancy.

For total and permanent disability annuities, an onset date that is earlier than the DLW in substantial gainful activity (SGA) can be set if the criteria for an unsuccessful work attempt (UWA) is met. For more information about UWA, see DCM10.5.3

3.4.9.4 Inferring a Disability Onset Date

In some cases, it may be possible, based on the medical evidence and non-medical evidence in file, for a RRB disability examiner or consultative physician or psychologist to infer that a disabling level of severity existed prior to the date of a first recorded medical examination, procedure, or test. In these situations the disability examiner or consultative physician or psychologist will count back a number of months, as determined by the facts of the case, to arrive at the month of disability onset. Notwithstanding any conflicting evidence, the last day of the month of disability onset shall be the inferred day of onset.

An inferred disability onset date is an estimated date when disability began which must be fully rationalized in D-Brief (Form G-325B) or a rationale (Form G-325.1).

Disability examiners should be cognizant of inferred disability onset dates and insured status requirements for disability freeze (DF) determinations. If a claimant was last

insured within a couple of months of an inferred disability onset date, it may be reasonable to conclude that disability began on the last day that insured status requirements were met.

In situations in which an inferred onset date and DF insured status requirement could be factors, the disability examiner should notify the consultative physician or psychologist to consider those facts when completing their medical opinion.

If a medical opinion(s) was already obtained but an inferred onset date and DF insured status requirement were not requested to be considered, the examiner would be justified in sending the claim folder back for a new medical opinion (a new accounting obligation would be required).

EXAMPLE 1: A claimant underwent a medical examination on March 12, 2010. The RRB consultative physician provides a RFC and indicates that the RFC applies "back six months from the date of the March 2010 exam". The onset date would be determined by counting back 6 months from the March 12, 2010 examination. Once the month is determined (September), use the last day of that month to determine the inferred date of the onset. In this example the onset date for this situation is September 30, 2009.

EXAMPLE 2: A claimant claims that he became disabled on July 1, 2010 based on both physical and mental impairments. Although the medical evidence indicates that he suffered from his physical impairments on his claimed onset date, it also shows that he did not begin psychotherapy treatments for depression until May 23, 2011. The RRB obtains consultative medical opinions for both his physical and mental impairments. The RFC provided for his physical impairments does not allow the disability examiner to determine that he was disabled based strictly on those impairments. The RFC provided for his depression indicates that the mental RFC applies "back three months from the date of the May 2011 exam. The combination of physical and mental impairments allows a rating of disabled. The inferred onset date would be February 28, 2011.

EXAMPLE 3: Same situation as Example 2 except the claimant was last insured for a DF on December 31, 2010. Presuming there are no other medical, non-medical, or administrative factors which would prevent December 31, 2010 from becoming the inferred disability onset date, the disability examiner should notify the consultative physician or psychologist that the claimant is last insured for a DF on that date and that he/she may provide an inferred onset date, if warranted.

3.4.100 Terminally Ill (TERI) and Compassionate Allowance (CAL) Claims

This procedure has been formulated to allow the Railroad Retirement Board to more expeditiously process claims for applicants who have a medical impairment which:

- Is generally expected to result in death;
- Involves a high probability that the applicant can be rated disabled;

AND

- The evidence of the applicant's allegations is expected to be easily and quickly verified.

The procedure standardizes the identification, development and processing of terminally ill (TERI) and compassionate allowance (CAL) claims. The coordinated efforts of field office and headquarters employees to timely handle TERI / CAL claims in accordance with this procedure will greatly improve our responsiveness to the needs of these individuals.

TERI and CAL claims both involve a high probability of allowance. While TERI claims generally involve an illness which cannot be reversed and is expected to result in death, not all CAL claims involve terminal illness.

There is no relevance if the claim meets the TERI criteria, the CAL criteria, or both. Once identified as a TERI / CAL claim, that designation remains on the case until all administrative appeals of that claim are exhausted or it is obvious that the TERI / CAL criteria are no longer met.

A. Identifying TERI Claims

Disability claims with an indication of a terminal illness will receive priority handling because of their sensitivity. TERI claim procedure became effective on September 1, 1991.

A claim may be identified as a TERI claim by using the following criteria:

1. There is an allegation from the claimant, friend, family member, doctor, representative payee, attorney, court or other medical source that the illness is terminal;

2. There is an allegation or confirmed diagnosis of Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome (AIDS);

   NOTE: All claims involving an allegation or a confirmed diagnosis of Human Immunodeficiency Virus (HIV) infection must also be handled expeditiously but should generally not be labeled as a TERI claim. An individual alleging or having a confirmed diagnosis of HIV infection may or may not be prevented from performing work under applicable sections of the Railroad Retirement Act (RR Act) or Social Security Act (SS Act) depending on the severity of the residual effects. Conversely, an individual who has AIDS has reached a progressively advanced stage of HIV infection with accompanying medical signs and symptoms which result in a poor prognosis and a reasonable expectation in eventual death.

3. The claimant is receiving in-patient hospice care or is receiving home hospice care, such as in-home counseling or nursing care;

4. There is an allegation or diagnosis of Amyotrophic Lateral Sclerosis (ALS), known as Lou Gehrig's Disease;

5. The claimant has a condition which medical records indicate is untreatable, cannot be reversed and is expected to end in death. These conditions would include but are not limited to the following:

   a. Chronic dependence on a cardiopulmonary life-sustaining device;

   b. Awaiting a heart, heart/lung, or bone marrow transplant (excludes kidney and corneal transplants);

   c. Chronic pulmonary or heart failure requiring continuous home oxygen <u>and</u> the claimant is unable to care for personal needs;

   d. A malignant neoplasm (e.g. cancer) which is:

      - Metastatic (has spread);
      - Stage IV (final stage);
      - Persistent or recurrent following initial therapy; or
      - Inoperable or unresectable.

   e. An allegation or diagnosis of:

      - Cancer of the esophagus;
      - Cancer of the liver;
      - Cancer of the pancreas;
      - Cancer of the gallbladder;
      - Mesothelioma;
      - Small cell or oat cell lung cancer;
      - Cancer of the brain; or
      - Acute Myelogenous Leukemia (AML) or Acute Lymphocytic Leukemia (ALL).

   f. Comatose for 30 days or more.

<u>The above list **is not** intended to be all-inclusive.</u> Rather, it should be used as general guidance in the identification of TERI cases. Other cases may be

considered TERI cases as long as the medical condition is untreatable and is expected to result in death.

Both field office and headquarters personnel are equally responsible for identifying TERI claims. DBD examiners should consult with a lead examiner or supervisor if, while adjudicating a disability claim, the examiner thinks that a case may qualify as a TERI case but has not been designated as such. A claim may also be identified and designated as a TERI claim during the reconsideration or appeals process when the evidence indicates a medical condition has developed or worsened as shown by the above guidance.

B. Identifying CAL Claims

Compassionate Allowance is a Social Security Administration (SSA) initiative to quickly identify diseases and other medical conditions that invariably qualify under the Listing of Impairments (DCM 4.12; POMS DI 34001.000) based on minimal but sufficient objective medical information that is readily available and can be obtained quickly. The RRB adopted this initiative effective on January 15, 2009 as a way of providing for the needs of individuals whose medical condition is so serious that it obviously meets the disability standards. Accordingly, conditions in the CAL list may be considered when adjudicating all disability claims under the Social Security Act (SS Act) as well as Railroad Retirement Act (RR Act).

The list of conditions that SSA has developed under this initiative is a result of information received from internal and external medical, legal, and scientific professionals, the public, and disability claims specialists throughout the country. SSA is solely responsible for and continues to evaluate conditions to be included in or removed from the list. Accordingly, since SSA adds and removes impairments from the CAL list, refer to POMS DI 23022.080 for the most current list.

POMS DI 23022.080 contains web links to summaries of all the CAL conditions. The summaries include information about:

- Alternate impairment names, if any;
- A detailed description of affected body systems and how each impairment incapacitates an individual;
- Diagnostic tests that are usually performed, if any;
- Physical and/or mental findings generally associated with each impairment;
- Onset and progression;
- Treatments, if any; and
- Suggested evidence to support the claimed impairment.

The list of CAL conditions **is** all-inclusive and contains adult, child, and infant-related medical conditions. An individual can be rated disabled as a result of having any condition in the CAL list regardless of age presuming that individual continues to be affected by that condition and sufficient medical evidence to support the claim has been obtained.

Both field office and headquarters personnel are equally responsible for identifying claims involving conditions in the CAL list. Adjudicating personnel are required to check SSA's CAL list if you see evidence of a medical condition which you are unfamiliar with or do not recognize the name of a medical condition which the applicant claims to have or has been diagnosed as having. DBD examiners should consult with a lead examiner or supervisor if, while adjudicating a disability claim, the examiner thinks that a case may qualify as a CAL claim but has not been designated as such. A claim may also be identified and designated as a CAL claim during the reconsideration or appeals process when the evidence indicates a medical condition has developed or worsened as shown by the above guidance.

C. General Handling, Development, Adjudication, and Disposition

The supervisor of the Initial Section of DBD (DBD-DIS) will secure the claim folder or have one created upon receiving notification from a field office that a TERI or CAL claim is being submitted. The claim folder will be marked with a special label (RRB Form G-20) marked "TERI / CAL CLAIM."

All TERI / CAL claims received in DBD will be controlled on Universal STAR (USTAR) using the appropriate USTAR code. (See FOM1 15120.5 for information about USTAR.) TERI / CAL claims shall be closed out on USTAR when a disability determination is effectuated **or** it is obvious that the TERI / CAL criteria are no longer met.

DBD rating examiners are to discuss with their lead examiners or supervisor if it appears that a claim no longer meets the TERI / CAL criteria. DBD lead examiners or supervisors shall decide when a claim no longer meets the TERI / CAL criteria. If it is decided that a claim no longer meets the TERI / CAL criteria, the lead examiner or supervisor will remove it from USTAR and the rating examiner will notify the field office via E-mail within 3 days that the claim no longer meets the TERI / CAL criteria. (See below for actions to take when a disability determination is effectuated.)

Once labeled as a TERI or CAL claim, all aspects of development, adjudication, coordination (including situations involving joint freeze and dual eligibility claims), and disposition require tight controls and expedited handling.

Despite being labeled as a TERI or CAL claim, sufficient medical and non-medical evidence and, if necessary, a medical opinion, is required to support a disability determination. Requests for both medical and non-medical development will be made by E-mail marked as "High Importance" to the field office that initially notified

DBD that a TERI / CAL claim was being submitted, even if it is not the same field office as the claimant's home field office.

Because the level of documentation differs for claims under the RR Act or SS Act, the adjudicator is only responsible for developing for information that is needed for the determination that (s)he is responsible for. If a TERI or CAL claim has not been previously adjudicated, efforts at development shall be limited to adjudication issues toward the disposition of the claim for a disability annuity. If the individual has already been approved for a disability annuity or full age and service annuity OR is not eligible for an annuity under the RRA, efforts at development shall be geared toward adjudication issues toward the disposition of the claim for disability freeze and/or Medicare coverage under the SS Act.

If required evidence is outstanding, DBD examiners and Reconsideration specialists are to follow the tracing schedule as shown in DCM 4.3.8 B by first checking Contact Log and any other online systems that are available to find out the status. All first requests for tracing will be made by the claims examiner or specialist via E-mail directed to the field office manager responsible for the claim. Second requests for tracing will be made by the claims examiner or specialist via E-mail directed to the responsible network office manager. All E-mails shall have a "High Importance" setting and be notated at the beginning of the message that it refers to a TERI or CAL claim.

Claim folders that are referred to medical consultants shall be designated by adjudicating personnel as "URGENT" and will be handled first by the reviewing doctors. All clerical functions including photocopying and typing will also be handled with priority.

TERI or CAL claims shall be notated as such in the Remarks section of OLDDS, the Remarks section of Form SSA-831, *SSA Disability Determination and Transmittal* (DCM 11 SSA-831), and at the beginning of the Summary of Medical Findings section of Form G-325B (*Disability Briefing Document*) (DCM 12.5.6.2) or Basis for Decision section of Form G-325.1 (*Disability Decision Rationale*) (DCM 11 G-325.1). Every effort will be made to expedite authorization of these claims.

After any final decision has been effectuated, the authorizer will deliver the claim folder back to the DBD rating examiner or Reconsideration specialist who will notify the responsible field office of that decision through E-mail within 3 days of authorization.

If the disability decision was a rating by DBD-DIS, the rating examiner will then deliver the USTAR control record sheet to the DBD-DIS lead examiner to close out the USTAR record and the claim folder to a lead examiner in the DBD-Disability Post Section (DBD-DPS) who will establish a new USTAR control record for the disability freeze (DF) or Medicare decision. After the new USTAR control record has been entered, the DBD-DPS lead examiner will then deliver the claim folder to the DBD rating examiner responsible for the DF or Medicare decision. DBD-DPS rating

examiners shall close the USTAR record after the DF or Medicare decision has been effectuated. In the Reconsideration Section, USTAR control records will be closed by the section supervisor.

If the disability decision was a rating by DBD-DPS or Reconsideration Section, expedite all appropriate actions to complete the case including:

- Establishing an appropriate CDR call-up, if necessary (See DCM 8.5.2 and 8.5.3);
- Sending Form G-405 to the Medicare Section as an E-mail attachment (See RCM 11 G405).

Once DBD or Reconsideration Section has completed all actions to effectuate a TERI / CAL claim, forward the claim folder (with the appropriate route slip notated “URGENT - TERI / CAL Claim”) to the appropriate headquarters section, if necessary, for any additional required actions or back to storage (i.e. Claim Files).

3.4.200 Effect of Railroad Work on the ABD for a Disability Annuity

In some disability cases an employee will attempt a return to railroad work. This return to work can affect the ABD depending on when the disability application was filed and when the return to railroad work was attempted.

- If the return to railroad work occurs after the disability application if filed, the railroad work can be considered an unsuccessful work attempt (UWA). If the railroad work is considered an UWA, it would not have an effect on the annuity beginning date. However no annuity is payable for any month the annuitant was in compensated service.
- If the return to railroad work occurs before the disability application is filed, that railroad work is considered the employee’s date last worked. This would mean the ABD could be no earlier than the day after the DLW.

3.4.201 Self-Employment Cases

Self-Employment is work performed in a person's own business, trade or profession, rather than for an employer. While self-employment is not LPE, some activities claimed by the applicant as self-employment may actually be employment for someone else (e.g., salesman or domestic worker). A person is not self-employed if he works in an incorporated business. The corporation is the person's employer. The fact that an applicant has reported earnings as self-employment to the Internal Revenue Service does not make his work "self-employment.” For more information on how to evaluate self-employment see DCM 10.4.5.

In disability cases, DBD must evaluate all past relevant work (see DCM 5.2.1) in order to determine SGA and whether or not substantial services were performed. Therefore, in disability cases, the field should secure an AA-4, Self-Employment and Substantial

Service Questionnaire, for work shown as self-employment. If the work does not affect C/C or LPE determination (e.g. the work covered on the AA-4 was performed more than 12 months before date last worked in RR or non-RR work), a determination by RBD or the field office is not necessary.

In some cases the information contained on the AA-4 will not be sufficient for an examiner to make a self-employment determination or may lead to the disability examiner having questions about the work being performed. In these instances, initial DBD examiners are to release Form G-252, Self-Employment/Corporate Officer Work and Earnings Monitoring to the applicant. The information provided on this form will provide additional information about the self-employed work being performed. See DCM 8.5.14 for additional information pertaining to Form G-252.

3.4.205 Wage Record Development During the Sequential Evaluation Process

Accurate documentation and evaluation of a claimant's work history is vital to steps 4 and 5 of the sequential evaluation process (DCM 3.6.1) in disability claims under the Railroad Retirement Act (and all disability freeze/Medicare claims under the Social Security Act) and to prevent possible fraud and insure program integrity. When material inconsistencies (see DCM 3.4.206) appear in the documentation, the disability examiner must resolve them and explain the resolution in the rationale. The methods (example, DEQY, The Work Number (TWN)) to resolve these inconsistencies are to be used by the disability examiner. **Note**: Examiners must not use internet resources such as social media sites (example, Facebook) to resolve inconsistencies.

Detailed Earnings Query (DEQY)

Disability examiners are required to obtain a Social Security Administration (SSA) Detail Earnings Query (DEQY) wage record for all Railroad Retirement Act disability claims and all Social Security Act disability claims when each claim is initially developed. Prior to May 4, 2015, paper DEQY wage record printouts were obtained and filed on the right side of the claim folder. Effective May 4, 2015 and later, DEQY wage record are obtained and sent directly to Imaging using the G-180MF, Mainframe Screen Capture. This process electronically sends screen captures directly to Imaging. Disability examiners must no longer print paper DEQY printouts.

> **NOTE:** A DEQY provides detailed information from each source of income as reported by the Internal Revenue Service for any year since 1978.

A DEQY must be obtained covering the 15-year time span shown in DCM 5.2.9.

General information about SSA's computer system and databases is found in RCM 19.2 Specific instructions how to access and logon to SSA's main screen is shown in RCM 19.2.5. Specific instructions how to access a DEQY is shown in RCM 19.2.15 D.

The following "details" should be obtained when completing a DEQY request:

1 Covered Details

2 Self-Employment

4 All Non-Covered Details

7 Special Wage Payment

8 Employer Address

Disability examiners should be mindful of possible changes in a wage record from approximately February 1 until June 30 of each year as a result of earnings information posted from the Internal Revenue Service (IRS). EDMA should be routinely checked and compared to the DEQY to see if there were any changes in the amount of income in the previous year before authorizing a disability determination. If any EDMA screen prints are necessary for documentation in the case, the EDMA screens must be electronically sent directly to imaging using the G-180MF screen capture process. In addition, SSA's SEQY can also be review to identify and compare earnings, and SEQY screens should be sent to imaging using the G-180MF screen capture process.

The Work Number (TWN)

The Work Number (TWN) allows the RRB to obtain income verification reports that contain basic employment information about an individual's job, title and employment status, as well as income. TWN provides the most recent income information since it is posted real-time to the TWN website. Income earned and posted within the year (i.e., past 12-16 months) should be shown on TWN. TWN is used in conjunction with other sources reporting income (earnings or wages) information (example, DEQY, EDM, and SEQY) which will enable us to obtain both past and recent income information.

Effective July 19, 2018, disability examiners must obtain and verify employment and income from TWN for all active and inactive status employers that are not on the DEQY and have not been reported on Form G-251, *Vocational Report*, prior to (just before) submitting a case for authorization. Information obtained from the TWN employment and income report must be taken into consideration when determining eligibility for disability benefits. Prior to this date, disability examiners were required to obtain and verify employment and income from The Work Number (TWN) for all Railroad Retirement Act disability claims and all Social Security Act disability claims when each claim was:

- Initially developed (upon case receipt or assignment); and
- Prior to (just before) the final disability decision is rendered to either award or deny.

TWN employment and income reports display a variety of information which includes, but is not limited to:

- Employee Name

- Employer Name
- Most recent hire date
- Termination date (if no longer employed)
- Job Title
- Rate of Pay
- Gross Earnings for current year, including base pay, overtime, bonuses, and commissions
- Total Net Earnings
- Hours Worked
- Average Hours Worked/Pay Period
- Workers' Compensation information

Note: Employment and income verification reports from TWN are not required when the only employer is a railroad employer and the railroad employer is listed on EDM, for inactive employers that are listed on the DEQY, or for cases that are denied due to 1) non-severity of all impairments; 2) failure to meet the 12 month duration requirement; 3) ability to perform past relevant work; and 4) application of medical vocation rule (i.e., generally a younger individual between ages 18-49).

If an error messages is received when initiating a TWN lookup, the DBD examiner should make at least two attempts to obtain the information. If the DBD examiner continues to receive an error message, he/she should consult with the supervisor, lead or other staff designated by the management official for resolution.

Cost to Use TWN

There is a **cost for each lookup using TWN**. Since each disability case requires a TWN lookup (prior to submitting for authorization), except as noted above, there should be a minimum of at least one lookup cost for each case. The RRB incurs a charge for each employer (non-railroad and railroad) that you select to view the detailed information.

Example

RRB is charged $9.72 for each employer lookup. An applicant has three active employers, the RRB will be charged a total of $29.16 for that case ($9.72 x 3 employers x 1 lookup). As such, disability examiners should not do any unnecessary additional TWN lookups since this increases the total cost to use TWN per case.

For more information on how to access TWN, the cost and how to obtain employment/income information disability examiners should follow the steps outlined in FOM 15155.15.

Use of TWN for Recent Earnings

TWN should be used for all active non-railroad employment and all inactive non-railroad employment that are not listed on the DEQY.

Case Development - The disability examiner should obtain a DEQY, EDM and TWN to verify employment and income. These reports must be reviewed with the AA-1 and AA-1D application and G-251, Vocational Report, for any inconsistencies.

Example

John Smith files an AA-1 and AA-1D for a disability annuity in April 2018. Upon receipt of the disability case for adjudication in May 2018, the DBD examiner should obtain a DEQY through 2017 (the probability is that earnings through 2016 not 2017 will be shown on DEQY). Prior to submitting the disability case for authorization, the DBD examiner must review TWN for t recent earnings. The information obtained from TWN should be evaluated to determine if there are any inconsistencies that need to be resolved (example: recent earnings from an employer not listed on the AA-1 or AA-1D). Specifically, if non-medical factors submitted by the applicant are inconsistent with DEQY, EDM, TWN, additional development should be considered. For more information on how to resolve inconsistencies see DCM 3.4.206.

NOTE: If the disability examiner accesses TWN and there are no active employers shown on the TWN screen, the examiner should image the screen using the G-180WC, Website Screen Capture, to document that they reviewed TWN. There is no cost for viewing this screen.

Example

Using the example from above, the DBD examiner completes medical and non-medical development and determines that the case is ready to be rated in July 2018. The DBD examiner should request a DEQY through 2017 (probability is that earnings through 2017, instead of 2016, will now be shown on DEQY). Prior to submitting the disability case for authorization, the DBD examiner must also review to ensure that no additional earnings have been reported. If additional earnings have been reported, consider if case should be denied. (For more information on compensated service, see DCM 3.2.6. Refer to the NOTE above regarding no employer shown on TWN. For more information on how to resolve inconsistencies see DCM 3.4.206.

Upon receipt of the disability case for review, the Disability Post examiner must confirm that the Initial Disability examiner reviewed TWN in order to identify any inconsistencies prior to authorization. The Disability Post examiner can confirm by checking Imaging for TWN screens and either the G-321, *Employee Initial Rating Checklist*; or G-321A, *Widow/Child Information Checklist*. Note: If the TWN results indicate "SSN Not Found", the Disability Post examiner should check TWN to verify results. **Note:** If the case is returned to the DBD initial examiner and resubmitted for authorization, the DBD initial examiner must obtain a new TWN report if it has been three months since the last TWN report was obtained.

Send copies of all TWN reports to Imaging using the G-180WC, Website Screen Capture. This process electronically sends screen captures directly to Imaging for

documentation and reference. Disability examiners should not print TWN reports. For more information on how to image, see FOM 15155.30.

3.4.206 Assessing the Applicant's Wage Record and Job Information

The disability case should be reviewed to determine whether the work history and wage record are generally consistent for the purpose of determining past relevant work (PRW). (DCM 5.2.1) All evidence must be considered.

Remember when evaluating an applicant's work activity for substantial gainful activity (SGA) purposes, be concerned with only those earnings that represent the individual's own productivity (DCM 10.4.4) or whether the work represents an unsuccessful work attempt (DCM 10.5.3).

A. Wage Record And Job Information That Is Generally Consistent

In this scenario, the applicant's reported occupations on Form G-251 generally coincide with the employers in the wage record. Earnings information shown on the applicant's forms/applications and other sources reporting income (example, DEQY, TWN, etc.) are consistent and show no material discrepancies. Since all information is generally consistent, no further action is necessary for assessing job information.

B. Wage Record And Job Information That Is Not Generally Consistent

Inconsistencies between the applicant's reported occupations on Form G-251 and the wage record must be reconciled only when they are material.

"Material inconsistency" is defined as the existence of evidence which reasonably prevents a disability adjudicator from making a sound disability decision regarding work history or if determining if a job should be considered PRW. Usually, this occurs when there is a significant unexplained omission or difference in the time frame that the applicant claims to have or not have worked in an occupation compared to the time frame which the wage record shows he/she was employed or self-employed. However, all reasonably questionable situations which may affect the disability decision require reconciliation of the wage record and occupational evidence regardless of the circumstances.

If material inconsistencies still exist after reasonable reconciliation efforts to contact the parties involved, the examiner should utilize other sources of job information to resolve the inconsistencies (DCM 5.2.2). Disability examiners are cautioned to not use data in the Dictionary of Occupational Titles (DOT) to fill in missing information about specific job at one workplace because the data in the DOT may represent an aggregate of the requirements of a job as workers perform it at a number of different workplaces. Also, internet resources such as social media (example, Facebook) sites must not be used to resolve inconsistencies.

EXAMPLE: An applicant indicates on Form G-251 that their only work in the 15-year relevant period was in non-railroad employment as a truck driver from July 2004 until April 2008 and as a carpenter from May 2008 until their claimed disability began in February 2012. The applicant's claim is being adjudicated in June 2012.

The applicant's DEQY wage record shows that they received income exceeding the SGA level from:

> Freight Van Lines from 1997 until 2001,
>
> School District 1 from 1999 until 2002,
>
> World Truck Delivery from 2004 until 2008, and
>
> Home Remodelers, Inc. from 2008 through 2011.
>
> It also shows that the applicant received $5,615 in income from McDonalds in 2003. It does not show any income earned in 2012.

It is reasonable to conclude that the applicant claimed occupation as a truck driver from July 2004 until April 2008 was for World Truck Delivery and their claimed occupation as a carpenter from May 2008 until February 2012 was for Home Remodelers, Inc. Therefore, a material inconsistency does not exist regarding this work.

However, material inconsistencies exist regarding the SGA earnings for Freight Van Lines from 1997 until 2001 and School District 1 from 1999 until 2002 as well as the possible SGA earnings for McDonalds in 2003.

Since the applicant didn't provide occupational information on Form G-251 about work for those employers, reasonable development for this information is required before the case is authorized.

Regarding the work for McDonalds, documentation would be sufficiently developed if it is reasonably shown that the time frame which the applicant worked would likely represent SGA or not. If the average monthly earnings are reasonably shown to be SGA, then the documentation would also be sufficiently developed if the G-251 reasonably provides adequate information by which to make a PRW decision. (See DCM 10.4 for information regarding SGA.) In this example, we would need to know how long the applicant worked for McDonalds in 2003. If the applicant worked 7 months or fewer in 2003, the income is likely SGA (because SGA in 2003 was $800/month; $800 x 7 months = $5,600) and we would then need to consider the occupational information on Form G-251 to determine if that work could be considered PRW.

Lastly, unless there is evidence that the applicant may have worked in an occupation other than as a carpenter which may be considered PRW or for an

employer in 2012 other than Home Remodelers, Inc., there is no material inconsistency because it is clear that their occupation as a carpenter is considered PRW regardless of whether the 2012 earnings were posted to their wage record.

3.4.300 Review and Authorization of Disability Determinations

All disability determinations are required to go through the disability review process. This includes initial Occupational and T&P disability claims under the Railroad Retirement Act as well as disability freeze (DF) claims under the Social Security Act. Joint DF claims are reviewed and signed by staff at Great Lakes Program Service Center (PSC) of the Social Security Administration (SSA). This action satisfies the review requirement; therefore, these claims do no need to go through the DBD review process. In addition, continuing disability review (CDR) determinations in the Disability Benefits Division (DBD) and Reconsideration Section must be reviewed by a second individual before the determination is authorized and ultimately processed into the appropriate RRB systems. The authorization process is a team effort. Sometimes a reviewer may or may not agree with an adjudicating examiner's disability determination. In addition, although a reviewer may agree with an adjudicating examiner's disability determination, sometimes he/she may identify adjudicative issues which should be addressed by the adjudicating claims examiner before a disability determination is authorized and processed into a RRB system. After a disability claim has been submitted into the authorization process for review, adjudicating examiners and reviewers must be willing to listen and work together, when necessary, toward the goal of validating an accurate disability determination.

Instructions for handling disability claims authorization in the Reconsideration Section are found in DCM 7.1.5.

3.4.301 Guidelines For Preparing And Authorizing Disability Determinations

The adjudicating and reviewing examiners should use the following guidelines when preparing an award for authorization. These guidelines will aid in producing quality work and make it easier for the reviewer to authorize the award. In general, remember to examine the evidence, medical opinions, rationale, OLDDS screens, determination letters, and all other documentation for sufficiency and/or accuracy.

In no way do the following guidelines encompass all possible considerations when adjudicating or reviewing a disability determination. Specific issues include but are not limited to:

1. Documents

    - Are the application and ancillary documents properly signed?

    - In the situation of an occupational disability claim, has it been 30 days since Form G-251A was released?

- Have sufficient proofs been provided or ordered if there is an issue of annuity eligibility?

- Have all contract examinations and medical opinions been paid for or cancelled as appropriate?

- Have all forms or other permanent documentation been sufficiently completed to allow anyone reviewing the case in the future to reasonably understand the determination or actions taken?

- Have all documents, information, and correspondence produced for the public been written in a clear and easily understood manner following the guidelines in the Plain Writing Act of 2010?

2. Impairment severity

   - Is the impairment severe?

   - In the situation of an occupational disability claim, has the railroad medically disqualified the employee from performing his or her regular railroad occupation?

   - In the situation of a disabled widow claim, does the medical evidence sufficiently show that disability began before the end of the prescribed period? (DCM 3.7.6)

   - In the situation of a disabled child claim, does the medical evidence sufficiently show that disability began before he/she attained age 22?

3. Impairment duration

   - Will the impairment last a continuous period of at least 12 months or is it expected to result in death?

4. Work activity and earnings

   - In the situation of an occupational disability, has the correct job been selected as the regular railroad occupation? (DCM 3.2.2)

   - Has/Is the individual worked/working in compensated railroad service?
   - Has a DEQY or The Work Number (TWN) report been obtained and documented for each type of disability determination? (DCM 3.2.205)? (Prior to May 4, 2015, the paper DEQY printout was filed down on the right side of the claim folder. Effective May 4, 2015 and later, DEQY screens are electronically sent directly to Imaging). (Effective May 12, 2017, send copies of all TWN reports to Imaging using the G-180WC, Mainframe Screen

Capture. Has/Is the individual worked/working in substantial gainful activity (SGA)? (DCM 10.4)

- In the situation of a disabled child claim, does the evidence show that the disabling impairment has prevented SGA continuously since attaining age 22? If not, does the evidence show that the child was unable to engage in SGA for a continuous period of time of at least 12 months since attaining age 22, but by the time the determination is made, improvement occurred and is no longer disabled (i.e. closed period of disability)?

- Has/Is the individual worked/working in self-employment or employment outside of the railroad industry?

- Has/Is the individual worked/working for a family-owned, controlled or managed business, including a business operated, managed, or owned by him/herself, a family member, friend, or close associate, whether for pay or not, and without regard to how the business is organized (e.g. sole proprietorship, partnership, corporation, limited liability corporation (LLC), etc?

- In the situation of railroad employee claiming a disability, has/is the individual earned/earning income in excess of the applicable disability work deduction threshold after his/her alleged onset date and/or annuity beginning date?

- Are there any special circumstances which allow the individual to work despite the presence of an impairment(s) which could be disabling? (DCM 10.4.4 A, DCM 10.5.3)

- Has all past relevant work (PRW) been properly documented and considered in the disability determination? (DCM 3.4.206; DCM 5.2)

- Has evidence of a settlement, judgment, or jury verdict involving pay for time lost involving railroad service been sufficiently been developed?

- Is the employee insured for a disability freeze? (DCM 6.3.2)

5. Multiple impairments

   - Are multiple but unrelated severe impairments involved? (DCM 4.9.3 B)

   - What is the combined effect of multiple concurrent severe impairments?

   - What is the effect of multiple unrelated impairments which do not last for the same period of time?

6. Change in medical condition

- Has the medical condition significantly improved or worsened? Has it generally remained the same?

- Is the claimant's condition likely to improve but the evidence insufficient to establish that (s)he could be expected to return to work within 12 months of onset? (DCM 4.3.7)

7. Sufficiency of medical evidence and non-medical information

   - Does the medical documentation sufficiently and reasonably support the proposed disability determination?

   - Are there sufficient medical reports from or attributable to acceptable medical sources? (DCM 4.2)

   - Have all medical-related reports which reasonably support a disability determination from or attributable to unacceptable medical sources been given due consideration?

   - Has all non-medical information been given due consideration and does it reasonably support the disability determination being proposed?

8. Alleged limitations

   - Have pain, fatigue, credibility, and other related issues been considered?

   - Have activities of daily living been considered when necessary?

9. Residual Functional Capacity (RFC)

   - Does the RFC assessment appear reasonable based on the medical evidence and other related issues?

   - Have all medical source opinions regarding a claimant's ability to do work-related activities, ability to reason, or make occupational, personal, or social adjustments, despite the claimant's impairment(s), been considered based on the medical evidence and other related issues?

10. Sequential Evaluation

    - Was the correct sequential evaluation process followed according to the standards for the type of claim for initial benefits or CDR?

    - Has the Dictionary of Occupational Titles (DOT) been checked to find all PRW as it is commonly performed in the national economy? Have printouts of jobs in the DOT been placed in the claims folder?

11. Rationale

- Has the disability determination been sufficiently rationalized with the medical and non-medical evidence?
- Does it show the correct Listing, Medical-Vocational rule, Occupational Table rule, or Dictionary of Occupational Titles (DOT) reference? The DOT reference(s) should include the 9 digit DOT job number(s), as well as the job title(s) as it appears in the DOT.
- Was the actual onset date explained if the alleged date was not afforded to the claimant?
- Have special situations (e.g. unsuccessful work attempts (DCM 10.5.3), transferability (DCM 5.5), past education (DCM 5.4), past arduous labor (DCM 5.2.10), etc.) been sufficiently explained?
- Since this is a formal document, does it make sense and does it use appropriate language?
- Does it show the name and/or signature of the adjudicating examiners?

12. Onset and ending date

- Do all the factors previously listed support the proposed onset date?
- Has there been significant improvement in the disabling condition which clearly shows that disability lasted for a finite (closed) period of time?
- Does this disability determination invade a previously disability determination which cannot be reopened? (RCM 6.2)

13. Diary actions

- If appropriate, has the correct CDR diary been established, revised, and/or removed?

14. Determination letters

- Is the name and address on the letter correct?
- In the situation of disability denials based on lack of medical severity, are all sources of the medical evidence listed and the dates of the report shown?
- Are there any grammatical, typographical, or factual mistakes?
- Has SSA Publication 05-10058, *Your Right To Question The Decision Made On Your Claim*, been enclosed with the correct disability freeze letter in joint freeze cases?

15. REQUEST

- Are all entries on REQUEST, including the name and address and date last worked, accurate when the claim is being finalized?
- Are there any outstanding RASI call ups that would prevent the claim from being finalized properly?
- Has the case been dumped from RASI before OLDDS processes if a constructive award is required? (DCM 3.5.1; FOM1 1582.10.1)

16. OLDDS

- Is all the data shown and accurate, especially date of birth, date last worked, diagnostic code, and diagnoses in order from most to least severe correct?
- Are all important comments, such as settlements, terminally ill (TERI) or compassionate allowance (CAL) claims, LMO or Congressional interest, and changes in onset, shown in the Remarks section?

17. Medicare issues

- Has Form G-405 (RCM 11 G-405) been completed or the claim folder been sent to the Medicare Section when required?
- Has the correct Medicare effective date been calculated?
- Has the correct Medicare termination date been calculated? (Consider the difference when disability ceased because of significant medical improvement vs. substantial gainful activity (SGA).)

18. Miscellaneous Issues

- Has Form G-331, Trial Work Period and Earnings Breakdown Worksheet, been properly documented in the situation of an earnings CDR?
- Has the SSA examiner and physician/psychologist properly signed Form SSA-831 in joint freeze cases?
- Has USTAR been properly documented and/or closed out? (FOM1 15120.5)
- Is the claim folder being forwarded to the appropriate location or back to claims files after authorization?

3.4.302 Reviewing a Disability Determination and the Authorization Process

A. Definition

Authorization is the act to review and approve a disability determination which:

- Grants or denies an entitlement to an annuity, disability freeze (DF), or Medicare coverage based on disability; or

- May affect an active entitlement to an annuity, DF, or Medicare coverage based on disability. This decision is generally known as a continuing disability review (CDR).

B. Authorization Process

1. Submitting a Determination For Review

When a DBD adjudicating examiner completes a disability determination for initial entitlement for annuity, DF, Medicare, or CDR determination, the claim folder is logged into the T0RE AFCS location and then placed in the designated holding area. Each workday, designated DBD personnel collect the claim folders from the holding area, record certain information, log the claim folder into the T0RE AFCS location a second time, and distribute an equal number of claims to each reviewer.

NOTE: DBD-DPS claims examiners are the primary reviewers/authorizers. However, any senior examiner or supervisor in DBD, DBD Quality Analyst, and the Director of DBD can also review and authorize a disability determination.

2. Reviewing the Evidence

In general, a reviewer/authorizer is responsible for thoroughly examining all aspects of a proposed disability determination for sufficiency, accuracy, and content, including but not limited to: medical and non-medical evidence, all medical opinions, determination rationale, system entries, formal determination letters of notification, and any other forms and documentation relevant to the decision.

3. Authorizing a Disability Determination

NOTE: See DCM 3.4.303 for instructions about the reviewer return process if the reviewer/authorizer disagrees with the disability determination.

If the reviewer agrees with the disability determination, (s)he shall take the following actions to completely authorize a disability determination:

a. Approve all appropriate systems inputs, such as OLDDS (DCM 12.1.4), D-Brief (DCM 12.5.9), and CDR Call-Up Program (DCM 12.3), and verify that they processed correctly into the system;

b. Print the appropriate number of copies and release the formal disability determination notification letter(s) to the claimant/annuitant or rep payee:

- Two (2) copies of the appropriate RRB disability determination letter are printed. One (1) copy is released to the claimant/annuitant or rep payee. One (1) copy of Form AB-32 is also released when a disability freeze determination letter is released. (See DCM 3.4.301 B.3.d for instructions regarding the second copy.)

- Two (2) copies of Form SSA-810 or SSA-813.1 are printed if a joint freeze determination is completed. One (1) copy is released to the claimant/annuitant or rep payee with SSA Publication 05-10058, *Your Right to Question The Decision Made On Your Claim*. (See DCM 3.4.301 B.3.d for instructions regarding the second copy.)

NOTE: The adjudicating examiner and authorizer are each responsible to proofread the disability determination letter for correct name and address, content, spelling, and grammar before it is released to the claimant or rep payee.

EXCEPTION: DBD does not release a determination notification letter if the following claimants are rated disabled:

- A child previously rated disabled for Retirement purposes (i.e. DAC Conversion case; DCM 3.10.15) (Survivor Benefits Division notifies the child of annuity entitlement). Or

- Medicare-only claims filed by a widow(er), surviving divorced spouse, or remarried widow(er) who are age 60 or older and receiving an annuity. (DCM 3.7.7) (Medicare section notifies the annuitant that (s)he has been or will be enrolled in Medicare.)

c. Enter an appropriate CDR call up diary (DCM 8.5.2 and 8.5.3), if it is warranted, using the CDR call up program (DCM 12.3), and print one (1) copy;

   NOTE: Existing medical diary call ups in the CDR call up program should be deleted.

d. Take all appropriate actions to permanently document the disability determination and related information in the RRB Privacy Act Systems of Records. In general, this means that, where appropriate, documentation is permanently filed in the RRB claim folder and sent to imaging.

   - Print one (1) copy of the D-Brief G-325B or RRAILS G-325.1 rationale and place it on the left side of the claim folder. Any rationale must also be sent to imaging.

   - Either physically sign the G-325 OLDDS printouts in ink OR make copies of each OLDDS screen showing both the rating examiner's and

authorizer's name signifying that the determination was authorized. The G-325 OLDDS printouts should be placed above the G-325B or G-325.1 rationale on the left side of the claim folder.

- If a CDR call up diary was entered into the CDR call up program, place the printout on the left side of the claim folder with the G-325 OLDDS and rationale.

- If an earnings CDR was completed, place Form G-331, Trial Work Period and Earnings Breakdown Worksheet, on the left side of the claim folder with the G-325a OLDDS and rationale.

- Place the remaining copy of the formal RRB disability determination notification letter(s) on the right side of the claim folder (RCM 5.12.10). The file copy shall be placed above all evidence that was received prior to the approval of the determination. All evidence received subsequent to the release of the letter shall be placed above the letter. Any RRB disability determination letter must also be sent to imaging.

  COMMENT: When a joint freeze determination is completed, attach one (1) additional copy of the G-325.1 rationale to the remaining copy of either the SSA-810 or SSA-813.1 and release them to the Social Security Administration. Do not place a copy of either letter in the claim folder. However, the letter must be sent to imaging.

e. If the Medicare effective date is in the previous month, the current month, or any of the five months following the award, notify the Medicare Section of the Medicare entitlement by either sending the claim folder to the Medicare Section or notify them via Form G-405 (See RCM 11 G405), whichever is appropriate.

f. When all is complete, the claim folder is forwarded to the appropriate section for additional actions or returned the claims files, whichever is appropriate.

3.4.303 Reviewer Return Process

If a reviewer disagrees with the disability determination or identifies adjudicative issues which should be addressed by the adjudicating examiner before a disability determination is authorized, follow the process in this section.

The adjudicating examiner, reviewer, and, when necessary, senior examiners and DBD management must handle disagreements with high priority. Adjudicating examiners and reviewers should review write-ups and take action within one business day of receipt. Senior examiners will review write-ups within a reasonable amount of time.

The procedure set forth below should be followed in most situations. However, it is acknowledged that highly unusual situations may occur which may result in a deviation

of this prescribed procedure. Regardless, a disputed disability determination should not be authorized until the adjudicating examiner, reviewer, and when necessary, the DBD-DIS and DBD-DPS senior examiners have made reasonable efforts to come to a mutual agreement.

NOTE: Reviewers, adjudicating examiners, and senior examiners are reminded that AFCS locations must show the accurate folder location during the review process.

3.4.303.1 General Information

Information in this section is applicable to claims adjudicated in either DBD-DIS or DBD-DPS.

A. Reviewer Actions

A reviewer is not required to authorize a disability determination if (s)he:

- Disagrees with that determination and can provide a reasonable explanation why it should not be authorized, or
- Identifies adjudicative issues which should be addressed by the adjudicating examiner before a disability determination is authorized.

B. Resolutions of Disagreements

The adjudicating examiner and reviewer may decide to try to informally resolve any minor adjudicative issue(s)/disagreement(s) in the same business day. If a minor issue(s)/disagreement(s) can be resolved in the same business day, Form G-383 does not need to be completed.

If a disagreement between the reviewer and adjudicating examiner cannot be informally reached or if the adjudicative issue(s) is generally more than minor, the reviewer shall complete "Authorizer Comments" section on Form G-383 (DCM 11 G-383) to formally identify adjudicative actions that may be incorrect, inconsistent, or incomplete with current procedure or provide reasons why authorizer disagrees with the proposed disability rating or continuing disability determination. The reviewer will then log the claim folder into the AFCS location of the adjudicating examiner and return it back to him/her.

3.4.303.2 Adjudicating Examiner Agrees With Reviewer Comments

A. Disability Determination Adjudicated in DBD-DIS

1. All minor changes should be completed within one business day of receipt.
2. If development actions need to be initiated, they should be initiated on or the next business day that the case is returned.

3. If the adjudicating examiner needs to consult with his/her senior claims examiner, the consultation should be initiated within one business day of receipt.

4. When the adjudicating examiner completes all necessary changes, he/she shall return the claim folder to the reviewer.

   - If Form G-383 was not completed to address a minor adjudicative issue, the adjudicating examiner may return the claim folder directly to the reviewer.

   - If a G-383 was completed, the claim folder should be placed into the designated area near the DBD-DPS senior claims examiners. The DBD-DPS senior claims examiners will then distribute the claim folder back to the reviewer.

   - Regardless, the adjudicating examiner should ensure that the claim folder is logged into the T0RE AFCS location before moving it. (The DBD-DPS senior claims examiner will keep the claim folder logged into the T0RE AFCS location when distributing it back to the reviewer.)

NOTE: If the original reviewer can no longer authorize the determination, the adjudicating examiner shall give the claim folder to the DBD-DPS senior examiner, who will then distribute it to a new reviewer.

B. Disability Determination Adjudicated in DBD-DPS

1. All minor changes should be completed within one business day of receipt.

2. If development actions need to be initiated, they should be initiated on or the next business day that the case is returned.

3. If the adjudicating examiner wants to briefly consult with his/her senior claims examiner, the consultation should be initiated within one business day of receipt.

4. When the adjudicating examiner completes all necessary corrections, he/she shall log the claim folder into the T0RE AFCS location and return it directly to the reviewer.

NOTE: If the original reviewer can no longer authorize the determination, the adjudicating examiner shall give the claim folder to the DBD-DPS senior examiner, who will then distribute it to a new reviewer.

3.4.303.3 Adjudicating Examiner Disagrees With Reviewer Comments

NOTE: Under no circumstance should the adjudicating examiner reinitiate the authorization process by resubmitting the claim folder, as described in DCM 3.4.302 B, or obtain another opinion by asking a different DBD-DPS claims examiner to review it.

A. Disability Determination Adjudicated in DBD-DIS

1. The adjudicating examiner must write a detailed rebuttal of the reviewer's comments in the "Examiner Comments" section on Form G-383 and attach it to the claim folder. The claim folder should then be logged to their assigned DBD-DIS senior examiner's AFCS location and placed in his/her cubicle.

2. The DBD-DIS senior examiner will review the comments from the reviewer and adjudicating examiner as well as the contents of the entire claim folder.

IF…	THEN…
DBD-DIS senior examiner agrees with the reviewer	The DBD-DIS senior examiner shall: • Complete the "Senior (Initial) Examiner Comments" section in writing on Form G-383 with instructions on how the adjudicating examiner should proceed with the claim. • Log the claim folder into the adjudicating examiner's AFCS location and return it directly to him/her. After the changes are completed, the adjudicating examiner will log the claim folder into the T0RE AFCS location and place it into the designated area near the DBD-DPS senior claims examiners. The DBD-DPS senior claims examiners will return the claim folder back to the reviewer to authorize the decision. (The claim folder shall remain logged into the T0RE AFCS location.)
DBD-DIS senior examiner agrees with the adjudicating examiner	The DBD-DIS senior examiner shall: • Complete the "Senior (Initial) Examiner Comments" section in writing on Form G-383 by explaining their reason(s) for agreeing with the actions taken by the adjudicating examiner. • Log the claim folder into the AFCS location of the DBD-DPS senior examiner that the reviewer is assigned to and place it in the DBD-DPS senior examiner's cubicle. The DBD-DPS senior examiner shall:

- Review the comments from the DBD-DIS senior examiner, reviewer, and adjudicating examiner as well as the contents of the entire claim folder.

IF…	THEN…
DBD-DPS senior examiner agrees with the DBD-DIS senior examiner	The DBD-DPS senior examiner shall: • Complete the “Senior (Post) Examiner Comments” section of Form G-383 explaining the reason(s) for agreeing with the opinion of the DBD-DIS senior examiner and actions taken by the adjudicating examiner. • Log the claim folder into the T0RE AFCS location and return it directly to the reviewer. • If the reviewer continues to disagree with the disability determination, (s)he will log the claim folder back into the to the DBD-DPS senior examiner’s AFCS location and return it directly to him/her. In this situation, the DBD-DPS senior examiner will be responsible for authorizing the disability determination as shown in DCM 3.4.302. If the reviewer agrees with the disability determination, the reviewer will authorize the disability determination as shown in DCM 3.4.302.
DBD-DPS senior examiner disagrees with the DBD-DIS senior examiner	The DBD-DPS senor examiner shall: • Complete the “Senior (Post) Examiner Comments” section of Form G-383 explaining the reason(s) for disagreeing with the opinion of the DBD-DIS senior examiner and actions taken by the adjudicating examiner.

- Log the claim folder back into the DBD-DIS senior examiner's AFCS location and return it directly to him/her.

- Both senior examiners will confer to resolve the disagreement and may consult with the DBD-DIS and DBD-DPS supervisors if necessary.

- If after conferring the DBD-DIS and DBD-DPS senior examiners agree with each other, the DBD-DIS senior examiner will log the claim folder to either:

  - The adjudicating examiner's AFCS location (for any necessary changes) and return it directly to him/her,

    Or

  - The T0RE AFCS location and return it directly to reviewer.

    After the changes are completed, the adjudicating examiner will log the claim folder into the T0RE AFCS location and place it into the designated area near the DBD-DPS senior claims examiners. The DBD-DPS senior claims examiner will then return it back to the reviewer to authorize the decision. (The claim folder shall remain logged into the T0RE AFCS location.)

    If the reviewer continues to disagree with the disability determination, (s)he will log the claim folder back into the to the DBD-DPS senior examiner AFCS location and return it directly to him/her. In this situation, the

		DBD-DPS senior examiner will be responsible for authorizing the disability determination as shown in DCM 3.4.302. If the reviewer agrees with the disability determination, the reviewer will authorize the disability determination as shown in DCM 3.4.302. • If the DBD-DIS and DBD-DPS senior examiners continue to disagree with each other, the DBD-DIS senior examiner will be responsible for authorizing the disability determination as shown in DCM 3.4.302.

NOTE: If the original reviewer can no longer authorize the determination, the adjudicating examiner shall give the claim folder to the DBD-DPS senior examiner, who will then distribute it to a new reviewer.

B. Disability Determination Adjudicated in DBD-DPS

1. The adjudicating examiner must write a detailed rebuttal of the reviewer's comments in the "Examiner Comments" section on Form G-383 and attach it to the claim folder. The claim folder should then be logged into their assigned senior examiner's AFCS location and place in his/her cubicle.

2. The senior examiner will review the comments from the reviewer and adjudicating examiner as well as the contents of the entire claim folder.

DBD-DPS senior examiner agrees with the reviewer	The DBD-DPS senior examiner shall: • Complete the "Senior (Post) Examiner Comments" section in writing on Form G-383 with instructions on how the adjudicating examiner should proceed with the claim. • Log the claim folder into the adjudicating examiner's AFCS location and return it directly to him/her. After the corrective actions are completed, the adjudicating examiner will log the case into the T0RE

	AFCS location and return the claim folder directly to the reviewer.
DBD-DPS senior examiner agrees with the adjudicating examiner	The DBD-DPS senior examiner shall: • Complete the "Senior (Post) Examiner Comments" section in writing on Form G-383 by explaining their reason(s) for agreeing with the actions taken by the adjudicating examiner. • Log the claim folder into the T0RE AFCS location and return it directly to the reviewer. • If the reviewer continues to disagree with the disability determination, (s)he will log the claim folder back into the to the DBD-DPS senior examiner's AFCS location and return it directly to him/her. In this situation, the DBD-DPS senior examiner will be responsible for authorizing the disability determination as shown in DCM 3.4.302. • If the reviewer agrees with the disability determination, the reviewer will authorize the disability determination as shown in DCM 3.4.302.

NOTE: If the original reviewer can no longer authorize the determination, the adjudicating examiner shall give the claim folder to the DBD-DPS senior examiner who will then distribute it to a new reviewer.

3.4.400 Special Circumstances Affecting Some Former Employees of the Long Island Rail Road

In 2008, the New York Times published a series of articles that drew attention to the high percentage of Long Island Rail Road (LIRR) employees filing for and receiving occupational disability annuities from the Railroad Retirement Board (RRB). The United States Attorney for the Southern District of New York and the RRB's Office of Inspector General (OIG) began an investigation which resulted in:

- **Indictments and Convictions** against a number of RRB annuitants and certain doctors who provided medical evidence in support of disability claims; and

- A **Voluntary Disclosure and Disposition Program** (VDDP) for certain disability annuitants offered by the United States Attorney.

In response to the outcome of the government's case against the doctors, the RRB issued:

- B**oard Order (BO) 13-33**, *Termination of Disability Annuities Awarded Based on Medical Evidence from Dr. Peter Ajemian*, **dated June 27, 2013; and**

- **Board Order (BO) 13-55,** *Termination of Disability Annuities Awarded Based on Medical Evidence from Dr. Peter Lesniewski*, **dated September 30, 2013**.

These Board Orders documented the handling of disability annuities paid under the Railroad Retirement Act (RRA) where the decision that the applicant is disabled was based in whole or in part upon medical evidence furnished by Dr. Peter Ajemian or Dr. Peter Lesniewski.

3.4.401 Guidance

Because of the unique circumstances presented by indictments, convictions, VDDP and Board Orders, Policy and Systems has released multiple Informational Bulletins (IB) and Instructional Memoranda (IM) which may have answered your questions.

Any additional questions that were not answered in these IBs and IMs regarding the Board Orders, the VDDP, or Department of Justice (DOJ) cases are to be forwarded to **Policy and Systems – RAC using the P&S Inquiry Group Mailbox**. Use a subject heading such as “Board Order 13-33 Inquiry”, or “Board Order 13-55 Inquiry”, or “LIRR VDDP Case”, or “LIRR DOJ Case” in the subject line.

3.5 Miscellaneous

3.5.1 Constructive Award To Disability Annuitant Due To Work Deductions

A disability annuitant working in non RR employment and earning over the current monthly disability earnings limit per month after deduction of disability related work expenses (refer to the chart in FOM 1125.5.2 for the monthly and annual earnings limits) may require a constructive award if no annuity is payable due to work deductions at the time the case is rated. (A constructive award is used to officially calculate the annuity rate when no award is being vouchered.)

Field offices have been instructed to enter a MAN OP code on request when the applicant is continuing in LPE and is expected to have excess earnings (over the current monthly disability earnings limit per month after deduction of disability related work expenses) after the ABD. If the field office fails to enter a code or if it is later discovered, prior to payment, that there may be excess earnings after the ABD, the case should be dumped from RASI and the following actions taken:

- Use a G-357 (and any other necessary award forms) coded as an OPO initial code 7. (See G-357 instructions in RCM 8.6) to make a constructive award. Use code 2 in item 16(F) so that EE receives G-19L (Annual Earnings Questionnaire for

Annuitants in Last Person Service) next year. Also, complete suspension code in item 80 with "09" (Employee disability annuitant earned over the current monthly disability earnings limit in a month).

- Complete award forms. (Calculate rates with LPE work deductions if the annuitant is in LPE). Since this will not be vouchered, send original to: "Research - statistical services."
- Use regular award letter containing usual appeal rights to inform EE of rates. Tell him/her to advise us if he/she earns less than the current monthly disability earnings limit (refer to the chart in FOM 1125.5.2 for the monthly and annual earnings limits) per month so we can reinstate his/her annuity.

3.6 Sequential Evaluation

3.6.1 The Sequential Evaluation Process For Total and Permanent Disability Determinations

In order to determine whether a claimant is totally and permanently disabled the evaluation of disability claims requires following a sequential evaluation process. This process is used by the Railroad Retirement Board and is explained in RRB regulation 20 CFR Section 220.100. An equivalent process is used by the Social Security Administration and is explained in SSA Regulations 20 CFR Section 404.1520.

The process consists of five (5) evaluation steps and questions. The answer to a question in each evaluation step determines whether the next question in the next step should be considered. When a decision that an individual is or is not disabled can be made at any step, evaluation under a subsequent step is unnecessary.

The total and permanent sequential evaluation process is as follows:

STEP	QUESTION	DECISION
1	Is the individual engaging in substantial gainful activity (SGA)? (DCM 10.4; DCM 10.5.3) **NOTE 1:** Obtain a SSA wage record (DEQY) and/or TWN when a claim is initially developed. (DCM 3.4.205) **NOTE 2:** When an individual is actually engaging in SGA or did so during any pertinent period so that the 12-month duration requirement cannot be met, and there is no	**YES**. Deny the claim. The individual is not totally and permanently disabled. **NO**. Go to Step 2.

	possibility that a determination of disability can be established, a finding must be made that the individual is not disabled. No consideration of either medical or vocational factors is needed. **Note 3:** If you notice any suspicious patterns, inconsistencies or suspect fraud, please refer to DCM 8.8.2, Investigation and Source of Evidence. For examples of fraud, click here Red Flags of Fraud.	
2	Does the individual have a severe medically determinable physical or mental impairment (or combination of impairments)? (DCM 4.8.3; DCM 5.1.4) **NOTE 1:** A severe impairment is an impairment which significantly limits the capacity to perform basic work activities. **NOTE 2:** The combination of impairments must exist concurrently. **NOTE 3:** If you notice any suspicious patterns, inconsistencies or suspect fraud, please refer to DCM 8.8.2, Investigation and Source of Evidence. For examples of fraud, click here Red Flags of Fraud.	**YES**. Go to Step 3. **NO**. Deny the claim. The individual is not totally and permanently disabled.
3	Does the individual have an impairment (or combination of concurrent impairments) which is medically disabling? (DCM 4.12) **NOTE 1:** The impairment (or combination of concurrent	**YES**. Allow the claim. The individual is totally and permanently disabled. **NO**. Obtain a residual functional capacity (RFC) assessment. (DCM 4.11; DCM 5.1.5) Go to Step 4.

	impairments) MUST meet the duration requirement. (DCM 4.9.3) **NOTE 2:** If you notice any suspicious patterns, inconsistencies or suspect fraud, please refer to DCM 8.8.2, Investigation and Source of Evidence. For examples of fraud, click here Red Flags of Fraud.	
4a	Does the individual have the physical and /or mental residual functional capacity (RFC) to perform past relevant work (PRW) as (s)he described the work in the vocational profile? (RFC: DCM 4.7.3; DCM 4.11; DCM 5.1.5) (PRW: DCM 5.2; DCM 5.2.3 A) **NOTE 1:** PRW is SGA performed within the 15 year relevant period and of sufficient duration for the individual to have acquired the information, learned the techniques, and developed the facilities needed for average performance of the occupation. **NOTE 2:** The individual's age and past education ARE NOT considered at this step. **NOTE 3:** Non-severe impairments can be combined with severe impairments in an RFC assessment. **NOTE 4:** If you notice any suspicious patterns, inconsistencies or suspect fraud, please refer to DCM 8.8.2, Investigation and Source of Evidence. For examples of fraud, click here Red Flags of Fraud .	**YES**. Deny the claim. The individual is not totally and permanently disabled. **NO**. Go to Step 4b.
4b	Does the individual have the RFC to perform PRW as it is generally ordinarily performed in the national economy?	**YES**. Deny the claim. The individual is not totally and permanently disabled.

	(RFC: DCM 4.7.3; DCM 4.11; DCM 5.1.5) (PRW: DCM 5.2; DCM 5.2.3 B) **NOTE 1:** The individual's age and past education ARE NOT considered at this step. **NOTE 2:** After determining which jobs are PRW, locate the occupational counterparts for those jobs in OccuBrowse. If there is no occupational counterpart in OccuBrowse for a job considered to be PRW, it is not possible to evaluate that PRW. **NOTE 3:** If you notice any suspicious patterns, inconsistencies or suspect fraud, please refer to DCM 8.8.2, Investigation and Source of Evidence. For examples of fraud, click here Red Flags of Fraud.	**NO**. Go to Step 5.
5	Does the individual have the RFC to perform any other work? (RFC: DCM 4.7.3; DCM 4.11; DCM 5.1.5) (Med-Voc Rules: DCM 5.6) (Age Considerations: DCM 5.3) (Educational Considerations: DCM 5.4) (Transferability: DCM 5.5) **NOTE 1:** "Other work" is SGA which exists in the national economy. **NOTE 2:** The claimant's age, past education, and transferability of work skills ARE considered at this step.	**YES**. Deny the claim. The individual is not totally and permanently disabled. **NO**. Allow the claim. The individual is totally and permanently disabled.

	NOTE 3: The following additional vocational adversities ARE also considered at this step: borderline age issues (DCM 5.3.6; DCM 5.6.6); arduous unskilled physical labor (DCM 5.2.10); isolated work industry, lifetime commitment to a field of work, or no work experience (DCM 5.2.11). **NOTE 4:** If you notice any suspicious patterns, inconsistencies or suspect fraud, please refer to DCM 8.8.2, Investigation and Source of Evidence. For examples of fraud, click here Red Flags of Fraud.	

A Total and Permanent Sequential Evaluation illustrative chart has been placed in DCM 3, Appendix E. This chart should be used as a reference tool in daily case adjudication.

Evaluation of disability claims to determine whether a claimant is occupationally disabled follows the sequential evaluation process described from DCM 13.3 through DCM 13.10. This process is explained in RRB regulation 20 CFR section 220.13.

3.7 Disabled Widow(er)'s Insurance Annuity

3.7.1 General Information

A disabled widow(er)'s insurance annuity (DWIA) may be paid to a widow(er) who has attained age 50 but has not attained age 60 and is totally and permanently disabled for any regular employment. A DWIA is entitled to a 100% share of the employee's Primary Insurance Amount (PIA) or Social Security Act (SS Act) maximum, whichever is applicable. This 100% share is reduced for the number of months the widow(er) is under age 65 on the entitlement date.

For information about the definition of a legal widow(er), de facto widow(er), etc, or procedure for determining windfall dual benefit entitlement, refer to instruction in the Retirement Claims Manual (RCM) - Chapter 2.1.

3.7.2 Definition Of Disability

A widow(er) meets the definition of disability if his or her physical or mental condition is such that he/she is unable to engage in any regular employment. The term "physical or mental condition" means an impairment that can be expected to result in death, or has

either lasted at least 12 months, or can be expected to last for a continuous period of not less than 12 months.

To be considered permanently disabled, the widow(er) must be unable to regularly perform substantial and material duties of any gainful employment (which is substantial and not trifling).

Both medical and non-medical factors are considered in determining whether a widow(er) meets the above definition. This is consistent with the definition of disability used for total and permanent employee disability determinations

3.7.3 Eligibility Requirements

In addition to being the legal or defacto widow(er) (see RCM 2.1.2 and 2.1.3) of a completely insured employee, the applicant must meet the following requirements:

A. Age Requirements - The widow(er) must have attained age 50 or will attain age 50 within 3 months of filing the application but not have attained age 60. (However, a widow(er) who has already attained age 60 can qualify for a DWIA for the month(s) he/she is under age 60 in the retroactive period.)

B. Marriage Requirements - The widow(er) must meet the nine-month marriage requirement or the deeming nine-month marriage provision for a regular widow(er)'s insurance annuity (WIA) as explained in RCM 2.1.20.

C. Disability Requirements - To be disabled, the widow(er) must have a permanent physical or mental impairment that begins before the end of the "prescribed period" of onset and is such as to be disabling for work in any regular employment. (See DCM 3.7.2 for complete definition of disability.)

D. One-Half Support - A widower must have been receiving one-half of his support from the employee at the time of her death or at the time her retirement annuity began for the annuity to begin before March 1, 1977; after March 1, 1977 a widower does not have to prove half-support except for payment of a windfall or employee annuity restored amount. There is no time limit for filing proof of one-half support.

3.7.4 Filing

To be entitled to a DWIA the applicant must:

- meet the eligibility requirements outlined in DCM 3.7.3.
- file an application (AA-17 and AA-17b).

3.7.5 Eligibility When Employee Had Less Than 120 Months Of Service

A. No One on Rolls When DWIA Application Filed - If the employee did not have 120 months of service and no member of the family group is on the rolls continuously from October 30, 1951, the widow(er) is not eligible for an annuity under the RR Act. (On the rolls includes the retroactive period of a new application.) In such cases, transfer the claim to SSA.

B. Family Members on Rolls When DWIA Application Filed - If a member of the family group has been on the rolls continuously from October 30, 1951, send the case to SAPT.

NOTE: See RCM 5.5 for provisions governing deemed current connection for survivor purposes.

3.7.6 Determining "Prescribed Period" Of Disability For DWIA

In order for a disabled widow(er), age 50 to 59, to qualify for a DWIA, the disability must have begun before the end of the "prescribed period."

A. When Period Begins - The widow(er)'s prescribed period of disability onset begins with the latest of the following:

- The month the employee died; or
- The last month for which he/she was entitled to a Widow(er) Current Insurance Annuity (WICA) based on the same employee's earnings record; or
- The last month for which he/she was previously entitled to a DWIA.

B. When Period Ends - The widow(er)'s prescribed period of disability ends with the earliest of the following:

- The month before the month the widow(er) attains age 60; or
- The close of the 84th month (7 years) following the month in which the period began.

EXAMPLE 1: The employee died August 14, 1984 when the widow was 51 years old. The prescribed period begins August 1984 (the month the employee died) and ends August 31, 1991 (the close of the 84th month following the month the period began). She qualifies if her disability began any time before September 1, 1991.

EXAMPLE 2: The widow age 40 became entitled to a WCIA when the employee died in March 1972. Her last child attained age 18 in July 1980. Her prescribed period begins June 1980 (the last month of entitlement to a (WCIA) and ends June 30, 1987 (the close of the 84th month following the month in which the

period began). She could qualify for an annuity effective February 1, 1988 if her disability began before July 1, 1987 and she is still under a disability on February 1, 1988.

It is not necessary for the precise date of onset to be established in many cases involving disabled widow(er)s since the claimant need only to have become disabled before the end of the prescribed period. However, if the widow(er)'s disability did not begin before the end of the prescribed period, he/she is not eligible for an annuity as a disabled widow(er), but he/she may qualify at age 60 for a regular WIA.

NOTE: If the widow(er) claims an onset date of disability that is after the "prescribed period" ending date (consider the dates in items 8 and 12 of the AA-17b), do not schedule any medical examinations or ancillary tests. Review any medical evidence of record submitted and the earnings record to determine if a disability onset date could be prior to the end of the prescribed period. Go ahead and deny the DWIA application on the grounds that the onset of disability is not within the "prescribed period."

3.7.7 Widow(er) Medicare Only Applications

A widow(er) who is otherwise ineligible for regular DWIA benefits can file for Medicare only coverage. Usually, a Medicare only claim is filed by a widow(er) alleging total disability in the following situations:

- The widow(er) is receiving an annuity (WCIA) based on having a child in his/her care; or
- The widow(er) is receiving an annuity (WIA) based on age 60 and older; or
- The widow(er) files a claim for a regular DWIA and onset cannot be established prior to age 59 and 7 months but there is a possibility of extending the prescribed period beyond age 60.

As in regular DWIA claims an exact date of disability onset is not always material as long as the established onset date is before the end of the prescribed period. Any onset date established on or before the end of the prescribed period results in a favorable determination for the annuitant (except as specified below in the last bulleted point).

Factors to consider when determining the Medicare onset date include the following:

- The beginning date of the prescribed period, which is established by following the guidelines for regular DWIA claims.
- The ending date of the prescribed period, which is the earlier of the following:
  - The month before the month in which the widow(er) attains age 65; or

- The close of the eighty-fourth month (7 years) following the month in which the prescribed period began.

- The month the widow(er) attains age 60 can be important because at age 60 the widow(er) is eligible to receive an aged widow(er)s annuity. The 5 month waiting period requirement can be satisfied before the first month of entitlement to a WIA if disability can be established on or before age 59 and 7 months.

- Although the prescribed period in Medicare only claims extends to the attainment of age 65, it is not necessary to consider an onset after age 62 years and 7 months, as any date after this would be within 29 months (the combined waiting period) of attainment of age 65. There is no advantage in a disability decision in this situation, and therefore, any Medicare Only application where the onset date is after the widow(er) reaches the age of 62 years and 7 months should be considered a technical denial.

3.7.8 Beginning Date

A DWIA begins on the latest of the following dates:

- The first day of the month of the employee's death; or

- The first day of the month in which the widow(er) attained age 50 and is under a disability; or

- The first day of the month in which the widow(er) is under a disability and has attained age 50 but has not attained age 60; or

- The first day of the first month for which the widow(er) is no longer eligible for a WCIA because he/she no longer has an eligible child in his/her care, providing he/she meets the age and disability requirements for a DWIA; or

- The first day of the 12th month before the month the application is filed; or

- The day designated by the widow(er) as the original beginning date (OBD); or

- February 1, 1968 for widows and dependent widowers; or

- March 1, 1977 for non-dependents widowers; or

- The first day of the sixth month after the month in which the RR Act disability onset occurs unless a waiting period is not required. This waiting period applies to applications filed September 1, 1983 and later. If a widow(er) is re-entitled before age 60 and within 84 months of the termination of a provisions disability annuity, no waiting period is required.

3.7.9 Disability And Medicare Waiting Period

Under the Railroad Retirement Act (RR Act), a disabled widow(er)'s annuity cannot begin until 5 full months have elapsed from the onset date of disability, and Medicare eligibility cannot begin until after 24 months of annuity entitlement have elapsed.

The Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, provides that prior entitlement months to Supplemental Security Income (SSI) under Title XVI of the Social Security Act or federally administered State Supplementary Payments (SSP) can be used to satisfy the 5-month waiting period for annuity entitlement and the 24-month qualifying period for Medicare for disabled widow(er)s and disabled surviving divorced spouses.

The same months of SSI/SSP which are credited toward the 5-month waiting period for widow(er)'s disability benefits may also be credited toward the 24-month qualifying period for Medicare.

Medicare coverage can begin the later of:

- the 25th month of entitlement to Railroad Retirement Benefits while under a disability.
- the 30th month after the disability began.

However, the earliest possible original beginning date or Medicare entitlement date for a widow(er) based on this provision is January 1, 1991.

EXAMPLE: A widow files a disability application in January 1991. Her disability onset is established as June 1, 1989, based on medical/vocational criteria. She received SSI/SSP from June 1989 through December 1990 (19 months). Considering her entitlement to SSI/SSP, her original beginning date would be January 1, 1991, since the 5-month waiting period based on the SSI/SSP entitlement ended before January 1, 1991. Her Medicare effective Date would be June 1, 1991, which is the regular Medicare effective date of January 1, 1993 (the 25th month of annuity entitlement), minus the 19 months of SSI/SSP.

3.7.10 Earnings Restrictions

A. Widow(er) under age 60 - The annual earnings test does not apply to a disabled widow(er) under age 60. However, any work performed before age 60 must be considered in determining whether the widow(er) has recovered from the disability. The work and earnings may demonstrate that the widow(er) is able to perform regular and gainful employment and, therefore, is no longer disabled for purposes of receiving a DWIA and/or early Medicare coverage. Work for a railroad (RR) employer during any month, of course, precludes payment of the annuity for that month.

As soon as the widow(er) reports that he/she is working, refer the case to the Disability Post and Continuing Disability Reviews (CDR) Section for a determination of whether or not he/she has recovered from the disability on which the DWIA and/or Medicare is based.

B. Widow(er) Age 60 and Over - A widow or widower who was receiving a DWIA prior to age 60 will continue to receive an annuity after age 60 but the DWIA will have been transformed into an age annuity. Therefore, regular survivor earnings restrictions apply beginning with the month the widow(er) attains age 60 and ending with the month before attainment of age 70 (effective January 1, 1983 or later). Work for an RR employer during any month precludes payments of the annuity for that month.

All earnings in the year of attainment of age 60 should be considered in determining excess earnings for that year. However, do not assess work deductions before January 1, 1975 in a case where a disabled widow(er) was between ages 60 and 65 at that time.

If the file indicates that the disabled widow(er) was told by the board that the annual earnings test did not apply to him/her until age 65, refer the case to BDMO/CPPS before charging work deductions to any month before age 65.

NOTE: Work or earnings may affect a widow(er)'s entitlement to early Medicare based on disability. Therefore after applying regular survivor work deductions, if applicable, refer the case to DPS - Post and CDR section for a determination of whether or not he/she has recovered from the disability on which the Medicare entitlement is based.

3.7.11 Disabled Widow(er) Previously Awarded Lump-Sum Death Payment (LSDP) Or Residual Lump-Sum (RLS)

A. LSDP Previously Paid - If the widow(er) previously received the LSDP and subsequently filed for a DWIA claiming to be disabled as of the month of the employee's death or earlier, the LSDP is erroneous if he/she is found to be disabled from the date claimed and no waiting period was required, i.e., the application was filed before September 1, 1983. In this situation, the date of disability onset and not the annuity beginning date (ABD) is the determining factor in deciding whether or not LSDP was erroneous.

EXAMPLE: The employee died on April 10, 1968 survived by a widow age 52. She filed for the LSDP on April 16, 1968 without claiming to be disabled and was awarded payment. On June 24, 1969, she filed for a DWIA claiming disability onset prior to the employee's death. Her "prescribed period" began April 1, 1968 and she was found to be disabled as of that date. Her ABD is June 1, 1968, but since her disability onset was April 1968, the LSDP was erroneous and must be recovered.

If the LSDP is determined to be erroneous, consider the possibility of payment of a deferred LSDP. See RCM 2.2.40 for more details concerning payment of a deferred LSDP in the cases.

If the widow(er) claims he/she became disabled after the month of the employee's death, do not presume that he/she was disabled in the month the employee died unless the medical evidence clearly shows that he/she was. When the medical evidence does show that he/she was disabled in the month of the employee's death instead of the month he/she claimed, refer the case to SAPT.

B. RLS Previously Awarded - If the widow(er) previously elected and was paid the RLS, he/she cannot receive a DWIA. Do not develop any medical evidence. Just go ahead and technically deny the widow(er)'s claim for a DWIA.

3.7.12 When Entitlement to A DWIA Ends

A DWIA terminates with the month before the month in which the widow(er):

- Dies;
- Remarries, however, if remarriage occurred January 1, 1984 or later, the disabled widow may be entitled to a remarried DWIA; or
- Attains age 60. Technically, a DWIA terminates when the widow(er) attains age 60; however, do not take any action to convert RRB records from a DWIA to a WIA. The widow(er) continues on the rolls as a disabled widow(er) as long as he/she continues to be entitled under the application on which the DWIA was awarded, and the award form symbol remains "R".

Also, a DWIA terminates with the second month following the month in which the widow(er) recovers from disability. However, the annuity continues if he/she attains age 60 on or before the last day of the third month following the month in which he/she ceased to be disabled.

3.7.13 When Entitlement To A Vested Dual Benefit Ends

The terminating events for vested dual benefit entitlement described in RCM 2.1.67 also apply to disabled widow(er)s. In addition, VDB entitlement ends with the second month following the month in which the widow(er) recovers from disability unless the annuity continues because he/she attained age 60 on or before the last day of the month following the month in which he/she ceased to be disabled. In this case, VDB entitlement would terminate only if he/she was entitled to Disability Insurance Benefit (DIB) at SSA which also was terminated and no entitlement to a Retirement Insurance Benefit (RIB) exists. Vested dual benefit entitlement would end on the earlier of the termination of the DIB or the DWIA.

3.7.14 Re-entitlement After Former Disability Ceases

A widow(er) can be re-entitled to a DWIA if he/she again becomes disabled after the former DWIA terminated because he/she ceased to be disabled.

A. Requirements for Re-entitlement - Such a widow(er), if he/she is otherwise qualified, can become re-entitled if he/she:

1. files a new application for a DWIA; and

2. has not attained age 60; and

3. is under a disability (as defined in DCM 3.7.2) that began before the end of the last month of the "prescribed period" which begins with the last month of previous entitlement to a DWIA and ends with the earliest of the following:

   - The month before the month in which he/she attains age 60; or

   - The close of the 84th month following the last month of previous entitlement to the former DWIA.

   NOTE: A widow(er) who is re-entitled within 84 months (or before age sixty) of a previous disability termination, is not required to serve a 5 month waiting period.

B. Date Payment Can Begin - The current DWIA is payable beginning on the first day of the month in which he/she is again under a disability or the first day of the 12th month before the month the application is filed, whichever is later.

C. Original Beginning Date - Although payment of the current DWIA is restricted to the dates mentioned above, continue to show the same original beginning date as before on the award form.

3.7.15 Evidence Requirements

Application: Always. SSA's survivor applications are also acceptable (see RCM 5.1.5). An application filed with the Veterans Administration (VA) by a widow(er) who is a survivor of a member or former member of the uniformed services is also an application for corresponding survivor benefits under the SS Act. If that application is transferred to RRB by SSA, consider it as claims lead (see RCM 5.1.5).

AA-17b, Supplement to application: Always

Field Office Personal Observation Record (G-626A): Always

Vocational Data (G-251): Always

Death of Employee: Always

Age of Widow(er): Always

Marriage: Always

Compensation: Always

Amount of SSA Benefits: Always

Proof of One-Half Support of Widower (G-134): Always, if dependency is claimed and:

- ABD could be before March 1, 1977; or
- An employee annuity restored amount is involved.

Widow(er)'s Employment History: Always. Request a DEQY from SSA. (See DCM 3.4.205)

Age of Employee: Only when employee's insured status, divisor quarters, or AMR would be affected and there is a conflict between the claimed DOB and the DOB shown on the employee's CER-1 or other evidence. (See RCM 4.2).

Termination of Prior Marriage: If there is reasonable doubt about whether a prior marriage of either widow(er) or employee was ended.

Legal Adoption of Child: Only when widow(er) seeks to meet marriage requirements on that basis.

Guardianship (AA-5): If guardian or other legal representative is selected as representative payee.

Military Service (M/S): Only when the employee's M/S after 1936 would be creditable either under the RR Act or under the SS Act.

Amount of VA Benefits: Only for annuities due before January 1975, when the employee's M/S after 1936 is creditable under the RR Act and a reduction in the RRA formula is required. (Send such cases to SAPT for verification of these benefits.Amount of Wages and Self Employment Income (SEI): On G-90.Public Pension: Always

3.7.16 Processing And Handling Of DWIA Cases

A. Processing DWIA Cases By Survivor Benefits Division - When receiving a DWIA claim, review to verify if the widow(er) cannot qualify because of non-medical reasons. If the claimant is ineligible because of non-medical reasons, deny the claim in the usual matter without sending the cases to DBD for a rating. Include a paragraph in the denial notice explaining that a disability determination has not been made since other eligibility requirements are not met.

If it appears that the widow(er) can qualify because of medical reasons check to see whether SS wage and benefit data have been developed. If not, release a request to SSA and then route the case to DBD if otherwise in order. Forward the case to DBD even if there is medical evidence outstanding.

B. Handling of DWIA Cases By DBD - The disability claims examiners in DBD reviews the DWIA case to determine if there is adequate medical and non-medical evidence in file to rate the widow(er)'s claim for disability. If there is adequate evidence in file, both medical and non-medical factors are considered in determining whether the widow(er) is considered permanently disabled and unable to work in any regular employment in accordance with the established criteria of the Board.

The disability claims examiner prepares OLDDS and Form G-325.1 or G-325B when the case is rated.

NOTE: For cases included in the financial interchange, the Social Security Act portion of the rating must be coordinated with SSA for survivor annuities as well as employee annuities, unless the annuity is being denied. (See DCM 6.7.3.D.) The initial disability examiner will handle the annuity rating and the post examiner will handle the SSA rating. Note that the annuity rating cannot be done on D-BRIEF.

The sample consists of employees, widows, and children in the following cases:

- Those where the claim number is A-979832 or lower and the last two digits of the claim number are 55; or,
- Those where the claim number is higher than A-979832 (including terminal digit claim numbers) and the last two digits of the claim number are 30.

Survivor cases that must be coordinated with SSA cannot be processed on D-BRIEF. (See DCM 12.5.1.) In these cases, the initial examiner should process the RRA decision and the post examiners should process the SSA decision. The survivor SSA decision should be processed by completing the SSA-831 and coordinating with SSA. Once the coordination is completed, the decision should be entered on page 3 of the OLDDS G-325 screen rather than on the OLDDS 831 screen.

If there is inadequate evidence in file, the disability claims examiner initiates development for either additional medical evidence from widow(er)'s treating physician, scheduling specialized examinations and/or ancillary tests or obtaining hospital records, etc., or non-medical (vocational work history) from him/her.

When the additional evidence is received, the disability claims examiner evaluates and determines whether the widow(er)'s disability is severe enough to prevent work in any regular employment in accordance to the law. Depending on

the appropriate disability decision, OLDDS Forms G-325.1 and G-225 when applicable, will be completed.

C. Handling Rated Cases By DBD

1. The widow(er) is found disabled within "prescribed period" - Send the case to SBD for payment of the DWIA.

2. Widow(er) found not disabled within "prescribed period" - DBD will deny the widow(er)'s on OLDDS, code out the application using Form G-661 and release a denial letter.

3. Widow(er) found not disabled - DBD will deny the widow(er)'s on OLDDS, code out the application using Form G-661 and release a denial letter.

NOTE: After the DWIA has been awarded, forward the case to Retirement Medicare Section so that disabled widow(er) is enrolled for early Medicare coverage.

3.7.17 Disabled Widow(er) Has Child In His/Her Care

A widow(er) who is entitled to a DWIA may have in his/her case a child of the employee (under age 18, or 18 or over and disabled) entitled to a CIA. For any month the disabled widow(er) has such a child in his/her care, his/her annuity is paid or a widow(er)'s current insurance annuity and the symbol "M" or "B" is shown on the award form. There are also cases in which a widowed mother or father age 50-59, entitled to WCIA, has been enrolled in Medicare on the basis of disability. When the last child leaves her care, attains age 18, dies, or marries, the WCIA terminates and his/her annuity is converted to a DWIA.

A. Diary Case - Last Child is Attaining Age 18

1. In the fourth month before the last child in the widow(er)'s care attains age 18, a notice is computer printed on RL-175 and sent to the annuitants. Along with information about the child's possible continued eligibility, RL-175 informs the widow(er) of the requirements he/she must meet to be eligible for an annuity.

2. In the last month for which the WCIA is payable, a termination referral is computer-printed on RL-1196/G-96a and sent to the appropriate unit for association with the file. Survivor examiner will terminate the WCIA and route the case to DPS for completion of the left side of Forms G-325. DPS will determine if additional medical evidence is needed.

3. After the necessary action is taken by DPS the examiners will award the DWIA, entering as his/her date of initial entitlement (DOE) the first of the month widow(er) no longer had a child in his/her care.

4. The widow(er) should submit a statement that he/she wishes to receive a reduced annuity. If the widow(er) does not want to receive a DWIA, he/she should submit a statement to that effect. If no statement is submitted or the widow(er) does not want this annuity and he/she has been enrolled for either hospital or medical insurance, route the case to BDMO-CPPS to determine the correct handling of his/her Medicare entitlement.

B. Last Child's Entitlement Terminates for Reasons Other Than Attaining Age 18 - Termination of a WCIA due to a child's marriage, death, or recovery from disability is handled in the same way as above for the widowed mother or father, age 50-59, who has been rated disabled for early Medicare.

C. Amount of Disabled Widow(er)'s Annuity After Child's Entitlement Terminates --

1. Widow(er) Has Not Attained Age 62 (65) - The annuity reverts to the rate previously paid her as a disabled widow(er). At age 62 (65), the annuity is adjusted to take into account those months he/she was entitled to a WCIA. Code the case for call-up at age 62 or age 65, whichever is applicable and show ARF as the reason. Show the symbol "R" on the award form.

2. Widow(er) Has Attained Age 62 (65) - In any case in which a WCIA was paid for one or more months after a DWIA had been awarded for him/her, adjust the rate of annuity to take into account those months he/she was entitled to a WCIA before age 62 or age 65, whichever is applicable. Show the appropriate symbol "R" or "A" for widow(er) on the award form.

3.7.18 Disabled Widow(er) May Be Entitled To Deferred LSDP

A deferred LSDP may be payable to the disabled widow(er) if he/she is eligible (see RCM 2.8) and;

A. The DWIA ABD is not retroactive to the month of the employee's death, or;

B. The widow(er)'s entitlement to a DWIA ended during the first year after the employee's date of death (DOD), for a reason other than the widow(er)'s death.

If the DWIA is paid on a manual award, determine whether the widow(er) is entitled to a deferred LSDP before the claim is submitted to authorization.

If the WIA is paid on an electronic data processing (EDP) award, determine whether the widow(er) is entitled to a deferred LSDP after the claim is paid.

Code the case for call-up one year after the employee's DOD if it appears a deferred LSDP may be payable.

3.7.19 When A Disabled Widow(er) Under Age 60 Works

A. General Information - A disabled widow(er) under age 60 who engages in any type of work activity, regardless of the amount of earnings on the duration of the employment, may have recovered from disability and, therefore, is no longer entitled to a DWIA. Beginning in 1970, disabled widow(er)s will be policed annually for changes in status and work activities. (See RCM 6.5.) It is extremely important that when a report of work by a disabled widow(er) is received, the case be promptly sent to DPS-Post and CDR Section for a continuation/cessation of disability determination or an investigation. (See DCM 10.3.1.)

B. Action By Survivor Benefits - When a report of a disabled widow(er)'s work activity is received, refer the case promptly to DPS-Post and CDR Section. Do not suspend payments unless the widow(er) is employed in the RR industry.

DPS Post and CDR Section are responsible for investigating the widow(er)'s employment and determining whether or not he/she has recovered from disability.

C. Action By DPS Post and CDR Section - DPS Post and CDR Section must make a determination of whether or not the annuitant has recovered from disability whenever a report of new work activity is received. In some cases, it may not be currently possible to make such a determination. Those cases should be coded for call-up and a determination made at that time.

All continuance/cessation determinations are made on Form G-325a (Determination of Continuance or Cessation of Disability). See Part 11 for instructions on preparing this form.

1. If Work Activity is Reconciled With Disability Rating - Notify that annuitant when such action is indicated and return the case to claim files.

2. If Annuitant Has Recovered From Disability -

    a. Use FAST to terminate payments as of the end of the second month following the month of recovery.

    b. Release a letter to the widow(er) advising of the termination of the DWIA.

    c. If an overpayment exists because DWIA payments continued after the second month following the month of recovery, send the case to the appropriate survivor benefit unit. Otherwise, return the DWIA case to claim files.

3.7.20 Handling Previously Denied Cases Or Reconsideration Request

A. Timely Reconsideration Request Not Made - If a request for reconsideration is not submitted timely and good cause for the delay is not evidence, examine the case to verify the correctness of the prior action. Although the period for requesting reconsideration has expired, consider if there is a basis for reopening the decision (See RCM 6.2 for guidelines). If the decision cannot be reopened, prepare a letter to the annuitant to notify him that his request for reconsideration is denied, giving the reason for denial. Do not use code paragraph 189 with this letter since the annuitant does not have a right to further appeal the initial decision.

Instead, use code paragraph 190 with an AB-25 back. The annuitant can request reconsideration of the decision regarding untimely filing. The reconsideration of this issue is done in the unit where the decision regarding untimely filing was made but not by the same person who made that decision. If the decision regarding untimely filing is reversed, reconsideration of the initial decision on proceed (See RCM 6.1.10). If the decision regarding untimely filing is affirmed, paragraph 189 should be given.

B. Timely Reconsideration Request Made - If the reconsideration request is timely filed the DPS Post examiner will take the necessary action to either develop more medical evidence or make a decision based on the reconsideration request. After all development actions are done, the DPS-Post examiner will determine if the initial decision still stands. If the widow(er) is found not disabled, the DPS-Post examiner will advise by sending an explanatory letter confirming that the initial denial determination is warranted. The letter will also include code Paragraph 189 about appeal rights.

A G-325 and a G-325.1 is prepared when a reconsideration allowance is made. The DPS-Post examiner will determine in accordance with the following section whether a new application is required based on the new evidence and widow(er)'s rating of disabled. If a new application is needed, DPS Post examiner will request it from the appropriate field office. Otherwise, the reconsideration allowance case will be sent to the Survivor Initial Section (SIS) for DWIA award action.

3.7.21 When A New Application Is Required

A. Previous Denial Rating Reversed Based on Evidence Or Correspondence Received Within Sixty Days of Denial Notice - A new application is only required when the applicant is found to be disabled from a date after the date of the denial letter.

B. Previous Denial Rating Reversed Based on Evidence Or Correspondence Received Sixty Days Or More After Denial Notice - A new application is always required.

3.8 Disabled Surviving Divorced Spouse's Annuity

3.8.1 General Information

A DWIA may be paid to a disabled surviving divorced spouse. A surviving divorced spouse is an individual divorced from an employee who has died and had 120 total months of railroad service or at least 60 months of RR service after 1995, and a current connection, but only if he/she had been married to the employee for period of 10 years immediately before the divorce became effective.

Beginning October 1, 1981, benefits are payable to a surviving divorced spouse. The term "surviving divorced spouse" refers to both a surviving divorced wife and a surviving divorced husband.

Effective January 1, 1984, if a surviving divorced spouse remarries, his/her annuity may continue. Prior to January 1, 1984, if a surviving divorced spouse remarried, his/her annuity terminated unless he/she married an individual entitled to a widow(er)'s father's/mother's, parent's or childhood disability benefit under the Railroad Retirement Act (RRA) or Social Security Act (SSAct). If a surviving divorced spouse's annuity was terminated because of remarriage, a new application is required for the individual to be re-entitled January 1, 1984 or later.

Disabled surviving divorced spouses must meet the definition of "disability" under the SSAct. He/she must be unable to engage in any substantial gainful activity because of his/her medically determined physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. Or he/she must meet the statutory blindness requirements (central visual activity of 20/200 is demonstrated in the better eye with the use of correcting lens or a limitation in the field of vision in the better eye shows that the widest diameter of visual fields subtends an angle no greater than twenty degrees or to ten degrees or less from the point of fixation which shall be considered as having a central visual activity of 20/200 or less).

3.8.2 Eligibility Requirements

A. Age - The disabled surviving divorced spouse must have attained age 50 but not age 60. A disabled surviving divorced spouse who has already attained age 60 can qualify for the months he/she is under age 60 in the retroactive period.

B. Marriage - The disabled surviving divorced spouse must:

- have been finally divorced from the employee; and
- hakve been married to the employee for a period of 10 years immediately before the date the final divorce became effective. (For further information on the 10-year marriage requirement, see RCM 2.1.104); and

- be unmarried, unless (s)he remarried after (s)he attained age 50, and the disability began prior to the remarriage, and (s)he met the disability requirements at the time of remarriage. This provision is effective for annuities payable January 1, 1984. Prior to that, a disabled surviving divorced spouse who had remarried after her/his divorce from the employee could not be eligible for an annuity unless the later marriage(s) had terminated. If a disabled surviving divorced spouse's annuity was terminated because he/she remarried, a new application is required for her or him to be re-entitled January 1, 1984 or later.

C. Social Security Entitlement - The entitlement of a surviving divorced spouse or remarried widow(er) to any social security benefit which is greater than the employee's primary insurance amount (PIA), prevents eligibility to a widow(er)'s insurance annuity under the RR Act. However if the social security benefit is smaller than the employee's PIA, but larger than the surviving divorced spouse's or remarried widow(er)'s age reduced rate, and the possibility of an age 62 or FRA adjusted reduction factor (ARF) exists that could increase the annuity rate above zero, the surviving divorced spouse or remarried widow(er) will be entitled to a zero annuity rate. Headquarters will process a constructive award and enter a call-up for the ARF.

The entitlement of a widow(er) to any social security benefit does not affect eligibility; however, such entitlement will affect the tier I amount payable.

D. Disability Requirement - If a surviving divorced spouse is claiming benefits based on disability, her/his disability must have begun before the end of a specified period (as in the case of a disabled widow(er) and he/she is subject to a waiting period during which benefits may not be paid.

1. When Disability Must Begin - The disability must have begun before the month in which the applicant attains age 60 and not later than the end of the 84th month after the latest of the following:

    - the month of the employee's death, or

    - the last month for which he/she was entitled to a surviving divorced mother's/father's annuity on the employee's account, or

    - the month in which his/her previous entitlement to a disabled surviving divorced spouse's annuity on the employee's account terminated because his/her disability ceased.

2. Waiting Period - A surviving divorced spouse's annuity based on disability cannot begin until after a waiting period of five full consecutive months throughout which he/she is disabled.

EXAMPLE: The surviving divorced spouse has a disability onset date of November 13, 1981. The five-month waiting period would run from December 1, 1981 through April 30, 1982. Her annuity could not begin until May 1, 1982. If the disability onset date was November 1, 1981, the five-month waiting period would run from November 1, 1981 through March 31, 1982 and her annuity could begin April 1, 1982.

The waiting period can begin no earlier than the later of

- The first day of the 17th month before the month in which she/he files an application or

- The first day of the 5th month before the month in which the period began as described above in D.

Months before the employee's death or before the month of termination of his/her surviving divorced mother's/father's annuity may be included in the waiting period if the surviving divorced spouse was disabled in those months and the disability continued.

3. Re-entitlement - No waiting period is required if a surviving divorced spouse was previously entitled to a surviving divorced spouse's annuity based on disability if he/she becomes disabled again within the period specified in D1 above. His/her annuity can begin with the first month during all of which he/she is again under a disability.

   EXAMPLE: A disabled surviving divorced wife's annuity terminated December 1982 because she recovered from her disability. She became disabled again February 13, 1986. Since she became disabled again before the end of the 84th month after the month in which her disability annuity terminated, her annuity can begin again March 1, 1986 (provided she is under age 60).

4. Disability That Occurs in Connection with a Felony or Confinement in Jail - The following disabling conditions cannot be considered in the disability termination:

   - Any physical or mental impairment, or any increase in severity of a preexisting impairment, that occurs in connection with a felony committed after October 19, 1980 for which the surviving divorced spouse is convicted cannot be considered in determining whether he/she is disabled. Subsequent conviction will invalidate a previous determination of disability based on an impairment that must be excluded under this rule.

   - Any physical or mental impairment, or any increase in severity of a preexisting impairment, that occurs in connection with confinement in a

jail, prison, or other penal institution or correctional facility for conviction of a felony committed after October 19, 1980 cannot be considered in determining disability for benefits payable for any month during the period in which he/she is imprisoned. However, he/she may become entitled to benefits based on disability on release from prison if he/she applies and is under a disability at that time.

For purposes of applying these provisions, in a jurisdiction which does not classify any crime as a felony, an offense punishable by death or imprisonment for a term exceeding one year is considered a felony. A person is considered confined even though temporarily or intermittently outside the facility (for example, on work release).

3.8.3 Filing

To be entitled to disabled surviving divorced spouse's annuity the applicant must:

- meet the eligibility requirements outlined in DCM 3.8.2.
- file an application (AA-17 and AA-17b).

3.8.4 Beginning Date

A disabled surviving divorced spouse's annuity begins on the latest of the following:

- the first day of the month of the employee's death;
- the first day of the month in which he/she has attained age 50 but not age 60;
  - October 1, 1981;
  - the day designated as the OBD;
- the first day of the first month for which the surviving divorced spouse is no longer eligible for a surviving divorced mother's/father's annuity because he/she no longer has an eligible child under age 16 in his/her care. Provided he/she meets the age and disability requirements for a disabling surviving divorced spouse's annuity;
  - the first day of the 12th month before the month the application is filed;
- the first day of the first month after completion of the 5-month waiting period unless the waiting period is not required; or
- Effective January 1, 1984, if the disabled surviving divorced spouse married after age 50 and was disabled before the marriage occurred (i.e., the disability onset date was before the date of marriage).

3.8.5 Earnings Restriction

A. Disabled Divorced Spouse Under Age 65 - The annual earnings test does not apply to a disabled surviving divorced spouse under age 65. However, any work performed before age 65 must be considered in determining whether the surviving divorced spouse has recovered from the disability.

As soon as the surviving divorced spouse reports that he/she is working, refer the case to the DPS-CDR Section for a determination of whether or not he/she has recovered from the disability on which the disabled surviving divorced spouse's annuity and/or Medicare is based.

If a disabled surviving divorced spouse age 60-64 recovers, his/her disability annuity is converted to an annuity based on age and regular survivor earnings restrictions apply.

B. Disabled Surviving Divorced Spouse Age 65 and Over - Regular survivor earnings restrictions apply beginning with the month the disabled surviving divorced spouse attains age 65 and ending with the month before attainment of age 70.

3.8.6 RLS Previously Paid

See the instructions in the section on surviving divorced spouse in RCM 2.1.108.

3.8.7 When Entitlement Ends

The entitlement of a disabled surviving divorced spouse ends:

- the month before the month in which one of the following occurs:
  - he/she dies;
  - he/she becomes entitled to an annuity which is higher than the annuity he/she is receiving as a surviving divorced spouse;
  - he/she becomes entitled to an RIB which equals or exceeds the employee's PIA;
  - he/she attains age 65. Technically, a disabled surviving divorced spouse's benefit terminates at age 65; however, do not take any action to correct RRB records from a disability annuity to an age annuity. The surviving divorced spouse continues on the rolls as a disabled surviving divorced spouse as long as he/she continues to be entitled under the application on which the disability annuity was awarded, and the award form symbol remains either "KR" or KA";
- at the end of the second month following the month in which his/her disability ceases unless he/she attains 60 on or before the last day of the termination month.

NOTE 1: Under the SS Act rules a disabled surviving divorced spouse's annuity terminates if he/she recovers before age 65. If he/she recovers between age 60 and 65, he/she must file a new application in order to qualify for a surviving divorced spouse's annuity based on age. However, we will allow the annuity of a disabled surviving divorced spouse who recovers after age 60 to convert to an age annuity as long as she meets the other qualifications. A new application will not be required.

NOTE 2: Before 1-1-84, remarriage was a terminating event unless the marriage was to an individual entitled to a widow(er)'s, father's/mother's parent's or childhood disability benefit under the RR Act.

3.8.8 Evidence Requirements

Application: Always, unless converting from a surviving divorced mother's/father's annuity.

AA-17b, Supplement to Application: Always.

Field Office Personal Observation Record (G-626A): Always.

Medical Evidence: Always.

Vocational Data G-251: Always.

Death of Employee: Always.

Age of Surviving Divorced Spouse: Always.

Marriage: Always.

Compensation, Wages and SEI: Always.

Amount of SS Benefits: Always.

Surviving Divorced Spouse's Employment History: Always. Request a DEQY from SSA. (See DCM 3.4.205)

Age of Employee: Only when employee's insured status or divisor quarters would be affected and there is a conflict between the claimed DOB and the DOB shown on the employee's CER-1 or other evidence. (See RCM 4.2.)

Termination of Prior Marriage: If there is reasonable doubt about whether a prior marriage of either surviving divorced spouse or employee was ended.

Legal Adoption of Child: Only when surviving divorced spouse seeks to meet marriage requirement on that basis.

Guardianship (AA-5): If guardian or other legal representative is selected as representative payee.

M/S: Only when the employee's M/S after 1936 would be creditable either under the RR Act or under the SS Act.

Proof of Divorce from EE: Always.

Proof of Termination of Remarriage: If the surviving divorced spouse had remarried after his/her divorce from the EE or if he/she remarried after his/her initial entitlement to a surviving divorced spouse's annuity and that annuity terminated.

Public Pension Information: Always.

3.8.9 Development And Adjudication

A. Field Office Development - The field office will initiate development for a disabled surviving divorced spouse's annuity when a surviving divorced spouse 50-59 who cannot qualify for a surviving divorced mother's/father's annuity alleges that he/she is disabled. If an inquiry is received from a surviving divorced spouse in this age group (or within 3 months of attaining age 50), and disability is alleged, request the field office having jurisdiction over the area where the surviving divorced spouse resides to develop a claim. If such a surviving divorced spouse is not within 3 months of attaining age 50, tell the individual to contact the local field office 3 months before he/she attains age 50.

B. Preliminary Processing By Survivor Section - Route the case to DBD for a disability rating if medical evidence is in the folder even though other evidence is outstanding unless it appears that the surviving divorced spouse cannot qualify because of non-medical reasons. If SS wage and benefit data have not yet been developed, release a request to SSA and then route the case to DBD if otherwise in order.

   If the claimant is ineligible because of non-medical reasons, deny the claim in the usual manner without obtaining a rating from DBD. Include a paragraph in the denial notice explaining that a disability determination has not been made since other eligibility requirements are not met.

C. Handling of Cases by DBD - Evaluate the medical evidence to determine whether the surviving divorced spouse's physical or mental impairments are such that he/she is disabled for work in any employment in accordance with the Social Security Act.

   Remember that any physical or mental impairment, or any increase in a pre-existing impairment, that occurs in connection with a felony committed after October 19, 1980 for which the surviving divorced spouse is convicted cannot be considered in determining whether he/she is disabled. Any disabling condition that results from or is aggravated by imprisonment for conviction of a felony committed after October 15, 1980 cannot be considered in determining disability for benefits payable while the person is imprisoned. Initiate development for

additional evidence, if necessary. Complete OLDDS and the G-325.1 or G-325B (Disability Decision Rationale Sheet) when the case is ready for rating.

NOTE: For cases included in the financial interchange, the Social Security Act portion of the rating must be coordinated with SSA for survivor annuities as well as employee annuities, unless the annuity is being denied. (See DCM 6.7.3.D.) The initial disability examiner will handle the annuity rating and the post examiner will handle the SSA rating. Note that the annuity rating cannot be done on D-BRIEF.

The sample consists of employees, widows, and children in the following cases:

- Those where the claim number is A-979832 or lower and the last two digits of the claim number are 55; or,
- Those where the claim number is higher than A-979832 (including terminal digit claim numbers) and the last two digits of the claim number are 30.

Survivor cases that must be coordinated with SSA cannot be processed on D-BRIEF. (See DCM 12.5.1.) In these cases, the initial examiner should process the RRA decision and the post examiners should process the SSA decision. The survivor SSA decision should be processed by completing the SSA-831 and coordinating with SSA. Once the coordination is completed, the decision should be entered on page 3 of the OLDDS G-325 screen rather than on the OLDDS 831 screen.

D. Handling Cases Rated By DBD

1. Surviving Divorced Spouse Disabled Within "Prescribed Period" - If the surviving divorced spouse is otherwise eligible, forward the case to SBD to award the disabled surviving divorced spouse's annuity.

2. Surviving Divorced Spouse Not Disabled Within "Prescribed Period - DBD will deny the surviving divorced spouse claim on Form G-661 and by releasing a denial letter.

3. Surviving Divorced Spouse Not Disabled - DBD will deny the surviving divorced spouse claim on Form G-661 and by releasing a denial letter.

3.8.10 Disabled Surviving Divorced Spouse Has Child In His/Her Care

A surviving divorced spouse who is entitled to a disabled surviving divorced spouse's annuity may have in his/her care a child of the employee (under age 16, or 16 or over and disabled) entitled to a CIA. For any month the disabled surviving divorced spouse has such a child in his/her care, his/her annuity is paid as a surviving divorced mother's/father's annuity and the symbol "KM" or "KB" is shown on the award form. There are also cases in which a surviving divorced mother/father age 50-59, entitled to

an annuity, has been enrolled in Medicare on the basis of disability. When the last child leaves his/her care, attains age 16, dies, or marries, the surviving child divorced mother's/father's annuity terminates and his/her annuity is converted to a disabled surviving divorced spouse's annuity.

NOTE: A child age 16-17 will continue to entitle a disabled widow(er) to a young mother/father annuity. However, Tier 1 is not payable for the period 10-1-81 through 7-31-92. Tier 1 is paid from 8-1-92 due to Board Order as the result of the Nancy Johnson case.

A. Last Child Attaining Age 16

1. When the last child attains age 16, terminate the surviving divorced mother's/father's annuity. Route the case with a "special" tag to DPS for completion of Form G-325. DPS will determine if additional evidence is needed.

2. When the case is returned from DPS, examiners will award the disabled surviving divorced spouse's annuity, entering as his/her OBD the first of the month he/she no longer had a child in his/her care.

3. The surviving divorced spouse should submit a statement that he/she wishes to receive a reduced annuity. If the surviving divorced spouse does not want to receive a disabled surviving divorced spouse's annuity, he/she should submit a statement to that effect. If no statement is submitted or the surviving divorced spouse does not want this annuity and he/she has been enrolled for either hospital or medical insurance, route the case to BDMO/CPPS to determine the correct handling of his/her Medicare entitlement.

B. Last Child's Entitlement Terminates for Reason Other Age 16 - Termination of a surviving divorced mother's/father's annuity due to the child marriage, death, or recovery from disability is handled in the same way as above for the surviving divorced mother/father, age 50-59, who has been rated disabled for Medicare.

C. Amount of Disabled Surviving Divorced Spouse's Annuity After Child's Entitlement Terminates -

1. Surviving Divorced Spouse Has Not Attained Age 62 (65) - The annuity reverts to the rate previously paid him/her increased for COLA's as a disabled surviving divorced spouse. At age 62 (65), the annuity is adjusted to take into account those months he/she was entitled to a surviving divorced mother's/father's annuity. Code the case for call-up at age 62 or age 65, whichever is applicable, and show "ARF" as the reason. Show the symbol "KR" or "KA" on the award form.

2. Surviving Divorced Spouse Has Attained Age 62 (65) - In any case in which a surviving divorced mother's/father's annuity was paid to a surviving divorced spouse for one or more months after a disabled surviving divorced spouse's annuity has been awarded, adjust the rate of annuity to take into account those months he/she was entitled to a surviving divorced mother's/father's annuity before age 62 or age 65, whichever is applicable. Show the symbol "KR" or "KA" on the award form.

3.8.11 Annuity Computation

The annuity consists of a Tier I component only. It is equal to a 100% share of the employee's PIA based on combined wages and compensation after 1936 reduced by 19/40 or 1% (i.e., 000179) for each month the disabled surviving divorced spouse is under age 60 on his/her OBD.

Payment of the Tier I benefit may be affected by certain SSA nonpayment provisions. Refer to SAPT any cases in which alien nonpayment provisions, convictions for subversive activities, deportation, (including deportation of the deceased employee due to associations with the NAZI government of Germany during World War II), or other nonpayment provisions of the SS Act are involved.

The annuity computation of the disabled surviving divorced spouse is not reduced for the family maximum or increased for the sole survivor maximum.

The annuity is reduced by:

- The amount of any SS benefit.
- The net Tier I amount as defined in RCM 8.9 G-364.1 item 83 instructions. If the disabled surviving divorced spouse becomes entitled to an RR retirement spouse annuity, only the higher of the spouse or disabled surviving divorced spouse's annuity is payable. If the Disabled Surviving Divorced Spouse Benefit is lower, that benefit should be terminated and the overpayment, if any, recovered from the spouse accrual.
- Two-thirds of the amount of any public pension if eligible for a public pension December 1, 1984 or later. See RCM 2.1.300 - 2.1.314 for further information on public service pensions.

3.9 Disabled Remarried Widow(er)'s Insurance Annuity

3.9.1 Remarried Disabled Widow(er) Defined

A remarried disabled widow(er) is the surviving legal or defacto wife or husband of a deceased employee who is disabled and who remarried after the employee's death and is now unmarried unless (s)he remarried after attaining age 50 and the disability began

prior to the remarriage and (s)he met the disability requirements at the time of remarriage.

3.9.2 Eligibility Requirements

In addition to being the legal or defacto widow(er) of a deceased employee who had 120 months of RR service or at least 60 months of RR service after 1995 and a C/C, a remarried disabled widow(er) must meet the following requirements:

A. Age - the remarried disabled widow(er) must have attained age 50 but not age 60. A widow(er) who has already attained age 60 can qualify for the months he/she is under age 60 in the retroactive period.

B. Marriage - The remarried disabled widow(er) must meet the marriage requirement as described in RCM 2.1.15 for widow(er)'s. Unlike the widow(er), however, the remarried disabled widow(er) may have remarried after the employee's death as long as:

- The marriage occurred after (s)he attained age 50 and (s)he was disabled before the marriage occurred (i.e., the SS disability date was before the date of marriage) and the survivor met the disability requirements at the time of remarriage. This provision applies to benefits payable January 1, 1984 or later. Before this change, if he/she remarried after her/his entitlement to a disabled widow(er)'s annuity, he/she must have married after age 60 or married an individual entitled to a widow(er)'s, mother's/father's, parent's or child's disability benefit; or

- He/she is now unmarried.

C. Social Security Entitlement - See Social Security Entitlement in DCM 3.8.2.

D. Disability - See disability requirements in DCM 3.7.2.

3.9.3 When Application Is Required

To be initially entitled as a remarried widow(er) the applicant must:

- Meet the eligibility requirements outlined above.

- File an application AA-17 and AA-17b.

No application is required for a remarried disabled widow(er)'s annuity if the individual was entitled to a disabled widow(er)'s annuity in the month he/she remarried. The field office will secure the date of marriage and the spouse's name and social security number so that his/her entitlement can be verified.

3.9.4 Beginning Date

- A remarried disabled widow(er)'s annuity begins on the latest of the following:
- the first day of the month of the employee's death;
    - October 1, 1981;
    - the day designated by the applicant as the OBD;
- first day of the 12th month before the month the application is filed;
- first day of the first month after completion of the 5 month waiting period unless the waiting period is not required (see DM 3.7.21);
- first day of the first month in which the remarried young mother/father is no longer eligible for a remarried young mother's/father's annuity because he/she no longer has an eligible child under age 16 in his/her care, provided he/she meets the age and disability requirements for a remarried disabled widow(er)'s annuity.
- first day of the first month the remarried widow(er) has attained age 50 but not age 60.
- January 1, 1984, if he/she remarried after age 50 and before age 60 and was disabled before the marriage occurred.

If a remarried disabled widow(er) was entitled to a disabled widow(er)'s annuity in the month he/she remarried, his/her remarried disabled widow(er)'s annuity begins in the month of marriage.

3.9.5 Earnings Restrictions

The earnings restrictions for remarried disabled widow(er)'s are the same as for disabled surviving divorced spouse. See DM 3.7.24 for earnings restrictions guidelines.

3.9.6 RLS Previously Paid

See instructions in the section on remarried widow(er)'s in RCM 2.1.209.

3.9.7 When Entitlement Ends

The entitlement of a remarried disabled widow(er) ends:

- the month before the month in which one of the following occurs:
    - he/she dies;

- he/she becomes entitled to a railroad spouse annuity which is higher than the annuity he/she is receiving as a remarried widow(er);

- he/she becomes entitled to an RIB which equals or exceeds the employee's PIA;

  - he/she attains age 65. Technically, a remarried disabled widow(er)'s benefit terminates at age 65; however, do not take any action to convert RRB records from a disability annuity to an age annuity. The remarried widow(er) as long as he/she continues to be entitled under the application on which the disability annuity was awarded and the award form symbol remains "RR" of "RA"; or

- at the end of the second month following the month in which his/her disability ceases unless he/she attains age 60 on or before the last day of the termination month.

NOTE 1: Under SS Act rules a remarried widow(er)'s annuity terminates if he/she recovers before age 65. If he/she recovers between age 60 and 65, he/she must file a new application in order to qualify for a widow(er)'s annuity based on age. However, we will allow the annuity of a disabled remarried widow(er) who recovers after age 60 to convert to an age annuity as long as he/she meets the other qualifications. A new application will not be required.

NOTE 2: Before January 1, 1984, remarriage was a terminating event unless the marriage occurred after the widow(er) attained age 60 or the marriage was to an individual entitled to a widow(er)'s, father's/mother's, parent's or childhood disability benefit under the RR Act or SS Act.

3.9.8 Evidence Requirements

Application: Always, unless he/she was entitled to a disabled widow(er)'s annuity in the month he/she married an individual entitled to certain benefits or unless converting from a remarried young mother's/father's annuity or he/she was receiving a disabled remarried widow's annuity and remarried, January 1, 1984 or later.

AA-17b, Supplement to Application: Always.

Field Office Personal Observation Record (G-626A): Always.

Medial Evidence: Always.

Vocational Data G-251: Always.

Death of Employee: Always.

Age of Remarried Disabled Widow(er): Always.

Marriage: Always.

Proof of Termination of Remarriage: If widow(er) remarried before age 50 or before the disability onset date.

Compensation, Wages and SEI: Always.

Amount of SSA Benefits: Always.

Remarried Disabled Widow(er)'s Employment History: Always. Request a DEQY from SSA. (See DCM 3.4.205)

Age of Employee: Only when employee's insured status or divisor quarters would be affected and there is a conflict between the claimed DOB and the DOB shown on the employee's CER-1.

Termination of Prior Marriage: If there is reason doubt about whether a prior marriage of either the remarried disabled widow(er) or employee was ended.

Legal Adoption of Child: Only when remarried disabled widow(er) seeks to meet marriage requirements on that basis.

Guardianship: If guardian or other legal representative is selected as representative payee.

M/S: Only when the employee's M/S after 1936 would be credited either under the RR Act or under the SS Act.

Public Pension Information: Always.

3.9.9 Disabled Widow(er) Currently On The Rolls Remarries

When a disabled widow(er) remarries his/her disabled widow(er)'s annuity terminates but he/she may be entitled to further benefits as a remarried disabled widow(er). (Before January 1, 1984, he/she married after age 60 or he/she married an individual entitled to a widow(er)'s, mother's/father's, parent's or child's disability benefits.) The remarried disabled widow(er) must be rated disabled under the SS Act.

A. Handling - When notice is received that the disabled widow(er) has married, the field office will use FAST to terminate the disabled widow(er)'s insurance annuity.

- If he/she is entitled to a remarried disabled widow(er)'s annuity, compute the amount of the remarried disabled widow(er)'s annuity and reinstate benefits under the new beneficiary symbol. If he/she is entitled to an SS benefit, allow that benefit to continue under the widow(er)'s claim number.

- If it is determined that there is no further entitlement, transfer his/her SS benefit to SSA as described in SSC procedure, sec 1000 et seq.

B. Overpayment Involved

- If payments have been released for any month in which there is no entitlement, ask for the gross amount back according to current overpayment procedure.

If there is entitlement to a remarried disabled widow(er)'s annuity for a month for which a not-due payment of his/her widow(er)'s annuity was made, withhold the accrual to recover his/her widow(er)'s annuity overpayment, start benefits in the current month, and follow due process procedures to recover the remaining overpayment.

3.9.10 Development And Adjudication

For information on development and adjudication see that topic under "Disabled Surviving Divorced Spouse in DCM 3.8.9.

3.9.11 Annuity Computation

Effective January 1, 1984, a remarried disabled widow(er) receives 100% share of the employee's PIA based on combined wages and compensation after 1936 reduced by 19/40 of 1% for each month in the period between ages 60 and 65. There is no additional reduction for months of entitlement before age 60 even if the remarried disabled widow(er) was previously entitled to a disabled widow(er)'s annuity.

The annuity consists of a tier 1 component only. Prior to January 1, 1984, a remarried disabled widow(er) receives 100% share of the employee's PIA based on combined wages and compensation after 1936 reduced by 19/40 of 1% (i.e., .00475) for each month in the period between ages 60 and 65 and 43/240 of 1% (i.e., .01179) for each month the remarried disabled widow(er) is under age 60 on his/her OBD.

If the remarried disabled widow(er) was previously entitled to a disabled widow(er)'s annuity, the age reduction is based on the number of months the widow(er) was under age 65 on her original date of entitlement.

The annuity is reduced by:

- The amount of any SS (RIB/DIB or survivor) benefit. For annuities awarded prior to August 12, 1983, it is not reduced for any spouse ("B") benefit.
- The net tier I amount of any employee annuity to which the remarried disabled widow(er) is entitled. (See RCM 8.9 G-364.1 item 81 instructions.) If the remarried disabled widow(er) becomes entitled to an RR retirement spouse annuity or is entitled to two remarried widow(er)'s annuities, only the higher of the two annuities is payable. (See RCM 2.1.208.)
- Two -thirds of the amount of any public pension if first eligible for a public pension December 1984 or later. (See RCM 2.1.300 - 2.1.314 for further information on public service pensions.)

3.10 Disabled Child's Insurance Annuity

3.10.1 General Information

A disabled child's insurance annuity (DICA) may be paid to a child who had a permanent physical or mental condition which began before he/she attained age 22, or to a child that meets the re-entitlement requirements described in DCM 3.10.10. Once a DCIA is awarded, the annuity remains payable for as long as the child is disabled or until a terminating event occurs. A disabled child is eligible even if the widow(er) previously elected and received a Residual Lump-Sum (RLS). No recovery of the RLS is to be made.

Effective September 1, 1954, annuity eligibility was extended to dependent disabled children age 18 or older if disability began before age 18. Effective January 1, 1973, the law was changed to extend eligibility to children disabled, age 18 or over if disability began before age 22.

3.10.2 When A Child's Disability Determination Is Governed By The Regulations Of The Social Security Act

In order to receive a DCIA, a child of the deceased employee must be found disabled under the RR Act. However, in addition to this determination, that child must be found disabled under the SS Act to qualify for Medicare based upon disability.

Although the child of a living employee may not receive an annuity under the RR Act, he/she, if found disabled under the SS Act, may qualify for the following:

1. inclusion as a disabled child in the employee's annuity rate under the social security overall minimum; or

2. entitlement to Medicare based upon disability.

3.10.3 Definition of Disability

A disabled child meets the same definition of disability as a disabled railroad employee if his/her disability began before he/she reached age 22. The child's physical or mental disabling condition must have lasted, or can be expected to last a continuous period of at least 12 months, or result in death.

A disabled child does not need to meet any waiting period requirement for payment.

3.10.4 Eligibility Requirements

To be eligible for a DCIA, a child of an employee who had at least 120 months of RR service or at least 60 months of RR service after 1995 and a current connection (C/C) must:

A. be unmarried (a child who is widowed or divorced at the time of filing an application for initial entitlement is considered unmarried); and

B. have been dependent on the employee when he died; and

C. be disabled before age 22.

3.10.5 Entitlement Requirements

To be entitled to a DCIA, a child must meet the above eligibility requirements and an application must be filed by or on behalf of that child.

A. A child entitled by reason of a disability and has been entitled as a disabled child for 24 consecutive calendar months, shall be entitled to hospital insurance benefits beginning with the 25th consecutive month of disability entitlement. The child is also eligible for the supplementary medical insurance benefit at the same time.

B. If the child no longer meets the above eligibility requirements, entitlement can be established for months in the retroactive period of his/her application in which all of the requirements are met. For example, a child may be entitled for months in the retroactive DCIA period before the month of his/her marriage.

C. DCIA entitlement is precluded if the child was convicted of the felonious and intentional homicide of the employee or if the child was found to have killed the employee by an act which, if committed by an adult, would be considered a felony.

D. If a DCIA is confined for at least 30 continuous days or more due to a conviction of a criminal offense, the Tier 1 Social Security Equivalent Benefit (SSEB) rate must be converted to a Non-Social Security Equivalent Benefit (NSSEB) rate. See FOM1 150 for more information.

E. Termination of a DCIA is subject to the same provisions as are applicable to an employee's entitlement to a "period of disability."

NOTE: A child may not receive a DCIA on more than one earnings record. Normally, the disabled child will receive only the higher of the two annuities but may elect to receive the lesser of two such annuities. See RCM 2.4.3 for more detailed information.

3.10.6 Beginning Date

Subject to legislative restrictions, a DCIA begins to accrue on the latest of the following dates:

September 1, 1954 - Earliest possible ABD for a disabled child age 18 or older if disability began before age 18; or

January 1, 1965 - Earliest possible date of inclusion in the employee's overall minimum O/M computation for a disabled child age 18 or older if disability began before age 18; or

September 1, 1973 - Earliest possible ABD for a disabled child age 18 or older if disability began before age 22; or

The first day of the month in which all eligibility requirements are met; or

For applications filed September 1, 1983 or later, the first day of the sixth month preceding the month in which an application was filed. Applications filed before September 1, 1983 had twelve months' retroactivity.

3.10.7 One Application Concept

If a child is disabled before age 18, he/she need submit only a modified AA-19a to his/her original application and furnish the Board with evidence of disability in order to receive benefits.

3.10.8 Earnings Restrictions

A. Restricted Employment - A DCIA is not payable for any month that the child works for an employer covered by the RR Act.

B. Other Employment - Do not assess work deductions against the earnings of a disabled child age 18 or older. Send all cases in which earnings or work activity are reported for a disabled child age 18 or over to the DPS post and CDR unit.

3.10.9 When Entitlement to A DCIA Ends

A DCIA ends with the month before the month in which the child:

1. Dies;

2. Marries; or

3. The last day of the second month following the month in which the child recovers from disability.

3.10.10 Requirements For Re-entitlement To A DCIA

Effective January 1, 1973, a child whose entitlement to a DCIA was terminated may be re-entitled upon filing an application, without reestablishing dependency on the employee, provided the child still meet the definition of "child" and he/she:

A. Meets one of the following criteria:

   1. Is under disability which began prior to his/her attainment of age 22 (effective January 1973); or

2. Is under a disability which began before the close of the 84th month following the month in which his/her most recent entitlement to a child's annuity terminated because his/her disability ceased (effective January 1973); or

3. Is under a disability which began **at any time** if the most recent entitlement was terminated due to earnings rather than medical recovery. This applies to annuities payable for months beginning in October 2004. If the re-entitlement begins after the close of the 84th month following the month in which the most recent annuity terminated, the child is entitled to tier 1 only (in such cases, the APPLE application must be marked for manual review); or

4. Had entitlement terminated prior to October 1972 due to adoption; and

And meets the requirements of B

B. Since last entitled to an annuity, has not married, unless the marriage was void or annulled. (A marriage that ended by death or divorce precludes re-entitlement.)

   A child re-entitled based on a disability may also be re-entitled to hospital insurance benefits and eligible for supplementary medical insurance benefits once the requirements of the law are met.

   A child, who becomes re-entitled to a DCIA, is again entitled to a trial work period (TWP).

See DCM 12.1.4, item 20 for instructions on completion of OLDDS

NOTE 1: Re-entitlement means a subsequent period of entitlement to the same type of annuity. For example, a child who may have been disabled before age 22, subsequently worked at an substantial gainful activities (SGA) level and becomes disabled again after age 22 (within 7 years of the prior disability) cannot qualify for re-entitlement provisions unless a DCIA is payable for at least one month of the first period of disability.

NOTE 2: The re-entitlement rules also apply to spouses and surviving mothers/fathers who are eligible based on having a disabled child in his/her care. If the child's new disability onset date begins after the close of the 84th month following the month in which the most recent annuity terminated, the spouse or surviving mother/father is entitled to tier 1 only. In such cases, the APPLE application must be marked for manual review.

3.10.11 Evidence Requirements

EVIDENCE	WHEN REQUIRED
Application:	Always.
Retirement	(disabled child for inclusion in O/M) AA-1, AA-19A and G-626A
Spouse	(under FRA with disabled child in care) AA-3, AA-19A and G-626A
Surviving Child	AA-19, AA-19a or modified AA-19a and G-626A. The modified AA-19a is only used if the child was previously rated for retirement purposes
Proof of Age of Child	Always.
SS number of child	Always
Proof of termination of marriage	When filing for initial entitlement and child was previously married but is unmarried at the time of application.
Proof of Relationship of Child to Employee	Always.
Proof of Child's Dependency on Employee	Always.
Proof of Death of Employee	All survivor cases.
Employee's Wage and Compensation Record	Always.
Age of Employee	In "A" cases POA is required only if the employee's DOB has not been previously verified. Effective 03-01-2004 POA of deceased employee is required in all "D" cases when a survivor recurring application is filed.
Application for Substitution of Payee for Survivor Annuity (AA-5)	If a person other than the natural, adoptive, or step-parent files an application on behalf of a minor child.
Medical Evidence	If child claims to be disabled.

Vocational and Wage Information for Child	Always. Request a DEQY from SSA. (See DCM 3.4.205) A description of work activities is contained in the AA-19a. However, a child must be disabled before attaining age 22. Therefore, if the child is currently over age 22, it is imperative to first determine if the evidence shows that the child did or did not perform substantial gainful activity (SGA) (DCM 10.4) since attaining age 22. If, after review of the wage record and the A-19a, it is determined that more work information is needed about the requirements of the job for RFC comparison purposes, request a G-251.
M/S	If employee's M/S after 1936 would be creditable under either the RR Act or the SS Act.
Amount of SS Benefits	If the child is entitled or may be entitled to SS benefits based on the wages of a person other than the deceased employee.
Certification	Always.

3.10.12 Application Filed As A Result Of RI-175

When a child on the rolls is within 4 months of attaining age 18, a computer-printed RL-175 is automatically released. This letter notifies the payee that benefits will terminate when the child attains age 18, but may continue after age 18 if the child is either disabled or a full-time student (FTS). The following sections pertain to the handling of a case where the child is disabled.

3.10.13 Development Of Child's Disability

A determination of the alleged disability of a minor child is not required until the child attains age 18, although a disability determination may be rendered as early as age 16 in order to qualify the mother or father for Tier I benefits. If a child is rated disabled before age 18 he/she will not be rated again at age 18 unless there is evidence that the condition has changed. When an alleged disabled minor child is on the rolls, development action is started 4 months before the child attains age 18, in order to avoid interruption of benefits.

A. Child on Rolls Before Age 18 - When a child on the rolls is 4 months from attaining age 18, the computer will print an RL-175 letter. This letter notifies the child's payee that the benefits will terminate when the child attains age 18, unless the child is either disabled or an FTS. The payee is advised to contact the

nearest field office to develop the necessary evidence. The filing date of an AA-19A has no bearing on the retroactivity of benefits. If payments ended at age 18, reinstate the child's annuity effective with the month the child attained age 18, regardless of when the AA-1A is filed, provided the evidence of disability is submitted within 1 year of the attainment of age 18.

B. Child Not on Rolls Before Age 18 - When an inquiry is received about benefits for an alleged disabled child, or there is information in file indicating that such a child survives, request the field office to develop the claim in accordance with the instruction in the FOM. Enter in the "Remarks" block of Form G-659a, any information in the file that may aid the field office in their development action (e.g.,) child alleged to be incompetent, child institutionalized due to his/her Intellectual Disability etc.). If the alleged disabled child resides outside the U.S. or Canada, write directly to the claimant or the person who inquired in behalf of the child. Inform the person of the evidence required to support his/her claim.

When the application is received and eligibility determined, BSB should prepare a G-325 and submit the case to DPS-initial for a determination. If additional evidence concerning the alleged disability is required, the DPS-initial claims examiner will request it.

NOTE: If the field office advises that there will be a delay in securing medical evidence for an alleged disabled child who is under age 19 and attending school full-time, have them develop the child's eligibility as an FTS so that survivor benefits may continue without interruption.

3.10.14 Securing Breakdown of Wages And Employers From SSA

If the alleged disabled child has an SS number, or has worked, secure a DEQY from SSA. (See DCM 3.4.205) If the wage breakdown shows a possible insured status, obtain a report of SS entitlement data for the child by requesting a G-90 on the child's social security number. In either case, after the report is received, send the case to DPS-initial for a disability determination.

3.10.15 Child Previously Rated For Retirement Purposes

If a child is disabled before age 22, he/she only needs to submit a modified AA-19a to his/her original application.

When a modified AA-19a is received after the employee’s death and the child has been rated disabled for:

- inclusion in the employee's O/M; or
- the purpose of awarding a spouse annuity under the RR Act; or
- early Medicare only,

- disability claims examiners will adopt the previous disability decision for the disabled child when they determine that:

  - No scheduled CDR has expired or the previous decision diary was a MINE, and

  - The child is not in SGA and has no history of being engaged in SGA since the previous disability decision.

NOTE: If no CDR diary was set for the original disability decision, determine what CDR diary should have been set at the time of the original decision.

- When the above criteria are met the disability examiner is to complete the disability decision on OLDDS. A G-325.1 is to be completed by stating "see previous disability decision dated mm/dd/ccyy" (with the examiner completing the date of the previous decision).

- If a scheduled CDR diary has expired, the disability examiner is to perform a CDR (or refer the case to the proper CDR examiner). If SGA is involved the examiner must investigate and reconcile the earnings.

NOTE: When CDR examiners make their determination, they are to complete their action on OLDDS, Form G-325, Disability Decision Sheet and not on Form G-325a, Determination of Continuance or Cessation of Disability. This is necessary for the case to be properly tracked on APPLE.

3.10.16 Handling Of Cases By DBD

The DBD Claims Examiner Will Take The Following Actions:

Check and verify if the child's alleged disability onset occurred

- after he/she attained age 22 or
- after the close of the eighty-fourth month in which his/her previous entitlement to a DCIA ended if the termination was due to medical recovery.

If the child's disability onset is after those two situations, no further development is needed and the DCIA claim is a technical denial. The new onset date in a re-entitlement case is not relevant if the previous termination was due to earnings and not to medical recovery,

If the child's alleged disability onset occurred

- before he/she attained age 22 or before the close of the eighty-fourth month in which his/her previous entitlement to a DCIA ended, or
- at any time for a re-entitlement case in which the previous termination was due to earnings

Evaluate the medical evidence to determine whether the child's physical or mental impairments are either severely disabling or not disabling according to the RRB regulation's listings of impairments.

A. Child Is Disabled - Complete OLDDS showing ratings of child disabled before age 22 under Section 2d (l)(iii)(c) of the Railroad Retirement Act in item 19(b) and under Section 202(d) of the Social Security Act in item 28(a). Also, Form G-325.1 or G-325B is prepared giving the rationale for the DCIA allowance. Case is sent to the Survivor Benefits Division (SBD) - Survivor Initial Claims Section for the awarding of DCIA payment.

NOTE: For cases included in the financial interchange, the Social Security Act portion of the rating must be coordinated with SSA for survivor annuities as well as employee annuities, unless the annuity is being denied. (See DCM 6.7.3.D.) The initial disability examiner will handle the annuity rating and the post examiner will handle the SSA rating. Note that the annuity rating cannot be done on D-BRIEF.

The sample consists of employees, widows, and children in the following cases:

- Those where the claim number is A-979832 or lower and the last two digits of the claim number are 55; or,
- Those where the claim number is higher than A-979832 (including terminal digit claim numbers) and the last two digits of the claim number are 30.

Survivor cases that must be coordinated with SSA cannot be processed on D-BRIEF. (See DCM 12.5.1.) In these cases, the initial examiner should process the RRA decision and the post examiners should process the SSA decision. The survivor SSA decision should be processed by completing the SSA-831 and coordinating with SSA. Once the coordination is completed, the decision should be entered on page 3 of the OLDDS G-325 screen rather than on the OLDDS 831 screen.

B. Child Rated Not Disabled - If the child is rated as not disabled before age 22, OLDDS is prepared showing the not disabled ratings in items 19(b) and 28(a). Also Form G-325.1 or G-325B is prepared providing the rationale for the DCIA denial. Since the DCIA claim is to be denied:

1. DBD will release a denial letter to the widow(er) if eligibility depends on having a child-in-care. DBD will complete Form G-661 to complete the denial action on the DCIA claim.
2. Also, DBD will release a denial letter to the child if there is no widow(er) or if the widow(er)'s eligibility does not depend on the child. DBD will complete Form G-661 to complete the denial action on the DCIA claim.

NOTE 1: IPI, Medicare only - Use custom letter for denial. Return the case to claim files after denial action is completed.

NOTE 2: After DCIA has been awarded, forward the case to PSD-MS so that the disabled child can be enrolled for Medicare coverage.

3.10.17 Selecting Payee For Disabled Child

A disabled child who can manage benefit payments in his/her own interest is considered mentally competent and can receive direct payment of his/her annuity. When making the disability rating, the DPS claims examiner will determine whether the disabled child is competent or incompetent. The determination that a representative-payee is needed will be reflected on Form G-325 item 20.

If DPS determines that the disabled child is competent to manage benefit payments in his/her own interest, an application must be secured from that child. In all other cases, a representative payee will be selected for the disabled child as outlined in RCM 5.10, normally by the appropriate field office.

3.10.18 Employment Of Disabled Child

The earnings of a disabled child are not subject to regular work deductions. However, when there is information received or in file indicating that the child is or has been employed, and the employment was not previously reconciled with the disability, send the case to DPS Post and CDR unit. Post examiners in that unit will determine whether the employment can be reconciled or if the child has recovered from disability. A continuance or termination decision will be made on Form G-325a following rules set forth in the Board's regulations and the rules contained in the Social Security Administration's regulations. Refer to DM Chapter 10 for specifics about continuances or terminations.

3.10.19 Resolving Inconsistencies In The History Of Child Disability Claims

When evaluating a child's disability, evidence covering a period of time is needed in order to establish the impairment's severity. And to determine if it is expected to last the 12-month duration.

A longitudinal history may reveal sudden changes in the child's functioning. Examiners should try to ascertain the reason for any changes whenever they are material to the decision. The nature of and reason for a sudden change in functioning should be considered. If these changes are consistent with the nature of the impairment, then a decision is needed as to whether the duration requirement will be met.

If a medically determinable impairment exists, it may not be disabling by itself. A temporary stressful situation may result in a decline of functioning that constitutes a medically disabling impairment that would not be expected to last for a 12-month period.

If there is no identifiable factor that can explain the sudden change in functioning and such change is not in keeping with the other evidence, the higher level of functioning should be used to determine whether a child is disabled. At that point it is reasonable to conclude that the low level of functioning is not due to the impairment. The possibility that parents may be coaching children to act-up or fail certain tests is always present. If the evidence clearly shows coaching, fraud should be suspected and appropriate value given to this evidence.

Appendices

Appendix A - Form G-325 Instructions

The Form G-325, Disability Decision Sheet, is now obsolete. Disability rating information that was previously entered on this form is now entered on Screen G-325 on OLDDS. See DCM 12.1.4.

Appendix B - Diagnostic CodesCODES FOR CLASSIFICATION OF DISABILITYEFFECTIVE JANUARY 16, 1995

DETAILED CODE	GROUP CODE	
		ACQUIRED IMMUNODEFICIENCY SYNDROME
004	20	AIDS
004	30	ARC
004	40	HIV Positive
		INFECTIVE AND PARASITIC DISEASES TUBERCULOSIS
010	01	Pulmonary
019	01	Other Forms
040	01	POLIOMYELITIS AND OTHER ENTEROVIRUS DISEASE OF CENTRAL NERVOUS SYSTEM
079	01	OTHER VIRAL DISEASES
084	01	Malaria
		SYPHILIS AND OTHER VENERAL DISEASES
090	01	Congenital Syphilis

091	01	Early Syphilis
093	01	Cardiovascular Syphilis
094	01	Syphilis of Central Nervous System
098	01	Gonococcal Infections
099	01	Other Venereal Diseases
104	01	Other Spirochetal Infection
117	01	Mycosis
129	01	Helminthiases
136	01	Other Infective Parasitic Diseases
		NEOPLASMS
140	02	Buccal Cavity and Pharynx
150	02	Digestive Organs and Peritoneum (colon, esophagus, liver, pancreas, etc.)
160	02	Respiratory System
170	02	Bone, Connective Tissue, Skin and Breast
180	02	Genitourinary Organs (prostate, etc.)
190	02	Other
200	02	Lympho sarcoma, Hodgkin's Disease, Multiple Myeloma, Leukemia, Polycythemia, Myelofibrosis
210	02	Benign Neoplasms
		ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES
240	03	Diseases of the Thyroid Gland
250	03	Diseases of Other Endocrine Glands (Diabetes Mellitus)
260	03	Avitaminosis and Other Nutritional Deficiency

270	03	Other Metabolic Diseases (Gout, obesity, etc.)
		DISEASES OF BLOOD AND BLOOD FORMING ORGANS
280	04	Iron Deficiency Anemias
284	04	Aplastic Anemia
289	04	Other Diseases of Blood and Blood Forming Organs
		MENTAL DISORDERS
290	05	Psychoses (Schizophrenia, paranoid state)
300	05	Neuroses, Personality Disorders and Other Non-Psychotic Mental Disorders (depression, anxiety, organic brain syndrome, etc.)
305	05	Drug Addiction
306	05	Alcoholism
310	05	Intellectual Disability
		DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS
320	06	Meningitis, Phlebitis, Thrombophlebitis of Intracranial Venous Sinuses, Intracranial and Intraspinal Abscess, Encephalitis, Myelitis, Encephalomyelitis
330	06	Hereditary and Familial Diseases of the Nervous System
340	06	Other Diseases of the Central Nervous System (multiple sclerosis, paralysis agitans, Parkinson's diseases, cerebral spastic infantile paralysis, migraine, other diseases of the spinal cord)
345	06	Epilepsy/Seizures
350	06	Diseases of the Nerves and Peripheral Ganglia (facial paralysis, trigeminal neuralgia, brachial neuritis, sciatica, polyneuritis and polyradiculitis, carpal tunnel syndrome, etc.)
360	06	Inflammatory Diseases of the Eye (conjunctivitis, ophthalmia, blepharitis, keratitis, iritis, choroiditis, etc.)

		OTHER DISEASES AND CONDITIONS OF THE EYE
370	06	Refractive Errors
374	06	Cataracts
375	06	Glaucoma
376	06	Detachment of Retina
378	06	Other Diseases of the Eye
379	06	Blindness
		DISEASES OF THE EAR AND MASTOID PROCESS
385	06	Meniere's Disease
389	06	Other Deafness
		DISEASES OF THE CIRCULATORY SYSTEM
390	07	Rheumatic Fever
391	07	Rheumatic Fever with Heart Involvement
392	07	Chorea
393	07	Chronic Rheumatic Heart Disease
400	07	Hypertensive Disease (malignant hypertension, essential benign hypertension, hypertensive heart disease, hypertensive renal disease)
410	07	Ischemic Heart Diseases (acute myocardial infarction, chronic ischemic disease, angina pectoris, coronary artery disease, etc.)
420	07	Other Forms of Heart Disease (acute pericarditis, endocarditis, myocarditis, chronic disease of pericardium or endocardium, cardiomyopathy, pulmonary heart disease, congestive heart failure, bundle branch block, etc.)
430	07	Cerebrovascular Disease (subarachnoid hemorrhage)
431	07	Cerebral Hemorrhage

433	07	Cerebral Thrombosis or Embolism
435	07	Transient Cerebral Ischemia (TIA)
440	07	Diseases of Arteries, Arterioles and Capillaries (arteriosclerosis, aneurysms, peripheral vascular disease, arterial embolism and thrombosis, polyarthritis nodosa, etc.)
450	07	Diseases of Veins and Lymphatics (pulmonary embolism and infarction)
451	07	Phlebitis, Thrombophlebitis, Varicose Veins, hemorrhoids, etc.
		DISEASES OF THE RESPIRATORY SYSTEM
490	08	Bronchitis
492	08	Emphysema
493	08	Asthma
510	08	Other Diseases of Respiratory System (empyema, abscess, pneumoconiosis due to silica)
518	08	Bronchiectasis, etc.
		DISEASES OF THE DIGESTIVE SYSTEM
520	09	Diseases of the Oral Cavity, Salivary Glands and Jaws
530	09	Disease of the Esophagus, Stomach and Duodenum
550	09	Hernia of Abdominal Cavity
560	09	Disease of Intestine and Peritoneum
570	09	Diseases of Liver, Gallbladder and Pancreas
		DISEASES OF GENITO-URINARY SYSTEM
580	10	Nephritis and Nephrosis
590	10	Other Disease of Urinary System
600	10	Diseases of Male Genital Organs

610	10	Diseases of Female Genital Organs
		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE
680	12	Infections of Skin and Subcutaneous Tissue
700	12	Other Diseases of Skin and Subcutaneous Tissue
		DISEASES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE
710	13	Arthritis (degenerative disc disease) and Rheumatism (except rheumatic fever)
720	13	Osteomyelitis and Other Diseases of Bone and Joint
730	13	Other Diseases of Musculoskeletal System (myasthenia gravis muscular atrophy, Paget's disease, progressive muscular dystrophy, herniated disc, fractures)
738	13	Amputations
		CONGENITAL ANOMALIES
740	14	Congenital Malformations
		SYSPTOMS AND ILL-DEFINED CONDITIONS
780	16	Symptoms Referable to Systems or Organs (burns, syncope, etc.)
790	16	Senility and Ill-Defined Diseases

Appendix C - List of Common Medications

The following link button allows the user to view a chart that lists common medications found in disability cases. The chart consists of three columns. The first column lists the medication by its Brand name. The second column lists the medication by its Generic name and the third column list under what conditions the medicine is usually prescribed (Indication).

The chart is formatted as an EXCEL document so the user can arrange each column in ascending or descending order by clicking on the ascending/descending arrow in their toolbar.

Appendix D - Employee Disability Annuity Legislative History

Effective Date	Employee Disability Annuity Provisions
6-24-1937	Full disability annuity at any age with 30 years of service if totally and permanently disabled.
6-24-1937	Reduced disability annuity at age 60 with less than 30 years of service if totally and permanently disabled.
1-1-1947	Full disability annuity at any age with 10 years of service if totally and permanently disabled (or at age 60 if less than 10 years of service).
1-1-1947	Occupational disability annuity with C/C at any age with 20 years of service or at age 60 with less than 20 years of service.
1-1-1947	Disability annuity terminated if annuitant under age 65 earns $75 or more in 6 consecutive months (Statutory termination).
11-1-1951	10-year minimum service requirement.
9-1-1954	Statutory termination repealed. Disability annuity terminated upon medical recovery.
9-1-1954	Disability annuity not payable for any month annuitant earns more than $100. Penalty deduction imposed for late or non-reporting of earnings.
1-1-1959	Earnings restriction liberalized. Disability annuity not payable for any month annuitant earns more than $100. If yearly earnings are $1250 or more, 1 month’s annuity is lost for each $100 of earnings in excess of $1200. No deductions applied to months in which earnings are $100 or less.
11-1-1966	Beginning with recovery determination made after 10-30-66, the disability annuity terminates 2 months after the month in which the annuitant recovered from disability.
1-1-1968	Earnings restrictions again liberalized. Disability annuity not payable for any month annuitant earns more than $200. If yearly earnings are $2500 or more, 1 month's annuity is lost for each $200 of earnings in excess of $2400. No deduction is applied to months in which earnings are $200 or less.

1-1-1989	Earnings restriction again liberalized. Disability annuity not payable for any month annuitant earns more than $400 after deduction of disability related work expenses. If yearly earnings are $5000 or more, 1 month's annuity is lost for each $400 of earnings in excess of $4,800. No deduction is applied to months in which earnings are $400 or less.
1-1-2002	Employee with an actual disability freeze may qualify for a total and permanent disability annuity at any age based on less than 120 months of railroad service, but at least 60 months of railroad service after 1995. The Tier 2 is not payable until the employee attains age 62 and the Tier 2 benefit is then reduced for the number of months the employee is under Full Retirement Age.
1-1-2007	Earnings restriction again liberalized. Disability annuity not payable in 2007 for any month annuitant earns more than $700 after deduction of disability related work expenses. The monthly earnings limitation for years after 2007 will be set as the larger of the monthly amount for the previous year or an amount calculated using a formula based on the national wage index. The yearly earnings limitation was also changed by using the monthly earnings limitation amount in effect for that year. A deduction will not be applied when earnings in any month in a year are less than or equal to the monthly earnings limitation for that year.

The employee disability freeze and DIB (O/M) legislative history table is in DCM 6 Appendix 4.

Appendix E – Total and Permanent Sequential Evaluation Process

The following link button allows the user to view an illustrative chart of the Total and Permanent Sequential Evaluation process. This chart can be printed and used as a reference tool in daily case adjudication.

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 treating physician whenever possible, since greater weight is given to the opinion of the treating physician who has treated a patient over a period of time. If there is medical evidence in file that indicates the claimant's condition meets/equals a SSA listing or the claimant is carrier disqualified, it is not necessary to develop additional medical evidence, such as the RL-11D1, Request for Medical Evidence from Employers. Adjudicate the disability case accordingly.

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. Deferred development may be necessary when the evidence is too current to determine if the condition will meet the duration requirement and establish severity for disability. If the AA-1D or medical evidence indicates the applicant has had recent surgery (within 3 months) or has an impairment that requires evaluation after a certain period of time (i.e. cardiac exacerbation/stroke), examiners can request additional medical evidence through the field office or contact the claimant directly for the necessary evidence for the specific timeframe.

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 pertinent 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.

Many 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, the case can be documented and evaluated immediately. Avoid unnecessary development. Also, if there is medical evidence in file that indicates

the claimant's condition is severe enough to meet/equal a SSA listing or the claimant is carrier disqualified, it is not necessary to develop additional medical evidence. Adjudicate the disability case accordingly. 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 determining the 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, they 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,Disability Director, lead examiners, and individual(s) designated by a management official to review and sign off on the form. 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 authorized individual, as indicated above, that the form was approved and imaged from RRAILS, the case can be sent to the authorization folder.

- If exclusion is denied – Once the examiner receives email notification from the authorized individual, as indicated above, that the exclusion was denied, the examiner is to update DBrief and/or OLDDS to reflect that the

case was not excluded from timeliness When that action is complete, the case can then be sent to the authorization folder for review.

B. Action By Authorized Individual Reviewing Form G-226 for Approval or Denial:

Only the individuals identified above in Part A of this section 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 individual responsible for reviewing the form will indicate the outcome of the review by indicating it is approved or denied:

- Approval – The authorized individual will review the form and if they agree with the exclusion, will approve it and release the form to imaging through RRAILS. Once the form is sent to imaging, the individual who is authorized to review Form G-226 will send an email back to the examiner advising that the exclusion was approved and the form is imaged.

  NOTE: The exclusion must be reviewed, approved or denied, and imaged by an authorized individual prior to sending the case to authorization.

- Denial - If the authorized individual responsible for reviewing Form G-226 disagrees with the exclusion, they 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. <u>CONDUCTION DISTURBANCES, ARRHYTHMIAS</u>

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. <u>Transient Ischemic Attacks</u> - 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. <u>CHRONIC ULCERATIVE COLITIS</u>

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. NEPHROTIC SYNDROME

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. <u>DOCUMENTATION STANDARDS OF COMMON SKIN DISORDERS</u>

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. <u>Speech</u> - 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. <u>Cranial Nerve Examination</u> - 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. <u>Cerebellar Function Tests</u> - 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. <u>Motor Function Examination</u> - 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. <u>Sensory System Examination</u> - 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. <u>Reflex Examination</u> - 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. <u>EPILEPSY (SEIZURES)</u>

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. <u>Mental Status</u> - 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 musculoskeletal system, and at times under other corresponding body systems. When the musculoskeletal 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 musculoskeletal, 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 musculoskeletal 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

5.1 Introduction

5.1.1 Purpose of Chapter

The non-medical and vocational factors are considered when determining the ability of the employee to perform his or her regular railroad occupation for a 2a(1)(iv) annuity under the Railroad Retirement Act (RR Act) and in the last two steps of the sequential evaluation process when determining whether an employee, widow or child is totally disabled for an annuity under the RR Act or for a disability freeze under the Social Security Act (SS Act). This chapter lists the sources for vocational information and defines terms used in evaluating the non-medical and vocational factors. The Social Security Administration's (SSA) Medical-Vocational Guidelines and SSA's Medical-Vocational Quick Reference Guide are included as Appendix A and Appendix B to this chapter.

5.1.2 Published Vocational Guides

A. Department of Labor's Dictionary of Occupational Titles (DOT) - Used primarily to determine non-railroad job duties and requirements.

B. The Lawshe Studies - Railroad Industry Job Analyses - Used primarily to determine railroad job duties, responsibilities, settings and requirements. It contains photographs and illustrations.

C. Booklets Compiled by the Association of American Railroads and Other Railroad Labor and Management Organizations - Used to obtain supplemental data pertaining to the demands of railroad occupations.

D. Railroad Retirement Board (RRB) Provisional Occupational Disability Rating Schedule - This manual groups types of railroad occupations, by levels of exertion required, into eight "family groups." The lower the family group number, the more arduous the work is considered. Thus, the occupations in family group I are considered the most arduous while the occupations in family group VIII are considered sedentary types of work. It lists the impairments which would prevent performance of activity within each group.

5.1.3 Ability To Work

A determination that work activity is not Substantial Gainful Activity (SGA) does not resolve the issue of the individual's ability to perform such work. It is merely one of the aspects to consider in making a total evaluation of the person's capacity for work.

The decision of ability to perform SGA requires consideration of medical and vocational factors. The claimant is considered to be unable to perform SGA if his or her physical or mental impairment(s) are of such severity that he or she is not only unable to do his

or her previous work but cannot, considering age, education and work experience, engage in any other kind of SGA, which exist in the national economy.

The decision of whether the claimant can perform SGA in the national economy does not consider whether such work exists in the immediate area in which the claimant lives, or whether a specific job vacancy exists, or whether the claimant would be hired if he or she applied for work.

5.1.4 Basic Work Activities

Basic work activities involve the abilities and aptitude necessary to perform most jobs. Examples of these include:

A. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; and,

B. Capacities for seeing, hearing and speaking; and,

C. Understanding, carrying out, and remembering simple instructions; and,

D. Use of judgment; and,

E. Responding appropriately to supervision, co-workers and usual work situations; and,

F. Dealing with changes in a routine work setting.

5.1.5 Residual Functional Capacity (RFC)

RFC is a medical assessment of a person's maximum sustained capability for work. It is the remaining ability to perform work related physical and mental activities. The claimant’s functional capacity must be defined in terms of the claimant's ability to functions in a work setting.

The RFC is determined before the vocational factors are considered. Then the interaction of the RFC with the other factors affecting vocational adaptability, i.e., age, education and work experience are analyzed. Other considerations may be descriptions by the contacting officials or the person himself concerning his or her appearance, conduct at the interview, work limitations, etc.

This capacity is defined as follows:

A. Physical Abilities - This considers the person's RFC for work activity on a regular and continuing basis. This includes the 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 person's ability to do work.

B. Mental Impairments - This includes factors such as the person's ability to understand, carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting.

C. Other Impairments - Some medically determinable impairments, such as skin impairments, epilepsy, and impairments of vision, hearing and other senses, and environmental restrictions do not limit physical exertion. However, this type of impairment, in addition to one that affects physical exertion, is considered in deciding a person's RFC.

EXAMPLE: Tolerating work related heat and humidity or tolerating work related fumes and odors.

5.1.6 Rationale

The rationale portion of the disability determination is the justification for the disability decision. The rationale must contain objective medical findings that prove the decision is correct. The rationale explains to any reader why a claimant is or is not disabled.

The rationale for initial disability decisions is completed on Form G-325B. The rationale for disability freeze ratings is completed on Form G-325.1, Disability Decision Rationale. The rationale for a continuing disability review is completed on Form G-325a, Determination of Continuance or Cessation of Disability.

When writing a rationale the information must be complete and the steps of sequential evaluation are to be followed (DCM3.6.1). All rationales must include three sections, the Introduction, the Body and the Conclusion.

Introduction

The introduction provides the background to the claim. It must include the age, the railroad occupation, the claimed impairment in order of severity and the history of the complaint. In addition, any surgeries, physical therapies or special circumstances should be mentioned.

Body

The body provides the objective medical findings that the disability decision is based on. Objective findings related to the applicant's condition such as lab reports, x-rays, EKG tracings, biopsy reports, etc., are to be included in the Body. Identify the reports used to support the disability decision by the dates of the medical evidence. Explain how these findings support the restrictions imposed by the impairment.

For CDR's you must reconcile work activity with the disability. You must address how the ability to do work indicates whether the person continues to be disabled or not and explain any special circumstances that allows the annuitant to work. If there is medical

improvement, it must be substantial and should be fully explained by an analysis of the medical evidence to clearly describe the areas of improvement.

Conclusion

The conclusion states whether the applicant is disabled or not disabled. When the conclusion is being drawn based on an RFC in file that RFC needs to be noted by the name of the doctor.

For every rationale it is necessary to note any circumstances that need clarification. If there are conflicting RFCs in file you must note why you have chosen one RFC over another.

For example, the treating physician sends office notes with a sedentary RFC. The office notes show minimal findings. A consultative examination shows minor restrictions with a medium RFC. The objective medical findings support the medium RFC, not the sedentary RFC, and the examiner needs to explain this.

All medical vocational rules, Listing of Impairment, disqualifying criteria, Tables (confirmatory test and disability test) or Independent Case Evaluation must be cited in the conclusion.

Upon finishing the conclusion of the rationale it is important to explain any unusual situations or discrepancies that are in file. For example, if the determined onset date is different than the alleged onset date, an explanation is necessary.

For CDR's any earnings amount or impairment related work expenses must be considered and explained. Also explain any months in the rolling trial work period and reentitlement period.

5.1.7 Non-Medical Factors

Non-medical factors are items which are not purely medical in nature, but which can assist in the determination as to whether a physical or mental condition exists and if it prevents the performance of work. Examples of non-medical factors are: job duties, changes in non-work activities, applicant's description of how the condition has affected him, work experience, educational achievement, special training, etc. A report of non-medical factors helps in the evaluation of the applicant's residual capacity for work. The information obtained from non-medical factors should be evaluated to determine if there are any inconsistencies that need to be resolved. Specifically, if non-medical factors are inconsistent with claimed impairment or medical evidence submitted by the applicant, additional medical development should be considered. However, internet resources such as social media sites (example, Facebook) must not be used to resolve inconsistencies. It is the consideration of non-medical factors that makes a disability decision, not just a medical decision. Therefore, good development of non-medical factors is just as important, in many cases, as development of medical evidence.

In general terms, non-medical factors include:

- The applicant's statement of how and when his/her condition affected his/her ability to work.
- A description from the applicant of his/her current daily activities and how they have been changed due to his/her medical condition.

NOTE: If any prior medical development or rating occurred for the applicant and there is an Activities of Daily Living (ADL) report in file, fax a copy of that report to the field office when making an ADL assignment for the current determination.

- A summary of the applicant's education and training.
- A description of the duties of the railroad and non-railroad job(s) the applicant performed in the five years and in the 15 years prior to filing a disability claim which are documented on Form G-251.
- An observation of applicant’s difficulties with skills, appearance, notable mannerisms or odd behaviors which are documented on Form G-626A.

5.2 Vocational Consideration

5.2.1 Past Relevant Work (PRW)

PRW is work which a claimant previously performed. We consider an individual's work experience to be PRW when it was done within the last 15 years, lasted long enough for the individual to learn and was SGA. We do not usually consider the work an individual did 15 years or more before the time we are deciding whether they are disabled. A gradual change occurs in most jobs so that after 15 years it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. The 15-year guide is intended to insure that remote work experience is not currently applied. If the individual has no work experience or worked only "off-and-on" for brief periods of time during the 15-year period, we generally consider that these brief periods of work do not apply. If the individual has acquired skills through their past work, we consider them to have these skills unless they cannot use them in other skilled or semi-skilled work that they can now do. If an individual cannot use their skills in other skilled or semi-skilled work, we will consider their work background the same as unskilled. However, even if an individual has no work experience, we may consider that the individual is able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

5.2.2 Sources Of Information About PRW

A particular job may or may not be identifiable in authoritative reference materials. The claimant is in the best position to describe just what he or she did in PRW.

Adequate documentation of past work would include factual information about those work demands which have a bearing on the medically established limitations. This involves the following:

A. Detailed information about strength, endurance and manipulative ability; and,

B. Information concerning job titles, dates work was performed, rate of compensation, tools and machines used, knowledge required, the extent of supervision and independent judgment required, and a description of tasks and responsibility to permit a judgment as to the skill level and the current relevance of the individual's work experience; and,

C. If the claim involves a mental/emotional impairment, care must be taken to obtain a precise description of the particular job duties which are likely to produce tension and anxiety e.g. speed, precision, complexity of tasks, independent judgments, working with others people, etc., in order to determine if the claimant's mental impairment is compatible with the performance of such work; and

D. If the claim involves a stress related physical impairment, information concerning the degree of stress in the job tasks, should be obtained for a decision as to whether the impairment is compatible with the performance of such work.

Form G-251, Vocational Report, has been developed to obtain job information. This form is completed by the claimant or his representative. If more than one job was performed during the 15-year period before adjudication (or in the 35-year period before adjudication if the claimant has a 6th grade education or less and performed only heavy unskilled labor) separate description of each job must be secured.

If the claimant or his representative is unable to describe PRW adequately, the employer, a co-worker, or a member of the family may be able to do so.

5.2.3 Determining Ability To Perform PRW

A basic disability rating principle is that a claimant's impairment must be the primary reason for his or her inability to engage in SGA. This reflects the intent of Congress that there be a clear distinction between disability benefits and unemployment benefits. Congress has also expressed the intent that disability determinations be carried out in as realistic a manner as possible.

A. Capacity To Perform Actual Past Relevant Job - Determine whether the claimant retains the capacity to perform the particular functional demands and job duties peculiar to an individual job as he or she actually performed it.

   Under this test, where the evidence shows that a claimant retains the RFC to perform the functional demands and job duties of a particular past relevant job as he or she actually performed it, the claimant should be found to be "not disabled."

B. Capacity To Perform Past Relevant Job As Ordinarily Required - Determine whether the claimant retains the capacity to perform the functional demands and job duties of the job as ordinarily required by employers throughout the national economy. (The DOT descriptions can be relied upon to define the job as it is usually performed in the national economy.) It is understood that some individual jobs may require somewhat more or less exertion than the DOT description.

A former job performed by the claimant may have involved functional demands and job duties significantly in excess of those generally required for the job by other employers throughout the national economy. Under this test, if the claimant cannot perform the excessive functional demands and/or job duties actually required in the former job but can perform the functional demands and job duties as generally required by employers throughout the economy, the claimant should be found to be "not disabled."

5.2.4 Vocational Profile

Initial development to secure information is done by a field contact representative when the disability claim is filed. The complete report includes:

A. A statement of events leading to and surrounding the applicant's current conditions; and,

B. A description of work and military experience and special training or rehabilitation that may be involved in the applicant's case; and,

C. A description of duties which might indicate the physical and mental requirements of past work; and,

D. A specific statement giving the applicant's number of years of formal education; and,

E. Observations of the applicant by the field service representative (including advice regarding any language barrier).

The disability examiner is to determine the vocational profile in each case. When necessary, request field development to clarify any vocational factor that is unclear or for which there are conflicting statements or controversy.

5.2.5 Current Vocational Relevance

The current vocational relevance of the claimant's past employment is based on five factors:

A. Job content;

B. Duration of the work;

C. Recency of the work;

D. Possibility that the work was not substantial gainful activity; and,

E. Possibility that work was performed under special conditions (e.g. sheltered workshop)

The relevance of past work in a foreign economy is no different from the relevance of past work in the U.S. economy with respect to the physical and mental demands of a particular past job.

5.2.6 Job Content

Job content consists of the skills and duties required plus the knowledge of the processes, materials, products and techniques of the company.

5.2.7 Duration Of Work

The duration of work is the amount of experience the applicant gained in the work. This is considered in the last step of the Sequential Evaluation Process.

A. Quantity of Work - The duration should have been sufficient for the worker to:

   1. Learn the techniques;

   2. Acquire information; and

   3. Develop the facility needed for average performance on the job.

B. Length of Time - The length of time required to attain average performance depends on:

   1. The nature of the job; and

   2. The complexity of the work.

5.2.8 Vocational Training

Training refers to skills and knowledge acquired on the job or through general experience in an industry or field of work. Both can significantly affect ability to work, and must therefore be considered in evaluating the impact of an impairment on an individual claimant in the last step of the sequential evaluation process.

Training that is vocationally significant prepares an individual to do a specific job or provides background to do a number of jobs in the same field. Training that is not reflected in the individual's actual work experience would raise questions as to its adequacy and current usefulness to the individual. Content, duration, and recency should be considered in determining the scope and application of training and its current

usefulness. Normally, if an individual completed training more than 15 years prior to the point at which the claim is being considered for adjudication (or when the earnings requirement was last met if earlier) and did not make use of it in his or her work, it would not affect the claimant's vocational outlook at the present time. Moreover, even if completed within the 15-year period, training would not ordinarily be expected to qualify an individual for more than entry level (e.g., at the apprenticeship or lowest beginning level) occupations. Therefore, care should be exercised to assure that undue weight is not attributed to training and to ascertain how training can be utilized in occupations.

5.2.9 Recency Of Work

Recency of work refers to the time which has elapsed since the work was performed. This affects the probability that the work remains of economic value. There could have been technological changes in the field since the applicant worked. Also, the applicant can suffer loss of abilities due to the length of time since the work was last performed.

The claimant's work history for the 15-year period prior to adjudication is, generally, vocationally relevant to evaluation of his current capacity to engage in SGA.

A. Initial, Reconsideration or Appeal - In initial, reconsideration or appeals cases the 15-year period is generally the 15-year prior to the time of adjudication.

B. Disability Insured Status Met Prior to Adjudication - In cases in which the claimant's disability insured status was last met prior to adjudication, the work performed for the 15-year period preceding the date the disability insured status requirement was last met would generally be considered relevant since the capacity for work as of that date represents a initial disability issue.

C. Issue of Continuing Disability - When deciding whether a beneficiary continues to be disabled, relevant past work is work he or she performed in the 15-year period prior to adjudication of the issue of continuing disability.

5.2.10 Work Experience Limited To Arduous Unskilled Physical Labor

When the disability examiner has reached the last step of the sequential evaluation process, the examiner must determine if the work experience of a claimant is limited to arduous unskilled physical labor. A vocational adjustment to other work may be inferred if the person is not engaging in SGA and meets the following requirements:

A. Severity of Impairment - An impairment must be severe enough to prevent the performance of arduous physical labor.

B. History of Arduous Unskilled Work - The individual's work history must have the following characteristics:

    1. Duration - The work experience must have lasted 35 years or more.

2. <u>Arduous Defined</u> - The work must meet the definition of "arduous." Arduous work is primarily physical work requiring a high level of strength or endurance. No specific physical action or exertional level denotes arduous work. While arduous work will usually entail physical demands that are classified as heavy, the work need not be described as heavy to be considered arduous. For example, work involving lighter objects may be arduous if it demands a great deal of stamina or activity such as repetitive bending and lifting at a very fast pace. Thus, there is room for judgment in deciding whether this criterion is met.

3. <u>Unskilled</u> - The work must have been basically unskilled. Employment in semiskilled or skilled work generally would rule out the application of this work profile. Isolated, brief, or remote periods of experience in semiskilled or skilled work, however, would not preclude the applicability of this work profile when such experience did not result in skills which enhance the person's present ability to do lighter work. Also, periods of semiskilled or skill work may come within the provisions of this work profile if it is clear that the skill acquired is not readily transferable to lighter work and makes no meaningful contribution to the person's ability to do any work within his or her present functional capacity.

C. <u>Marginal Education</u> - The claimant must meet the criteria for marginal education. (See Educational Consideration.)

5.2.11 Absence Of Work Experience

An individual has no relevant work experience when, during the 15-year period prior to adjudication, he or she:

A. Has not worked; or

B. Has worked only sporadically or for brief periods of time; or,

C. Has worked but on the basis of job content, duration, or recency, the present work capability is not enhanced.

The lack of work experience is a vocationally adverse factor. A person who has not been in the labor market has not developed any basic knowledge of work products or services, the ability to relate and communicate to supervisors and coworkers, the work habits of scheduling time, etc. Recognizing that as a person grows older the ability to compensate for the lack of work experience diminishes, SSA established a policy in 1975 which provided that, up to a point, all other factors being equal, claimants without experience and those who have performed only unskilled work would be treated the same. That point is advanced aged. The policy decision, in effect, directs a finding of disability where a person has a severe impairment of any nature, is of advanced age, has only the limited educational competence required for unskilled work, and has no work experience at all or no recent and relevant work experience.

5.2.12 Sheltered Employment

Sheltered employment is employment provided for handicapped individuals in a protected environment under an institutional program. The most common types of sheltered employment occur in sheltered workshops, hospitals and similar institutions, homebound programs, and VA domiciles. Impaired individuals engaged in sheltered employment are generally less productive than impaired workers in commercial employment. They usually do not seek sheltered employment when regular jobs are available for handicapped individuals in private industry. Typically, they are limited to lower than average earnings in a sheltered environment, where their handicaps are tolerated to a degree not found in outside employment. The following is a description of some types of sheltered employment:

A. Sheltered Workshops - Sheltered workshops are engaged in manufacturing, assembly, reconditioning, repair, and other work operations. These may involve direct sales to consumers and retailers, or the fulfillment of industrial contracts. Some workshops, in addition to providing employment, furnish services or facilities for medical care, physical restoration, psychiatric therapy, recreation, vocational evaluation and training, job placement, etc.

B. Hospitals, VA Domiciliaries and Long-term Care Institutions - Hospitals VA domiciles and similar institutions for the care of individuals suffering from long-term impairments, usually have occupational therapy programs designed to encourage the use of patient's residual physical and mental capacities. If the institution furnishes room and board to working patients (as for example, VA domiciles do) the value of room and board is not considered as remuneration for those patients who work for the institution while in patient status. However, an individual who works for an institution after he/she has been discharged from patient status may receive room and board as part of regular pay.

C. Homebound Employment - "Homebound employment" refers to work done at home by individuals who are working under public or institutional programs designed to provide them with remunerative employment. Pay for the work is usually on a piece-rate basis. The employer delivers raw materials to the individual's home and picks up finished merchandise. The assistance of family members in performing the work may constitute a subsidy to the impaired individual, the value of which should be deducted from wages before the earnings guides are applied.

5.3 Age Considerations

5.3.1 Establishing Age

The proof of age is always required when an application for an annuity is filed under the Railroad Retirement Act. However, a disability annuity may be awarded before establishment of the date of birth when age is not a factor of eligibility.

The consideration of age, in the disability determination process, recognizes the increasing physiological deterioration in the senses, joints, eye-hand co-ordination, reflexes, thinking processes, etc., which diminish a severely impaired person's aptitude for learning and adaptation to a new job.

The specific use of chronological age rather than physiological age is a constitutional means of classification. It is rationally related to those bodily changes which occur with approaching advanced age.

5.3.2 Younger Individual

Depending on the individual's RFC, a younger individual is defined as either:

A. Under age 50; or

B. Age 45 to 49; or

C. Age 18 to 44.

5.3.3 Individual Approaching Advanced Age

An individual approaching advanced age is defined as age 50 to 54. Individuals approaching advanced age may be significantly limited in vocational adaptability.

5.3.4 Individual Of Advanced Age

An individual of advanced age is defined as age 55 or over. An individual of advanced age may be significantly limited in vocational adaptability.

5.3.5 Individual Closely Approaching Retirement Age

An individual closely approaching retirement age is defined as age 60 to 64. For a finding of transferability of skills to light work for an individual closely approaching retirement age, there must be very little, if any, vocational adjustment required in terms of tools, work processes, work setting, or the industry.

5.3.6 Borderline Age Situations

The considerations given to age are not applied mechanically in borderline situations, i.e., in cases where only a few days or few months exists before the claimant would pass from one age category to another age category and such passage would affect the ultimate finding of disabled or not disabled.

No fixed guidelines as to when borderline age situations exist can be given since such guidelines would themselves reflect a mechanical approach. However, for disability rating purposes, examiners can usually use about a 6-month time frame.

EXAMPLE: Evidence establishes that a claimant for a total and permanent disability annuity has a light RFC with environmental restrictions of avoiding excessive fumes, dust, other respiratory irritants and cold temperatures. He has a limited education. He is 54 and 2 months as of the alleged onset date (August 31, 1992). Past work was of a medium exertional level. He has no transferable skills. Using medical-vocational rule 202.11 for the decision you arrive at a decision of not disabled. However, considering the claimant's adverse profile as mentioned above, it would be appropriate to deem him as age 55 six months prior to his actual age 55 attainment date of June 1993. Thus using medical vocational rule 202.02 for your decision, you arrive at a decision of disabled as of December 1, 1992.

When an individual has not quite attained a critical age (45, 50, 55 or 60) but has been deemed that age, an explanation must be given.

5.4 Educational Consideration

5.4.1 Education Defined

Education is a term primarily used to mean formal schooling or other training which contributes to ability to meet vocational requirements. For example, reasoning ability, communication skills, and arithmetical ability.

5.4.2 Establishing Educational Level

Unless there is evidence to contradict a person's statement as to the grade level completed in school, the statement will be used to determine the person's educational abilities. However, the person's present level of reasoning, communications, and arithmetical ability may be higher or lower than the level of formal education. When evidence of the kinds of responsibilities the person had when working, any acquired skills, daily activities, and hobbies, as well as the results of testing indicate that the person will meet the criteria for a different educational level, establish the educational level considering both his or her statements and the evidence pertinent to evaluating that person's educational capacities.

In evaluating educational level use the following categories: Illiteracy, Marginal Education, Limited Education, High School Education and Above, and Inability to Communicate in English.

5.4.3 Illiteracy

Illiteracy is defined as the inability to read or write. Consider someone illiterate if they cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her name. Generally, an illiterate person has had little or not formal schooling.

While illiteracy may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with objects (rather than with

data or people). Thus, literacy has the least significance with work functions at the unskilled level.

5.4.4 Marginal Education

Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. Generally, consider formal school at a 6th grade level or less to be marginal education.

5.4.5 Limited Education

Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. Generally consider that a 7th grade through 11th grade level of formal education is limited education.

5.4.6 High School Education And Above

High school education and above means, abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. Generally consider that a person with these educational abilities can do semi-skilled through skilled work.

The Social Security Administration's Medical Vocational Guidelines criteria of "high school graduate or more-provides for direct entry into skilled work" is met when there is little time laps between the completion of formal education and the date of adjudication, and the content of the education would enable the individual, with a minimal degree of job orientation, to begin performing the skilled job duties of certain identifiable occupations within their RFC.

5.4.7 Inability To Communicate In English

Since the ability to speak, read and understand English is generally learned or increased at school, this is considered to be an educational factor. Because English is the dominant language of the country, it may be difficult for a person who doesn't speak and understand English to do a job, regardless of what the person's other language is and the amount of education in that language.

While inability to communicate in English may significantly limit an individual's vocational scope, the primarily work functions in the bulk of unskilled work relate to working with things or objects (rather than with data or people) and in these work functions at the unskilled levels, literacy or ability to communicate in English has the least significance.

5.5 Transferability Of Work Skills

5.5.1 When Transferability Of Work Skills Is An Issue

Transferability of skills is an issue only when an individual's impairment(s), though severe, does not meet or equal the criteria in SSA's listing of impairments but does prevent the performance of past relevant work and that work has been determined to be skilled or semiskilled. Transferability will be decisive in the conclusion of "disabled" or "not disabled" in only a relatively few instances. Even if it is determined that there are no transferable skills, a finding of "not disabled" may be based on the ability to do unskilled work.

5.5.2 Past Relevant Work And Transferable Work Skills

A claimant is considered to have transferable work skills when the skilled or semi-skilled work activities done in past relevant work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

A person's acquired work skills may or may not be commensurate with his or her formal educational attainment. Transferability is distinct from the usage of skills recently learned in school which may serve as a basis for direct entry into skilled work.

Skills are not gained by doing unskilled jobs. Also, a person has no special advantage if he or she is skilled or semi-skilled but can qualify only for an unskilled job because his or her skills cannot be used to any significant degree in other jobs.

5.5.3 Determination Of Skill Levels Of Past Relevant Work

In many cases, the skill level of past relevant work will be apparent simply by comparing job duties with the regulatory definitions of skill levels. This is especially true with most unskilled and most highly skilled work. Job titles, in themselves, are not determinative of skill levels. When it is not apparent, the adjudication should consult vocational reference sources such as the Dictionary of Occupational Titles. A vocational specialist is sometimes required to assist in determining the skill level of past work.

5.5.4 Basic Skill Requirements

In order to evaluate skills and to help determine the existence in the national economy of work, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, materials published by the Department of Labor are used. The requirements of the different skill levels are as follows:

A. Unskilled Work - Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, consider jobs unskilled if the primary work duties are handling, feeding, and off-bearing (that is

placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

B. Semi-Skilled Work - Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

C. Skilled Work - Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

5.5.5 How To Determine Skills That Can Be Transferred To Other Jobs

Transferability is most probable and meaningful among jobs in which -

A. The same or a lesser degree of skill is required because people are not expected to do more complex jobs than they have actually performed;

B. The same or similar tools and machines are used; and

C. The same or similar raw materials, products, processes, or services are involved.

A complete similarity of all these factors is not necessary.

5.5.6 Degrees Of Transferability

There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs.

Some people with highly skilled work backgrounds (architect, stress management analyst, air conditioning and heating mechanic, and various professional and executive or managerial occupations) have a much greater potential for transferability of their skills. Their skills encompass a greater number of occupations at the same and lower

skill levels. Usually, the higher the skill level, the more the potential for transferring skills increases. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or in the railroad industry - for example, a locomotive engineer) that they are not readily usable in other industries, jobs, and work settings, they are not considered to be transferable.

Consultation with Dictionary of Occupational Tittles may be necessary to ascertain whether and how skills are transferable

5.5.7 Medical Factors And Transferability

Severe medical impairments should result in a finding of disability in step 4 of the Sequential Evaluation Process. However, cases in which the employee retains a RFC for work but is unable to do past relevant work will require a determination of transferability of work skills.

All functional limitations included in the Residual Functional Capacity must be considered in determining transferability. Physical limitation may prevent a claimant from operating the machinery or using the tools associated with the primary work activities of his or her past relevant work. Similarly, environmental, manipulative, postural, or mental limitations may prevent a claimant from performing semi-skilled or skilled work activities essential to a job.

Examples are switchmen with hand tremors, painters with allergic reactions to paint fumes, craftsmen who have lost eye-hand coordination, locomotive engineers whose back impairments will not permit jolting and business executives who suffer brain damage which notable lowers their IQ's.

These factors as well as the physical exertions requirements of the job must be considered in assessing whether or not a claimant has transferable work skills. If the impairment(s) does not permit acquired skills to be used, transferability of skills can be easily resolved.

5.5.8 Inability To Obtain Work

If the claimant's RFC and vocational abilities make it possible for him or her to do work which exists in the national economy, but the claimant remains unemployed, he or she will <u>not</u> be considered "disabled" because of:

A. Inability to get work;

B. Lack of work in the claimant's local area;

C. The hiring practices of employees;

D. Technological changes in the industry in which the claimant has worked;

E. Cyclical economic conditions;

F. No job openings for him or her;

G. The claimant would not actually be hired to do work he or she could otherwise do; or

H. The claimant does not wish to do a particular type of work.

5.5.9 Affect Of Age On Transferability

The Social Security Administration's regulations provide that advancing age is an increasingly adverse vocational factor for persons with severe impairments. The chronological ages 45, 50, 55 and 60 may be critical to a decision.

Individuals approaching advanced age (age 50-54) may be significantly limited in vocational adaptability.

For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60-64) there must be very little, if any, vocational adjustment required in terms of tools, work processes work setting or the industry.

A disability freeze cannot begin after a worker's disability insured status has expired. When the person last met the insured status requirement before the date of adjudication, the oldest age to be considered is the person's age at the date last insured. In these situations, the person's age at the time of decision-making is immaterial.

5.6 Medical-Vocational Guidelines

5.6.1 Introduction

The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determination physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not

disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

The existence of jobs in the national economy is reflected in the "Decisions" shown in the rules; i.e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the "Dictionary of Occupational Titles" and the "Occupational Outlook Handbook," published by the Department of Labor; the "County Business Patterns" and "Census Surveys" published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

In the application of the rules, the individual's residual functional capacity (i.e., the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience must first be determined. See Appendix B for vocational concepts and terms commonly used in the medical-vocational evaluation.

The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile, If an individual's specific profile is not listed within this Section, a conclusion of disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g. the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific cases situations in this Section. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decision making, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other, nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully

applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

A. In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this Appendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

B. However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this Section, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

5.6.2 RFC Limited To Sedentary Work

Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).

A. Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and bench work classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and bench work occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

B. These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

C. Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and

basic educational competencies provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g., has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

D. The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

E. The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

F. In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

G. Individuals approaching advanced age (age 50-54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

H. The term "younger individual" is used to denote an individual age 18 through 49. For those within this group who are age 45-49, age is a less positive factor than for those who are age 18-44. Accordingly, for such individuals;

1. who are restricted to sedentary work,

2. who are unskilled or have no transferable skills,

3. who have no relevant past work or who can no longer perform vocationally relevant past work, and

4. who are either illiterate or unable to communicate in the English language, a finding of disabled is warranted. On the other hand, age is a more positive factor for those who are under age 45 and is usually not a significant factor in limiting such an individual's ability to make a vocational adjustment, even an adjustment to unskilled sedentary work, and even where the individual is illiterate or unable to communicate in English. However, a finding of disabled is not precluded for those individuals under age 45 who do not meet all of the criteria of a specific rule and who do not have the ability to perform a full range of sedentary work. The following examples are illustrative:

   Example 1: An individual under age 45 with a high school education can no longer do past work and is restricted to unskilled sedentary jobs because of severe medically determinable cardiovascular impairment (which does not meet or equal the listing in Appendix 1). A permanent injury of the right hand limits the individual to sedentary jobs which do not require bilateral manual dexterity. None of the rules in Appendix 2 are applicable to this particular set of facts, because this individual cannot perform the full range of work defined as sedentary. Since the inability to perform jobs requiring bilateral manual dexterity significantly compromises the only range of work for which the individual is otherwise qualified (i.e., sedentary), a finding of disabled would be appropriate.

   Example 2: An illiterate 41 year old individual with mild Intellectual Disability (IQ of 78) is restricted to unskilled sedentary work and cannot perform vocationally relevant past work, which had consisted of unskilled agricultural field work; his or her particular characteristics do not specifically meet any of the rules in Appendix 2, because this individual cannot perform the full range of work defined as sedentary. In light of the adverse factors which further narrow the range of sedentary work for which this individual is qualified, a finding of disabled is appropriate.

5. While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capability for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those

individuals age 18-44 even if they are illiterate or unable to communicate in English.

5.6.2.1 - Sedentary Work Medical-Vocational Rules

Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary Work as a Result of Severe Medically Determinable Impairment(s)

ADVANCED AGE (55 and over)RULE	**EDUCATION**	**PREVIOUS WORK EXPERIENCE**	**DECISION**
201.01	Limited or less	Unskilled or none	Disabled
201.02	Limited or less	Skilled or semiskilled - skills not transferable	Disabled
201.03	Limited or less	Skilled or semiskilled - skills transferable	Not Disabled
201.04	High school graduate or more – does not provide for direct entry into skilled work	Unskilled or none	Disabled
201.05	High school graduate or more – provides for direct entry into skilled work	Unskilled or none	Not Disabled
201.06	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled - skills not transferable	Disabled
201.07	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills transferable	Not Disabled
201.08	High school graduate or more – provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

CLOSELY APPROACHING ADVANCED AGE (50 to 54)

RULE	**EDUCATION**	**PREVIOUS WORK**	**DECISION**

		EXPERIENCE	
201.09	Limited or less	Unskilled or none	Disabled
201.10	Limited or less	Skilled or semiskilled – skills not transferable	Disabled
201.11	Limited or less	Skilled or semiskilled – skills transferable	Not Disabled
201.12	High school graduate or more – does not provide for direct entry into skilled work	Unskilled or none	Disabled
201.13	High school graduate or more – provides for direct entry into skilled work	Unskilled or none	Not Disabled
201.14	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Disabled
201.15	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills transferable	Not Disabled
201.16	High school graduate or more – provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

YOUNGER INDIVIDUAL (AGE 45 to 49)

RULE	**EDUCATION**	**PREVIOUS WORK EXPERIENCE**	**DECISION**
201.17	Illiterate or unable to communicate in English	Unskilled or none	Disabled
201.18	Limited or less – at least literate and able to communicate in English	Unskilled or none	Not Disabled
201.19	Limited or less	Skilled or semiskilled – skills not transferable	Not Disabled

201.20	Limited or less	Skilled or semiskilled – skills transferable	Not Disabled
201.21	High school graduate or more	Skilled or semiskilled – skills not transferable	Not Disabled
201.22	High school graduate or more	Skilled or semiskilled – skills transferable	Not Disabled

YOUNGER INDIVIDUAL (AGE 18 to 44)

RULE	**EDUCATION**	**PREVIOUS WORK EXPERIENCE**	**DECISION**
201.23	Illiterate or unable to communicate in English	Unskilled or none	Not Disabled
201.24	Limited or less – at least literate and able to communicate in English	Unskilled or none	Not Disabled
201.25	Limited or less	Skilled or semiskilled – skills not transferable	Not Disabled
201.26	Limited or less	Skilled or semiskilled – skills transferable	Not Disabled
201.27	High school graduate or more	Unskilled or none	Not Disabled
201.28	High school graduate or more	Skilled or semiskilled – skills not transferable	Not Disabled
201.29	High school graduate or more	Skilled or semiskilled – skills transferable	Not Disabled

5.6.3 RFC Limited To Light Work

Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).

A. The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous

jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

B. The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competencies for unskilled work.

C. However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

D. Where the same factors in paragraph (c) of this section regarding education and work experience are present, but where age, though not advanced, is a factor which significantly limits vocational adaptability (i.e., closely approaching advanced age, 50-54) and an individual's vocational scope is further significantly limited by illiteracy or inability to communicate in English, a finding of disabled is warranted.

E. The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

F. For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60-64), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

G. While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs.

This in turn, represents substantial vocational scope for younger individuals (age 18-49) even if illiterate or unable to communicate in English.

5.6.3.1 - Light Work Medical-Vocational Rules

Residual Functional Capacity: Maximum Sustained Work Capability Limited to Light Work as a Result of Severe Medically Determinable Impairment(s).

ADVANCED AGE (55 and over)

RULE	EDUCATION	PREVIOUS WORK EXPERIENCE	DECISION
202.01	Limited or less	Unskilled or none	Disabled
202.02	Limited or less	Skilled or semiskilled - skills not transferable	Disabled
202.03	Limited or less	Skilled or semiskilled - skills transferable	Not Disabled
202.04	High school graduate or more – does not provide for direct entry into skilled work	Unskilled or none	Disabled
202.05	High school graduate or more – provides for direct entry into skilled work	Unskilled or none	Not Disabled
202.06	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled - skills not transferable	Disabled
202.07	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills transferable	Not Disabled
202.08	High school graduate or more –provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

CLOSELY APPROACHING ADVANCED AGE (50 to 54)

RULE	EDUCATION	PREVIOUS WORK EXPERIENCE	DECISION
202.09	Illiterate or unable to	Unskilled or none	Disabled

	communicate in English		
202.10	Limited or less – at least literate and able to communicate in English	Unskilled or none	Not Disabled
202.11	Limited or less	Skilled or semiskilled – skills not transferable	Not Disabled
202.12	Limited or less	Skilled or semiskilled – skills transferable	Not Disabled
202.13	High school graduate or more	Unskilled or none	Not Disabled
202.14	High school graduate or more	Skilled or semiskilled – skills not transferable	Not Disabled
202.15	High school graduate or more	Skilled or semiskilled – skills transferable	Not Disabled

YOUNGER INDIVIDUAL (Age 49 and under)

RULE	**EDUCATION**	**PREVIOUS WORK EXPERIENCE**	**DECISION**
202.16	Illiterate or unable to communicate in English	Unskilled or none	Not Disabled
202.17	Limited or less – at least literate and able to communicate in English	Unskilled or none	Not Disabled
202.18	Limited or less	Skilled or semiskilled – skills not transferable	Not Disabled
202.19	Limited or less	Skilled or semiskilled – skills transferable	Not Disabled
202.20	High school graduate or more	Unskilled or none	Not Disabled
202.21	High school graduate or more	Skilled or semiskilled – skills not transferable	Not Disabled
202.22	High school graduate or more	Skilled or semiskilled – skills transferable	Not Disabled

5.6.4 RFC Limited To Medium Work

Maximum work capability limited to medium work as a result of severe medically determinable impairment(s).

A. The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills previous experience and which can be performed after a short demonstration or within 30 days.

B. The functional capacity to perform medium work represents such substantial work capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired individual retains the functional capacity to perform medium work. Even the adversity of advanced age (55 and over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, an individual with a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled labor, who is not working and is no longer able to perform this labor because of a severe impairment(s), may still be found disabled even though the individual is able to do medium work.

C. However, the absence of any relevant work experience becomes a more significant adversity for individuals of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less, militates against making a vocational adjustment to even this substantial range of work and finding of disabled is appropriate. Further, for individuals closely approaching retirement age (60-64) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

5.6.4.1 - Medium Work Medical-Vocational Rules

Residual Functional Capacity: Maximum Sustained Work Capability Limited to Medium Work as a Result of Severe Medically Determinable Impairment(s).

CLOSELY APPROACHING RETIREMENT AGE (60 to 64)

RULE	EDUCATION	PREVIOUS WORK EXPERIENCE	DECISION
203.01	Marginal or none	Unskilled or none	Disabled
203.02	Limited or less	None	Disabled
203.03	Limited	Unskilled	Not Disabled

203.04	Limited or less	Skilled or semiskilled - skills not transferable	Not Disabled
203.05	Limited or less	Skilled or semiskilled - skills transferable	Not Disabled
203.06	High school graduate or more	Unskilled or none	Not Disabled
203.07	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled - skills not transferable	Not Disabled
203.08	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills transferable	Not Disabled
203.09	High school graduate or more – provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

ADVANCED AGE (55 to 59)

RULE	**EDUCATION**	**PREVIOUS WORK EXPERIENCE**	**DECISION**
203.10	Limited or less	None	Disabled
203.11	Limited or less	Unskilled	Not Disabled
203.12	Limited or less	Skilled or semiskilled - skills not transferable	Not Disabled
203.13	Limited or less	Skilled or semiskilled - skills transferable	Not Disabled
203.14	High school graduate or more	Unskilled or none	Not Disabled
203.15	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled - skills not transferable	Not Disabled
203.16	High school graduate or	Skilled or semiskilled –	Not Disabled

	more – does not provide for direct entry into skilled work	skills transferable	
203.17	High school graduate or more – provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

CLOSELY APPROACHING ADVANCED AGE (50 to 54)

RULE	EDUCATION	PREVIOUS WORK EXPERIENCE	DECISION
203.18	Limited or less	Unskilled or none	Not Disabled
203.19	Limited or less	Skilled or semiskilled - skills not transferable	Not Disabled
203.20	Limited or less	Skilled or semiskilled - skills transferable	Not Disabled
203.21	High school graduate or more	Unskilled or none	Not Disabled
203.22	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled - skills not transferable	Not Disabled
203.23	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills transferable	Not Disabled
203.24	High school graduate or more – provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

YOUNGER INDIVIDUAL (Age 49 and under)

RULE	EDUCATION	PREVIOUS WORK EXPERIENCE	DECISION
203.25	Limited or less	Unskilled or none	Not Disabled
203.26	Limited or less	Skilled or semiskilled - skills not transferable	Not Disabled
203.27	Limited or less	Skilled or semiskilled - skills transferable	Not Disabled

203.28	High school graduate or more	Unskilled or none	Not Disabled
203.29	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled - skills not transferable	Not Disabled
203.30	High school graduate or more – does not provide for direct entry into skilled work	Skilled or semiskilled – skills transferable	Not Disabled
203.31	High school graduate or more – provides for direct entry into skilled work	Skilled or semiskilled – skills not transferable	Not Disabled

5.6.5 RFC Limited To Heavy Work

Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).

The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work - either of which would have already provided a basis for a decision of "not disabled." Environmental restrictions ordinarily would not significantly affect the range of work existing in then national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

5.6.6 Attainment of Age and the Medical-Vocational Rules

Based on using the medical vocational rules, if the determination is a denial but the claimant will attain an age that would make the determination an allowance within 120 days, forward the case to your supervisor for guidance.

Appendices

Appendix A – The Medical-Vocational Guidelines

In order to promote consistency with adjudicating disability determinations under 2a(1)(iv) of the Railroad Retirement Act, or for a disability freeze decision adjudicated under the Social Security Act, refer to The Social Security Administration's (SSA)

Medical-Vocational Guidelines (DI 25025.001) to address issues in the Total and Permanent sequential evaluation process.

Appendix B – Medical-Vocational Quick Reference Guide

For vocational information and definition of terms used in evaluating the non-medical and vocational factors during the Total and Permanent sequential evaluation process, see the Social Security Administration's (SSA) Medical-Vocational Quick Reference Guide found in DI 25001.001.

6.1 Introduction

6.1.1 General

Every disability annuitant is also rated under the Social Security (SS) Act for a period of disability. Non-disability annuitants may also file for a disability freeze (DF). However, the annuitant has the right to request that a DF not be granted. (See DCM 6.3.1)

The freeze provision of the SS Act protects disabled workers and their families against the loss of, or the reduction in, benefits because of the worker's disability. When a freeze is established, the worker's wage record is frozen and the period during which he is disabled and not likely to have substantial earnings is excluded to the worker's advantage when determining insured status and benefit amounts.

The Railroad Retirement Board (RRB) uses the freeze provision in retirement cases to increase primary insurance amounts (PIA), make the tier I portion taxable like a social security benefit, establish early Medicare and windfall entitlement, and to apply the Disability Insurance Benefit (DIB)-Overall Minimum (O/M). In survivor cases, the freeze may produce higher monthly rates that would otherwise not be payable.

A survivor can file an application to establish a DF for a deceased employee if the application is filed within 3 months of the employee’s death. Although a disability annuity cannot be paid to the survivor, the establishment of the DF may increase the amount of survivor annuity. For background information and processing instructions, see RCM 8.1.185.

6.1.2 History Of And Agency Authority To Make Freeze Determinations

The original period of disability (disability freeze) SS Act provisions were enacted in 1954 to preserve the rights of individuals who are under disability. The provisions preserved the individual's insured status and the amount of the benefit from the time the person qualified for a disability freeze. Since the person's rights were preserved from that time, these provisions became commonly known as the disability freeze provisions. At this point, benefits could be increased when the person attained age 65 if a disability freeze was established.

The 1956 SS Act Amendments provided cash disability benefits effective 1-1-57 or later to wage earners who had attained age 50. Auxiliary benefits became payable 9-1-58 or later on the same basis as those made to auxiliaries of retired workers.

Prior to September 6, 1958, the Social Security Administration (SSA) had sole authority under the law to establish a disability freeze for career railroad (RR) employees who would be insured under the SS Act if their RR service after 1936 were credited as employment under that Act. Under an agreement between SSA and RRB, the RRB was delegated authority to obtain disability freeze applications and other necessary

evidence from RR employees to make disability freeze determinations. These disability freeze determinations were subject to the review and approval of SSA.

Since September 6, 1958, RRB has had independent statutory authority to determine a disability freeze for any RR employee who files an application for a disability annuity and has completed 10 years of RR service. For such determinations, an employee's RR service after 1936 is to be considered as "employment" under the SS Act.

RRB may accept an earlier disability freeze determination made by SSA. If there is no inconsistency between the SSA disability freeze determination and the rating of disability made by RRB, the SSA decision may be used without further development.

6.1.3 DF Decisions Completed By The RRB

The RRB completes DF decisions for career railroad employees only. There are three types of DF decisions.

A. Single Freeze (SF)

SF cases are those disability claims filed by or on behalf of career railroad employees (DCM 6.7.2) with the RRB where there is little or no potential for Social Security benefits ever being paid.

Authorized RRB personnel prepare a SF determination and complete it without SSA review. SF decisions can be completed at all adjudicative levels.

B. Joint Freeze (JF)

JF cases are those disability claims filed by or on behalf of career railroad workers (DCM 6.7.2) which are processed jointly by RRB and SSA where there is some likelihood of social security benefits being paid **or** cases included in the financial interchange (FI) sample (DCM 6.7.3).

Authorized RRB personnel prepare a JF determination and SSA reviews and countersigns the decision.

A JF case originates as a claim for a disability annuity filed with the RRB by or on behalf of a career railroad worker. In other words, a disability application filed with SSA before a disability application is filed with the RRB is not considered as a JF. This includes SSA Title II (Disability Insurance Benefits [DIB]) or Title XVI (Supplemental Security Income [SSI]) applications.

> **EXCEPTION:** ALL disability applications in the FI sample must be processed in our systems using OLDDS SSA-831 regardless of whether it was initially filed at SSA or RRB.

See DCM 6.7.3 and the list of exceptions as to when a JF decision is or is not required. In general,

- All proposed JF awards or denials adjudicated in DBD are coordinated with SSA (EXCEPT when the same claim for RR Act disability annuity is denied).

- A claim denied as a JF in DBD but subsequently awarded at the reconsideration level is coordinated with SSA.

C. Unilateral Freeze

Unilateral freeze cases are those disability claims where the RRB makes an independent decision on a DF claim after the RRB and SSA are unable to reach an agreement through the JF reconciliation process **or** when a claim is awarded at the RRB appeal level (decisions completed by a hearings officer or the three-member Board).

Authorized RRB personnel attempt to reconcile differences in a JF decision with SSA. Unreconciled JF decisions are completed with DBD or Reconsideration Section supervisory or senior examiner signatory approval but without SSA countersigning the decision.

NOTE: A courtesy copy of the administrative record and determination rationale are sent to SSA for DF claims awarded by a hearings officer or three-member Board only in the FI sample, as shown in DCM 6.7.3 D.

6.2 Disability Insured Status For Freeze

6.2.1 Requirements For A Freeze

An employee qualifies for a freeze if all the following requirements are met:

A. Application, as explained in DCM 6.3.1

B. Freeze Insured Status, as explained in DCM 6.3.2

C. Disability Under the SS Act, as explained in DCM 6.3.3

D. Waiting Period, as explained in DCM 6.4.3

6.2.2 Using SS Disability Standards

For freeze decisions, the RRB follows statutory standards of the SS Act. The following technical standards and guides furnished by SSA are used.

Social security regulations

Program operations manual system (POMS)

Social security rulings-Disability

6.3 Development And Evidence Requirements

6.3.1 Application

Disability freeze ratings (both grants and denials) are to be made in all disability cases, regardless of whether or not the rating will actually affect the annuity payment or the Medicare effective date. An application for a disability annuity is legally considered to be an application for a disability freeze also, and the claimant has the right to be notified of our decision in that regard. He/she also has reconsideration and appeals rights for the disability freeze decision which are described to him/her on the Form AB-32 enclosed with the disability freeze notification letter.

EXCEPTION: The annuitant has the right to request that a disability freeze not be granted. This could occur for a number of reasons (e.g. employee and spouse would get better coverage under private insurance than under Medicare.) In such cases, have the field obtain a signed statement from the employee that all of the advantages of the freeze (early Medicare, O/M, possible tier 1 increase, tax advantage, possible survivor benefit increase) have been explained to him and that he still does not want to be rated for a disability freeze. Once the statement is received, do a technical denial of the disability freeze even if there is sufficient evidence to make a favorable decision. Make a notation in the remarks section of OLDDS that the DF was denied per employee's request. Use RL-260c as a notification letter. This can be done even if the case would ordinarily be a joint freeze decision.

6.3.2 Freeze Insured Status

A disability insured status is established when an employee has at least 20 quarters of coverage (QC) in a period of 40 consecutive calendar quarters (10 years) ending with the quarter of the disability onset date.

In most cases, when the employee is also fully insured under the SS Act, the case must be adjudicated as a joint disability freeze (see DCM 6.7.3 for exceptions, RCM 5.6.11 for detailed explanation of disability insured status, and RCM 5.6.5 for detailed explanation of insured status under the SS Act). DCM 6 Appendix 5 shows how many QC's are required depending on the employee's age on the date of the disability, to be fully insured under the SS Act.

An employee who has a disability onset before the quarter in which (s)he attained age 31, must have acquired QC's equal to one-half of the quarters that elapsed between the quarter after (s)he attained age 21 and the quarter before his disability began to receive a disability insured status.

For benefits payable 1-1973 or later, a statutorily blind worker does not need to meet a "20/40" or "disability before age 31" insured status test. In determining the number of QC's required for fully insured status, the individual must have at least one quarter of coverage for each year elapsing after 1950 (or, if later, the year in which (s)he attained age 21) up to the year in which the qualifying QC is earned. (There is a minimum

requirement of 6 QC's). Where the disability freeze does not begin with the quarter of onset, because insured status is not met at that point, it will begin in the first quarter thereafter in which fully insured status exists provided the wage earner is disabled in that quarter. (Fully insured status is determined as if the wage earner attained SS Act retirement age in that quarter.) This provision applies regardless of the age at which the individual is disabled.

A statutory blind wage earner who had a disability insured status before 1-1973 by reason of meeting the "20/40" or "disability before age 31" insured status requirement, in addition to having fully insured status, may have a disability freeze established beginning at an earlier date, based on fully insured status only, if (s)he files an application in or after 10-1972. Any increase in benefits due to the revised disability freeze can be effective no earlier than 1-1973.

6.3.3 Disability Definition Under SS Act

Disability means either:

A. Inability to engage in any substantial gainful activity (SGA) because of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. The physical or mental impairment(s) must be of such severity that the individual is not able to do his previous work and cannot, considering his age, education and work experience, engage in any other kind of SGA which exists in the national economy regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applies for work. The phrase "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country; or

B. Statutory blindness, which is central visual acuity of 20/200 or worse in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision such that the widest diameter of visual field subtends an angle no greater than twenty degrees shall be considered as having a central visual acuity of 20/200 or less.

   When the disability definition of blindness is met, the activity to engage in SGA will be disregarded for the purpose of the disability freeze only but not for Disability Insurance Benefits (DIB) purposes. This means that the wage record is preserved for purposes of insured status and PIA calculations from the time the medical criteria is met, but the person cannot receive cash benefits while SGA continues.

   Blind applicants under age 55 must continue to meet the test of "inability to engage in any SGA (as shown in DM 6.3.3A) to become entitled to a DIB.

6.3.4 Wage Record Development

Before making a disability freeze determination, the disability examiner will check the wage record from the Retirement Estimate Annuity Program (REAP) program for joint disability freeze cases and check the wage record on-line for single disability freeze cases. After viewing the REAP record, the examiner will send it directly to imaging.

NOTE: Effective May 4, 2015, printing of wage records containing federal tax information (FTI) such as DEQY/SEQY records and report from The Work Number (TWN) is no longer allowed. These items should be imaged for documentation.

6.3.5 Social Security Act Application Requirements

A freeze or disability cash benefits cannot begin until an application for a disability determination under the SS Act is filed. An AA-1d is an application for a freeze and a DIB under the SS Act.

The filing date of the AA-1d is deemed to be the filing date with SSA in joint freeze decisions. (See Appendix B for deemed filing dates before September 7, 1958.)

If the period of disability has ended, the freeze may be established only if the application is filed by the earlier of:

A. 12 months following the month FRA is attained; or,

B. 14 months following the month the disability ceased.

Note: The 1967 SS Act amendments extended this period to 36 months after the end of the period of disability when failure to file was due to a physical or mental condition which prevented execution of an application.

If the employee died before filing, the application requirement for a freeze is met if a survivor files a disability application within 3 months after the month that the employee died.

6.3.6 Development Of The Disability Freeze (DF) RATING When A CDR Is Due

A disability application is not considered finalized until the disability freeze determination is completed. Therefore, DBD policy is that a disability freeze rating must be completed before a CDR determination can be made on the same case. In some instances, an examiner may have a case in which a disability freeze and a CDR (due to work) determination are both required. In these situations, the disability freeze decision should be done prior to the continuance decision.

This does not preclude the examiner from putting the disability annuity into suspense due to earnings or work activity. After the examiner puts the case into suspense for earnings or work activity, the case should be developed for the disability freeze determination. Any information which may affect the continuance determination should also be used when making the disability freeze determination. For example, any work activity the annuitant may be involved in should be considered when making the disability freeze determination. If earnings above the SGA level are involved, the examiner should consider the possibility of a closed period of disability in the disability freeze determination.

A. Disability Freeze Denial Determination Made

If a disability freeze denial decision is rendered and the disability freeze denial letter released, the case should be routed to the dormant cabinet with a 60 day call-up pending a possible reconsideration request. When the case is pulled from the dormant cabinet, the CDR determination will be handled. If the annuitant requests a reconsideration of the disability freeze determination, route the case to the reconsideration section to handle the reconsideration decision before the CDR determination is made.

B. Disability Freeze Allowance Determination Made

If the examiner makes a disability freeze allowance determination, he/she should then develop for the CDR. However, if the reason for the CDR is due to earnings and/or work activity and the work/earnings are reconciled with the disability freeze allowance, the examiner should set an appropriate CDR call-up.

NOTE: Code Paragraphs 2717, 2718 and 2719 are used in disability freeze denial letters to indicate that the employee's disability freeze is denied but there is no effect on the employee's annuity. These paragraphs cannot be used if the annuity has been put into suspense due to earnings and/or work activity. Therefore, a modified RL-260 letter should be used in cases where the annuity is in suspense.

Once the initial disability freeze determination is completed, applications for subsequent disability freeze determinations should be considered before the CDR if the application was filed prior to the CDR call-up date or earnings notification. If the CDR call-up date or earnings notification is prior to the filing date of the subsequent application for a disability freeze, the CDR should be conducted first.

6.3.7 Examiner's Determining Residual Functional Capacity Assessments

In certain single freeze cases, disability claims examiners have the latitude to render a decision based on a section of a treating source RFC or consultative examination RFC that is supported by the objective findings, even if the RFC in its entirety is not supported.

These single freeze cases require the following:

- The claimant's age to be 55 years or older at the time of the disability onset date,
- the physical RFC leads to a decision finding of a grant, and
- the physical RFC from a treating source or consultative examination is supported by the objective findings based on the disability claims examiner's judgment.

6.4 The Disability Freeze

6.4.1 Beginning Date For A Disability Freeze

The beginning date for a disability freeze (DF) is the first day within the effective period of the application on which an employee:

- Has a DF insured status (earnings requirement) (DCM 6.3.2); and,
- Is under a disability as defined in the SS Act (medical requirement) (DCM 6.3.3).

Normally, the beginning date for a DF will be the actual date of onset. Where the employee is not fully insured until a later quarter, the DF will begin on the first day of the quarter in which a DF insured status is acquired. (However, Medicare coverage based on age begins at age 65, regardless of FRA.)

EXAMPLE: A RR employee met the SS Act disability requirement in August 2011 but had only 19 quarters of coverage (QC) in the 40 calendar quarter period ending in September 2011 (i.e. the calendar quarter of onset). He was paid sufficient vacation allowance in the next succeeding calendar quarter (i.e. calendar quarter beginning October 2011) which would give him the required 20 QC's. Therefore, the qualifying QC requirement for the DF is met on the first day of the calendar quarter in which he was paid the vacation allowance which gave him the required 20 QC's. Accordingly, he met both the medical and earnings requirements on October 1, 2011, and that date is the beginning date of the DF.

Beginning in January 1973, an employee must be disabled for a continuous period of not less than 5 full calendar months (i.e. the waiting period) before a DF can be established. (Prior to January 1973, the requirement was 6 full months. Therefore, a DF will always be at least 5 months.) As long as the waiting period requirements are met, a DF rating can be completed. If the waiting period requirements are not met, the DF claim must be technically denied.

EXCEPTION: If an employee qualifies for a DIB without a waiting period (DCM 6.4.4), he would qualify for a DF for any month he is entitled to a DIB, even as short as 1 calendar month.

A DF cannot begin at full retirement age (FRA) or later. However as long as:

- An application was filed within 12 months following the month after the RR employee attained FRA (DCM 6.3.5), and
- The RR employee meets the definition of disability under the SS Act (DCM 6.3.3), and
- The RR employee fulfills the waiting period requirement (DCM 6.4.3),

the rating can be completed. If the waiting period requirement cannot be met before FRA was attained and a previous DF period did not end within 60 months of the earliest possible date that disability under the SS Act could begin as a result of the current application, the claim does not require a formal disability determination and should be technically denied.

EXAMPLE: Joe's previous disability for DF purposes terminated December 31, 2000 as a result of returning to work. While working, he injured himself on January 15, 2008 and could no longer perform past relevant work. However, his employer allowed him to perform light duty work. He attained FRA on February 15, 2008 and his employer laid him off on March 31, 2008. Since he could not find another job, he finally filed an application for disability on November 1, 2008 claiming an onset date of January 15, 2008.

Presuming the medical evidence cannot establish an onset date any earlier than January 15, 2008, Joe's claim would have to be technically denied. Since Joe's previous DF period ended more than 60 months prior to the earliest possible date of current disability, he must meet the DF waiting period requirement. However, since he was not disabled for 5 months prior to FRA, his claim must be technically denied.

In cases in which a DF has previously been denied, and does not meet the criteria for re-opening, and the reconsideration period has passed, the onset date of the new decision cannot be prior to the date of the previous decision. For purposes of setting the onset date of the new decision, the date of the previous decision is either:

- The date the physician/medical specialist signed the SSA-831 in joint freeze cases.
- The date the reviewer signed the OLDDS decision for single freeze cases or unilateral freeze cases.

NOTE: The date of the previous DF denial letter is used for reconsideration and re-opening purposes, but not for the purposes of setting an onset date.

6.4.2 Ending Date For A Disability Freeze

The ending date for a period of disability is the earliest of:

- The last day of the month in which the worker dies.
- The last day of the month preceding the month in which the worker attains FRA.
- The last day of the second month after the month in which the disability ceases.

When determining a disability cessation date, the trial work period does not apply to the freeze unless the worker is also entitled to:

- A DIB under the SS Act; or,
- The DIB O/M under the Railroad Retirement Act (RR Act), even if it does not apply.

6.4.3 Waiting Period

Before payments based on a disability freeze in accordance with the SS Act can be awarded or before entitlement to Medicare benefits can begin prior to age 65, the waiting periods of 5 full months for a disability freeze and 24 months after the ABD or 29 months after the disability onset date for Medicare entitlement must be met. HOWEVER, THE DISABILITY FREEZE RATING DETERMINATION CAN BE MADE BEFORE THE DISABILITY FREEZE WAITING PERIOD IS SERVED.

DISABILITY FREEZE ONSET - The waiting period begins with the first full calendar month after the date of disability onset, if onset is not on the first day of the month, during which the person met disability freeze-insured requirements.

Although the waiting period is counted in full calendar months, a disability freeze may begin on the day onset is determined to have occurred even if it is not the first day of the waiting period, provided insured status requirements are met on that day.

6.4.4 Waiting Period Not Required

A waiting period is not required if a previous freeze or DIB ended within 60 months before the month the current disability began. In this situation a freeze will exist for any month there is DIB entitlement. Refer to RCM 3.2.22 for additional information and instructions.

The 60-month period begins with the month in which the prior disability freeze ceased or DIB terminated and ends with the month before the first full month the worker is under a disability.

Therefore, when the current disability begins on the first day of a month, the 60-month period ends with the preceding month; if it begins on other than the first day of the month, the 60-month period ends with the month in which the current disability began.

If the worker does not have DIB insured status in the month his current disability begins, he is not eligible for a DIB until the first month in which he has an insured status. Consequently, more than 5 years may elapse between the end of his previous disability and the first month of his current period of DIB entitlement, but no waiting period is required if the current disability began within the 60-month period.

6.4.5 Felony Conviction Provisions That Affect Disability Freeze Determinations

P.L. 96-473 contains provisions which imposed restrictions on SSA title II disability determinations and payments to prisoners who are convicted of an offense punishable by imprisonment for more than one year, regardless of the actual sentence imposed. (For purposes of this procedure, the word "felony" is used interchangeably with an offense punishable by imprisonment for more than one year.) These restrictions affect disability freeze determinations. Sub-sections A and B discuss the two situations where the prisoner conviction provisions can affect a disability determination. Sub-section A will affect the disability freeze determination while sub-section B will not. Subsection C consists of definitions explaining the concepts involved in this law. Additional information about prisoner conviction cases can be found in RCM 6.3.7.

A. "Permanent Disregard" of Felony-Related Determinations - An impairment(s) arising or aggravated (but only to the extent of the aggravation) in connection with the commission of an offense is to be permanently disregarded for disability freeze purposes. This applies only for offenses committed after October 19, 1980, and for which the claimant has been subsequently convicted. It is not necessary that there be a causative connection between the commission of the offense and the impairment, but is must be closely related to, or associated with, the commission of the offense. The impairment or aggravation of a pre-existing impairment must occur at a time and location that is near to the offense.

EXAMPLES:

An impairment arising from an automobile accident which occurred while fleeing the scene of an offense, such as a bank robbery, would be considered associated with the commission of the offense.

An impairment arising from an automobile accident a week after the bank robbery (e.g., a car runs a red light and runs into the robber's car injuring the robber; the police find the stolen money in the car and charge the robber with a felony), would be too remote to be considered to have arisen in connection with the robbery. This accident ordinarily would not be considered sufficiently close in time and place to the scene of the robbery to be considered associated with the offense.

Since the permanent disregard of an impairment or aggravation of a pre-existing impairment incurred in the commission of a felony hinges on the individual's subsequent conviction, there may be claims allowed considering all the medical evidence in which the person has been charged with but not convicted of a

felony. Thus, in a case where benefits were allowed on the basis of an impairment which may arise, or aggravation of a pre-existing impairment incurred in connection with the commission of a felony, the subsequent conviction of the individual for that offense could affect the earlier award.

In such a case of subsequent conviction, DBD will reevaluate the original disability freeze decision to exclude any such impairments or aggravations. If the disability freeze is then denied because of this exclusion, the increased benefits, if any, paid under the original award will be considered overpayments. Conversely, a denial because of disregard of an impairment(s) connected with a felony may be reopened under the rules of administrative finality in the event the felony conviction is subsequently overturned.

B. "Temporary Disregard" of Impairments Connected with Confinement - For any month during which the individual is confined, any impairment which arises, or the aggravation of an impairment which occurs, in connection with an individual's confinement due to conviction of an offense committed after October 19, 1980, must be disregarded in determining whether the individual is under a disability for purposes of benefits payable.

Impairments connected with confinement cannot be considered in determining disability for the payment of benefits for any month during confinement. However, this provision does not preclude consideration of confinement-related impairments for purposes of establishing a disability freeze.

Thus, DBD may use these impairments to establish a disability freeze for a claimant. (The disability freeze provision does not apply to Child Disabled Benefit (CDB) and Disabled Widow Benefit (DWB) applicants.)

C. Definitions

1. CONFINED

An individual who is under a sentence of confinement, pursuant to a conviction, to a jail, or other penal institution or correctional facility, including any facility which is under the control and jurisdiction of the agency in charge of the penal system, or any facility in which convicted criminals can be incarcerated, is considered confined.

2. COURT OF LAW

Any duly constituted judicial tribunal administering the laws of the State or nation is a court of law.

3. FELONY

A crime is a felony if it is an offense which constitutes a felony under applicable law. However, some legal jurisdictions, such as the State of

New Jersey, the U.S. military under the Uniform Code of Military Justice, and some foreign countries, do not classify any crime as a felony.

In jurisdictions such as the above, an offense punishable by death or imprisonment for a term exceeding 1 year will be considered a felony for purposes of this procedure. As a general rule, if an individual has been sentenced for a term of more than a year for conviction of an offense, correctional authorities consider that individual to be a felon.

4. PENAL INSTITUTION OR CORRECTIONAL FACILITY

In general, penal institutions or correctional facilities are those facilities which are under the control and jurisdiction of the governmental agency in charge of the penal system, or are facilities in which convicted criminals are incarcerated, such as a hospital for the criminally insane.

6.4.6 Disability Freeze Notices

Disability freeze (DF) notices in the RL-210 series (RL-210, RL-210b, RL-210c, and RL-210d) and the RL-260 series (RL-260, RL-260a, RL-260b. RL-260c, and RL-260d) are found on RRAILS. These letters can also be accessed through D-BRIEF. The RL-210 series is used when the DF decision is a grant. The RL-260 series is used when the DF decision is a denial. A copy of the letter is filed in the annuitant's claim folder and sent to imaging. Form AB-32 is sent with every letter. In joint freeze (JF) decisions, an SSA letter must be sent in addition to the letter from the RL-210 or RL-260 series in most instances.

Most letters contain inserts as do some of the commonly used code paragraphs. Some of the letters may contain pop-ups or drop-downs. The letters do not contain "edits" that ensure completion of inserts, drop-downs, etc. Therefore, **you must tab through the letter from the beginning** to see all of the places that choices or inserts are needed. However, when typing in an unprotected area, use the mouse to enter and exit the unprotected area.

It is important to proof read every letter before it is sent to imaging and released. If the letter is to a rep payee, you must change the pronouns in any codes paragraphs used from "you/your" to "he/she/his/her."

This chapter describes the situations in which each letter is used.

6.4.6.1 The Single Freeze OR Unilateral Freeze Decision is a Grant

A. Complete a RL-210 when:

- the DF onset date is the same or later than annuity onset date, and

- there is either no Medicare based on Social Security (SS) entitlement or the SS Medicare effective date is the same as or later than the RRA Medicare effective date. (The information that can be used to calculate a Medicare effective date based on SS benefits can be found on PREH Screen 3206, which gives the SSA disability entitlement date and the SSA disability onset date.)

There are 2 date inserts on the RL-210: the DF onset date and the RRB Medicare effective date.

B. Complete a RL-210b when:

- the DF onset date is earlier than the annuity onset date (initial annuity decision and DF decision are not simultaneous), and
- the annuity onset date is being changed to match the DF onset date.

There are two date inserts in the RL-210b: the DF onset date and the Medicare effective date.

C. Complete a RL-210d when:

- the DF onset date is the same or later than annuity onset date, and
- the employee is entitled to a Medicare effective date based on SS entitlement that is earlier than the Medicare effective date based on RR ABD and onset date. (The information that can be used to calculate a Medicare effective date based on SS benefits can be found on PREH Screen 3206, which gives the SSA disability entitlement date and the SSA disability onset date.)

There are two date inserts in the RL-210d: the DF onset date and the Medicare effective date. Use SSA's Medicare effective date.

6.4.6.2 The Single Freeze OR Unilateral Freeze Decision is a Denial

A. Complete a RL-260 when the DF is denied for failure to meet the medical requirement.

B. Complete a RL-260a when:

- the DF is denied for failure to meet the earnings requirement, and
- there is no Medicare entitlement.

While you are tabbing through the letter on RRAILS,

- a pop-up will appear with the following question: "Claimed onset after DLI?" (DLI: Date Last Insured) If the alleged disability onset date is earlier than the

actual disability onset date and the claimant did not have an insured status in the alleged onset date quarter, answer “yes”. Otherwise, answer “no”.

- another pop-up will appear asking for either the alleged onset date or the annuity onset date

- Another pop-up will appear with the following question: “Is this letter being sent to a third party?” If you answer “yes” to this question, you will also get a pop-up that says: “Is the claimant male?”

- After you have answered the pop-ups, continue tabbing through the letter to move through the gray boxes that require additional entries.

If you answer “yes” to the question about the claimed onset after the DLI, code paragraph 2714 (see RCM 10.5.170.2714) will be inserted in the letter. If you answer “no”, code paragraph 2715 (see RCM 10.5.170.2715) will be inserted in the letter. If the alleged disability onset date is earlier than the actual disability onset date and the claimant did not have an insured status in that quarter, answer “yes” to insert code paragraph 2714 in the letter. Otherwise, answer “no” to insert code paragraph 2715.

There are 3 date inserts for code paragraph 2714: the alleged disability onset date, the first day of the first month of the calendar quarter in which the alleged disability onset date occurs, and the last day of the last month of the calendar quarter in which the claimant is last insured. A pop-up will ask you for the alleged onset date, but the other dates must be entered manually into the body of the letter.

> **EXAMPLE :** The alleged disability onset date is February 12, 2003 and the claimant was last insured in the second quarter of 2000. The date inserts would be February 12, 2003, January 1, 2003, and June 30, 2000.

There are 3 date inserts for code paragraph 2715: the actual disability onset date, the first day of the first month of the calendar quarter in which the actual disability onset date occurs, and the last day of the last month of the calendar quarter in which the claimant is last insured. A pop-up will ask you for the annuity onset date, but the other dates must be entered manually into the body of the letter.

> **EXAMPLE:** The actual disability onset date is May 12, 2003 and the claimant was last insured in the first quarter of 2000. The date inserts would be May 12, 2003, April 1, 2003, and March 31, 2000.

After you have tabbed to and filled in all of the dates, press the tab key again. A pop-up will appear asking if you wish to open Form AB-32. After you have answered, another pop-up will appear that offers a selection of the following code paragraphs: 4000, 4001, 4002, and 4003. If you answered “no” to the question “Claimed onset after DLI?”, select one of the first three paragraphs (4000, 4001, or 4002) and code paragraph 4003. Code paragraphs 4000, 4001, and 4002 require

date inserts and code paragraph 4003 requires the list of medical records used in the decision. Bear in mind, that if the letter is to a rep payee or third party, you will need to manually change the pronouns "you" and "your" to "he/she" or "his/her" in the code paragraphs.

Following these paragraphs, there is an unprotected area for free form typing. Other code paragraphs can be accessed by pressing Ctrl/Shift/F4.

C. Complete a RL-260b when:

- the DF is denied for failure to meet the earnings requirement, and
- there is Medicare entitlement. Medicare entitlement can be established when the 1974 Act provisions apply (see DCM 6.8.1) or when government employment can be used as quarters of coverage (see DCM 6.8.2).

While you are tabbing through the letter on RRAILS,

- a pop-up will appear asking: "Claimed onset after DLI?" If the alleged disability onset date is earlier than the actual disability onset date and the claimant did not have an insured status in the alleged onset date quarter, answer "yes". Otherwise, answer "no".
- Another pop-up will appear with the following question: "Is this letter being sent to a third party?" If you answer "yes" to this question, you will also get a pop-up that says: "Is the claimant male?"
- After you have answered the pop-ups, continue tabbing through the letter to move through the gray boxes that require additional entries.

There are 4 date inserts for the RL-260b: the disability onset date or the alleged onset date, the Medicare effective date, the first day of the first month of the calendar quarter in which the disability onset date occurs, and the last day of the last month of the calendar quarter in which the claimant is last insured. A pop-up will ask you for the alleged onset date or the annuity onset date, but the other dates must be entered manually into the body of the letter.

> **EXAMPLE:** The disability onset date is May 12, 2003, the ABD is November 1, 2003, and the claimant was last insured in the first quarter of 2000. The date inserts would be May 12, 2003, November 1, 2005, April 1, 2003, and March 31, 2000.

After you have tabbed to and filled in all of the dates, press the tab key again. A pop-up will appear asking if you wish to open Form AB-32. After you have answered, another pop-up will appear that offers a selection of the following code paragraphs: 4000, 4001, 4002, and 4003. If you answered "no" to the question "Claimed onset after DLI?", select one of the first three paragraphs (4000, 4001, or

4002) and code paragraph 4003. Code paragraphs 4000, 4001, and 4002 require date inserts and code paragraph 4003 requires the list of medical records used in the decision. Bear in mind, that if the letter is to a rep payee or third party, you will need to manually change the pronouns “you” and “your” to “he/she” and “his/her” in the code paragraphs.

Following these paragraphs, there is an unprotected area for free form typing. Other code paragraphs can be accessed by pressing Ctrl/Shift/F4.

D. Complete a RL-260c when the employee has submitted a statement that he does not want to be considered for a DF. There is one date insert in this letter: the date of the statement.

E. Complete a RL-260d in cases with a filing date of January 1, 2008 or later when the total and permanent annuity rating is based on alcoholism or drug addiction (see DCM 4.8.4) and no other impairment is severe enough to be a grant for the DF. (For occupational annuity cases, use the RL-260.) There is one date insert in this letter: the annuity onset date.

NOTE: If you access letters in the RL-260 series from D-BRIEF rather than from RRAILS, you will not get a pop-up asking if the letter is to a third party or if the claimant is male. The correct pronouns will be pre-filled from D-BRIEF.

6.4.6.3 The Joint Freeze Decision is a Grant

A. Complete a RL-210 when:

- there is agreement between RR and SS about the DF onset date, and
- the DF onset date is the same or later than annuity onset date.

If the person does **not** have a DF insured status (DCM 6.3.2), also send a SSA-L810 and enclose SSA Publication No. 05-10058, *Your Right To Question The Decision Made On Your Claim*.

B. Complete a RL-210b when:

- there is agreement between RR and SS about the DF onset date, and
- the DF onset date is earlier than annuity onset date, and the annuity onset date is being changed to match the DF onset date.

If the person does **not** have a DF insured status (DCM 6.3.2), also send a SSA-L810 and enclose SSA Publication No. 05-10058, *Your Right To Question The Decision Made On Your Claim*.

C. Complete a RL-210c when there is disagreement between RR and SS about the DF onset date. If the person does **not** have a DF insured status (DCM 6.3.2), also send

a SSA-L810 and enclose SSA Publication No. 05-10058, *Your Right To Question The Decision Made On Your Claim*.

6.4.6.4 The Joint Freeze Decision is a Denial

Complete a RL-260 and SSA-L813.1 and enclose SSA Publication No. 05-10058, *Your Right To Question The Decision Made On Your Claim*.

6.5 RRB/SSA Coordination

6.5.1 General Guidelines

In order to properly coordinate disability decisions, SSA and RRB must exchange medical evidence and wage records, review medical decisions, settle/reconcile disagreements about disability decisions, and institute an authorization process for certain types of disability freeze (DF) cases. All attempts to coordinate RRB/SSA claims shall be made to help limit or prevent different decisions from being effectuated and to avoid duplication of development of evidence. The RRB prepares and signs railroad (RR) disability determinations for career RR workers or the dependents of deceased career RR workers and SSA prepares and signs Social Security determinations for the same claimants. Coordination of decisions is based on a signed Memorandum of Understanding (MOU) between both agencies. Each agency has mutually agreed to share evidence which it has obtained.

A. Disability Freeze Decisions

Independent DF decisions made by either SSA or RRB are not binding on the other agency. However, joint freeze (JF) decisions completed at the initial and reconsideration levels of adjudication are. See DCM 6.7.3 when a JF is to be completed. See DCM 6.7.4 for JF processing procedure.

Where all aspects of JF decisions are coordinated between SSA and DBD, independent single freeze (SF) decisions are not required to be coordinated although each agency has agreed to furnish required information about disability decisions made for RR employees. See DCM 6.6.4 for DBD examiner or Reconsideration Section handling of a SF.

If both agencies are unable to reach an agreement on a JF decision through the coordination and reconciliation processes or when a claim is awarded at the RRB appeal level (DCM 6.1.3 C), the RRB will complete a unilateral freeze decision. Unilateral freeze decisions completed by a DBD-DPS examiner require supervisory or senior examiner signatory approval. Unilateral freeze decisions completed by a Reconsideration Section specialist require signatory approval by a second specialist. See DCM 6.7.4 for DBD or Reconsideration Section handling of a unilateral freeze.

6.5.2 Coordination Actions

When a disability application is filed at the RRB, the TRIC request made for the application will earmark the SS record. SSA takes no action on the earmark unless they have a pending application.

If our disability application or other evidence in file indicated that the claimant also filed for a DIB or SSI benefits, the field office will request, by Form RR-5, the medical evidence and decision from SSA's Disability Program Branch (DPB) to be sent directly to DBD. DBD will either telephone (only when a case must be expedited) or use Form RR-5 to request this information from DPB when the field office has not released a Form RR-5 request. The RR-5 is either sent to:

Disability Program Branch
Great Lakes Program Service Center
Social Security Administration
Post Office Box 87755
Chicago, Illinois 60680

Or, the request can be sent by email with the RR-5 as an attachment to CHI.ARC.PCO.DPB@ssa.gov. Type “RR-5” in the subject line. Do not include the SSA disability examiner’s name, claimant’s name, social security number, or other personally identifiable information in the subject line. If known, type the name of the SSA disability examiner who is assigned these terminal digits and the full claim number in the body of the email.

If, upon examination of the SSA evidence, the disability rating examiner cannot reach a disability decision under section 2(a)(1)(v) that is consistent with the disability determination previously made by SSA, the rating examiner should refer the case to the supervisor or senior examiner. (S)he will decide on what further action, if any, should be taken to reconcile the conflict in the disability determination.

If DBD receives an application for a disability annuity and it is determined that the employee has less than 120 RR service months and less than 60 RR service months after 1995, the application and pertinent claims material are transferred to SSA.

When a disability application is filed at SSA, DPB will query their systems to determine service months when their applicant indicates railroad service. If 120 months of RR service or 60 months after 1995 are verified, DPB will furnish DBD with the claim number and request medical evidence. We reply with Form RL-34b the status of claims activity at DBD. SSA will transmit information on their decision with Form SSA-415. DBD will review the SSA decision. If the file indicates a disability rating allowance under the RR Act can be made, use G-239 to secure an application from the career RR employee if one has not been filed.

6.6 Single Freeze Determinations and Simultaneous Ratings

6.6.1 Definitions and General Program Policy

A simultaneous disability annuity (D/A) rating and a disability freeze (DF) rating should be completed except when DBD management has advised that simultaneous D/A and DF ratings should not be completed due to DBD workload or other agency considerations. This would occur in both single freeze (SF) cases and "no conflict" cases. SF cases are those disability claims filed at the RRB by or on behalf of career railroad employees where there is little to no potential for social security benefits ever being paid. The DF rating for these cases can be made by the RRB alone. "No conflict" cases are those in which SSA has already made a disability decision which we have reviewed and concur with the medical determination, vocational determination, and onset date. "No conflict" case decisions "adopted" by the RRB are handled as a SF because a claim for DF was already filed at SSA.

HOWEVER, DO NOT DELAY THE AWARD OF D/A FOR DEVELOPMENT OF ADDITIONAL EVIDENCE OR INFORMATION NEEDED FOR A DF DECISION.

The annuitant has the right to request that a DF not be granted. (See DCM 6.3.1)

When the claim for a D/A is denied, the DF is automatically and concurrently denied. If a previously denied D/A is reopened and revised to an allowance, the DF determination must also be reconsidered by completion of G-325 or an SSA-831, even if the decision will still be a denial.

6.6.2 When Simultaneous D/A And DF Decisions Cannot Be Made

A simultaneous rating cannot be made in the following cases:

A joint freeze determination is required. (See DCM 6.7.3)

Additional medical evidence (M/E) is required because M/E that was obtained in support of the employee's D/A rating is not adequate for making a disability freeze determination.

SS wage data has not been received and such record is required. (E/R of employee has an "SS" indication.)

Additional vocational information is required about a claimant's non-railroad work for making a disability freeze determination when the decision is based on both medical and vocational factors.

6.6.3 Actions By DPS To Determine Whether Applicant Has QC

A. As of Alleged Quarter of Disability (AQD) - First determine whether the applicant meets the insured status test as of the AQD (i.e., the quarter in which he became

unable to work) based on the filing or deemed filing date of the disability freeze application. If the applicant does not have a 20/40 insured status, as of the AQD, see whether he has the qualifying QC's after or before the AQD. When making the appropriate test, keep in mind when a disability freeze recalculation is applicable, and when DIB entitlement could otherwise begin.

B. After the AQD but Not in Alleged Quarter - An applicant who has insufficient earnings when first disabled may be eligible for a disability freeze period if he meets the qualifying QC requirement after the onset of his impairment. In such cases, the disability freeze period begins on the first day of the quarter in which the qualifying QC requirement is met.

If an employee has only 19 quarters in the 40-quarter period ending in the AQD, and was paid sufficient vacation allowance in the next succeeding quarter which could give him the required 20 QC's, he would meet the qualifying QC requirement for disability freeze on the first day of the quarter he was paid the vacation allowance. However, if he was awarded a D/A which began to accrue on or before the date he was paid the vacation allowance, that quarter cannot be used to meet the qualifying QC for disability freeze, unless his annuity is re-certified to begin on the date following the last day for which he was paid the vacation allowance. In such a case, the annuity payments previously made to him are erroneous.

If an employee has insufficient quarters in the 40-quarter period ending in the AQD, and was paid miscellaneous compensation in a period which could give him the required 20 QC's, the miscellaneous compensation can be used to give the required QC’s.

This is also true, if an employee is receiving regular compensation that does not provide a service month in a period which could give him the required 20 QC’s. The regular compensation can be used to provide the required QC’s.

C. Before AQD But Not In or After That Quarter - Even when it appears that the qualifying QC requirement cannot be satisfied at any time in or after the alleged quarter in which disability occurred, the applicant may be eligible for a disability freeze if he had the necessary qualifying QC at some point before the AQD. This is so because the actual date of disability may have been much earlier than that alleged. This actual date cannot ordinarily be established until medical development and examination have been completed.

If the applicant appears to have the qualifying QC at some point earlier than the alleged date of onset of his disability, and the earnings record (E/R) indicates that his earnings ceased before the alleged date, it is possible that the date of onset was incorrectly stated by the applicant. However, it is also possible that the applicant was merely unemployed or engaged in work not covered by the RR Act or the SS Act. In such cases, the disability examiner considers the merits of the applicant's explanation given on Form AA-1d and decides whether medical

development should be undertaken to determine whether the applicant was unable to engage in any SGA in or after the quarter in which he had the qualifying QC.

D. Development When Applicant Does Not Appear to Have Qualifying QC in or After AQD - When the applicant apparently does not meet the qualifying QC requirement either in or after the quarter when alleged disability began, compare his allegations of his work history with his reported earnings. Assume that the E/R is correct unless development on the basis of any conflicting allegations of the applicant proves it to be incorrect. If the applicant alleges employment or SE not reflected by the earnings data and such work would be sufficient to establish the necessary qualifying QC, it should be investigated. No further action should be taken with respect to the application for a disability freeze until the question is resolved.

E. Explanation of Earnings After AQD - When the applicant has the qualifying QC as of the AQD and the E/R shows that he has earnings after the quarter in which the disability allegedly began, the earnings reported for periods after the AQD, should be satisfactorily explained on Form AA-1d completed by the applicant as to whether the amounts reported after the AQD are special payments (sick pay, vacation pay, bonuses, etc.), or payments for services actually rendered after the AQD.

F. Determining QC's at RRB January 1, 1978 or Later - Effective January 1978, a QC is based on yearly earnings and is not assigned to a specific calendar quarter in the year. For calendar years 1978 or later, the amount of earnings required for a worker to be credited with a QC is written into the SS Act and will be adjusted each year with the rise in average wage levels (see RCM 5.6.18). Therefore, even though an employee may only have worked in one quarter in a particular year, the employee may be credited up to 4 QCs if his earnings are high enough.

6.6.4 Making Single Freeze Decisions

Single Freeze (SF) decisions are not coordinated with the Social Security Administration (SSA) and may be completed by DBD examiners or Reconsideration specialists using the following process:

A. DBD Handling

1. Distribution of Incoming Claims

   Cases are generally distributed to and adjudicated by DBD examiners according to terminal digits.

2. Adjudication and Evidence Development

Adjudicators review the evidence in file and, when necessary, take appropriate actions to develop for sufficient evidence needed to make a reasonable disability decision. Actions include but are not limited to development of: pertinent medical and non-medical evidence, vocational reports, earnings record (DCM 6.3.4), application forms, activities of daily living, and medical consultant's opinion (MO).

See DCM 4.10.13 for information regarding the age of medical evidence in SF cases.

NOTE 1: Adjudicating personnel must check to see if an application for Disability Insurance Benefits (DIB; Title II) or Supplemental Security Income (SSI; Title XVI) was already filed at SSA. Indications that a disability application was filed at SSA can be found in/on:

- Form AA-1 (APPLE and paper);
- Form AA-1d;
- SSA Master Benefit Record (MBR);
- SSI Record;
- DATAQ;
- DEQY (if already in file or in imaging); and
- Contact Log.

Adjudicators can request a MBR, SSI record, and DEQY from RRB personnel who have been authorized by SSA to access their system. Instructions how to read a MBR can be found in POMS SM 00510. Instructions how to read a SSI record can be found in POMS SM 01601. Adjudicators can also request a report from The Work Number (TWN); see DCM 3.4.205.

NOTE 2: Medical evidence of record may conclusively show that the severity of a RR employee's impairment or combination of impairments is medically disabling without considering his or her age, education, or work experience. Examples include but are not limited to: a biopsy report indicating that the claimant has been diagnosed with small-cell (oat cell) carcinoma of the lung; the claimant suffering amputations of both hands; the claimant who has received a lung or liver transplant and the case is being completed within 12 months of the transplant surgery. The severity of any medically-documented impairment(s) included in the Listing of Impairments (DCM 4.12; POMS DI 34001.000), as issued by SSA, is considered medically disabling.

In addition, a RR employee may have a medically-documented terminal illness (TERI) or a medical condition in SSA's Compassionate Allowance (CAL) list. An illness which is generally considered terminal or a medical condition in the CAL list (DCM 3.4.100) indicates a high probability that the RR employee is disabled.

Presuming that there is no other conflicting medical evidence in file which would lead one to question whether the severity of an impairment(s) is medically disabling as shown in the SSA Listing of Impairments, situations such as these do not require a MO and DBD-DIS or DPS examiners and Reconsideration specialists have the latitude to complete SF decisions without the MO. A case tagged as a TERI or CAL claim (DCM 3.4.100) has no bearing on this decision, although it may be an indication that a MO may not be needed.

As a general rule of thumb, however, if a medical judgment by a licensed physician or psychologist is required to determine whether the severity of an impairment(s) is medically disabling, a MO must be obtained. (See DCM 4.11.1 through 4.11.4).

NOTE 3: Any case in the Financial Interchange (FI) sample (DCM 6.7.3 D) must always be recorded into the RRB systems as either a joint freeze or unilateral freeze, even if an application for DIB or SSI was already filed at SSA.

3. Administrative Actions Before Authorization

After reviewing all of the information and coming to a determination, the examiner:

a. Composes a rationale (D-Brief G-325B if completing a concurrent D/A and SF decision; RRAILS G-325.1 if completing a SF only decision). (See DCM 5.1.6)

   The rationale must be sent to the imaging authorization folder if the decision requires authorization. (See DCM 3.4.304 for guidelines when a case does not require authorization.)

b. Completes the appropriate OLDDS G-325 screen entries (see DCM 12.1.4).

   NOTE: If a SF allowance ALSO allows an earlier D/A onset date, a single OLDDS entry may be completed on the same day.

c. Composes the appropriate RRAILS RL-210 series or RL-260 series letter. (See DCM 6.4.6).

   The letter must be sent to the imaging authorization folder if the decision requires authorization. (See DCM 3.4.304 for guidelines when a case does not require authorization.)

d. If necessary, sets an appropriate CDR call-up (see DCM 8.5.2 and 8.5.3).

e. If required, submits the case for authorization. (See DCM 3.4.304 for guidelines if the case does not require authorization.

NOTE: Printouts of the G-325 OLDDS screens, G-325B or G-325.1 rationale, and, if applicable, CDR call-up sheet are to be filed on the left side of the claims folder by the rating examiner.

4. Authorization Process (IF NECESSARY)

Follow the instructions in DCM 3.4.302.

When all is complete, the claims folder is sent to:

- Claim Files, if the SF is allowed EXCEPT when a DF has been granted for a deceased railroad employee (DCM 6.9.1).
- Reconsideration Section, if the SF is denied.

NOTE 1: See DCM 3.4.300 and 3.4.301 for general information about the authorization process in DBD and Reconsideration Section.

NOTE 2: Simultaneous disability annuity (D/A) and SF ratings should be completed except when DBD management has advised that simultaneous D/A and SF ratings should not be completed due to DBD workload or other agency considerations.

If D/A and SF ratings are authorized simultaneously, the SF determination letter shall NOT be released at the same time as the D/A determination letter. Rather, the claims folder will be held in AFCS location T0SP until the D/A award has been paid partial or final by the RRB. The SF determination letter will be released after the D/A has paid partial or final by appropriate DBD personnel.

In addition, SF-only decisions (i.e. SF decisions which are not rated simultaneously with a D/A decision) must not be authorized on OLDDS and the SF determination letter shall not be released until the D/A award has been paid partial or final by the RRB.

NOTE 3: DBD examiners and authorizers are both responsible to proofread the disability determination letter for the correct name and address, accurate content, and proper grammar before it is sent to the imaging authorization folder (or released to the claimant and imaging system if the decision does not require authorization by another examiner).

B. Reconsideration Section Handling

1. Incoming Claims and Distribution

DBD sends claims folders to the Reconsideration Section at the time that an individual is rated not disabled for a SF in anticipation of a possible request for reconsideration.

Incoming requests for reconsideration of a wholly or partially unfavorable SF determination are screened to determine if the request was made timely. Timely requests are logged into USTAR (FOM1 15120) and a letter acknowledging receipt of the request is released. A USTAR tracking sheet is printed and attached to the request and claims folder. (Claims folders not already in the Reconsideration Section are obtained).

Requests for reconsideration are distributed to Reconsideration specialists by date of receipt, the oldest requests being distributed first, except when there is special (i.e. Congressional, Board member, etc) interest.

2. Adjudication and Evidence Development

   See DCM 6.4.4 A.2

3. Administrative Actions Before Authorization

   After reviewing all of the information and coming to a determination, the adjudicating specialist:

   a. Rationale (See DCM 5.1.6)

      - If fully affirming a previous determination

        Composes a rationale explaining why the previous determination was reasonable. The document is then placed in the Reconsideration Rationale SharePoint site.

        Do not place a copy in the claims folder.

      - If partially or fully revising a previous determination

        Completes Form G-325.1 (DCM 11 G-325.1).

        Place a copy of Form G-325.1 on the left side of the claims folder before submitting the case for authorization.

   b. OLDDS (If necessary) (DCM 12.1.4)

      OLDDS is only completed if the SF determination in effect is changed (allowance/denial) or a disability onset date is revised.

If completed, a copy of all OLDDS screens is placed on the left side of the claims folder before submitting the case for authorization. (See RCM 5.12.10)

c. Disability Determination Letter

Appropriate Reconsideration Section code letters and paragraphs are used. The adjudicating examiner must send the letter to the imaging authorization folder.

NOTE: Reconsideration Section specialists are responsible to proofread the reconsideration determination letter for the correct name and address, accurate content, and proper grammar before it is released to the claimant/annuitant and sent to the imaging authorization folder.

d. Reversal Sheet (if necessary)

A reversal sheet is completed only if partially or fully revising a previous determination. It is placed in the claims folder.

4. Authorization Process (IF NECESSARY)

SF decisions at the reconsideration level require authorization by another specialist ONLY if partially or fully revising a previous disability determination.

If the case requires authorization by another specialist:

a. The adjudicating specialist will log the claims folder into the AFCS location of the fellow specialist reviewing the case and bring it to him/her.

b. The authorizing specialist will thoroughly review all aspects of the proposed disability determination for sufficiency, accuracy, and content, including but not limited to: medical and non-medical evidence, all medical opinions, determination rationale, system entries, formal determination letters of notification, and any other forms and documentation relevant to the decision.

The authorizing and adjudicating specialists will immediately discuss the case if there are any disagreements in any aspect of the decision. As a last resort, the Reconsideration Section supervisor should be consulted if the disagreements cannot be rectified informally.

c. The authorizing specialist will approve OLDDS and verify that it processed correctly into the system.

d. After the case has processed into the system, the authorizing specialist will log the claims folder into the AFCS location of the adjudicating specialist and return it to him/her.

5. Administrative Actions After Authorization

   a. The adjudicating specialist will print three (3) copies of the formal disability determination notification letter. One copy is released to the individual requesting reconsideration. One copy is placed on the right side of the claims folder. One copy is given to the Chief of the Reconsideration Section.

      A fourth copy (carbon copy; cc:) is printed if an attorney is or appears to represent a claimant/annuitant. Send the cc: to the attorney if the reconsideration determination is partially or fully favorable. Send the cc: to the claimant/annuitant if the original determination is fully affirmed.

      All letters must be sent to imaging.

   b. Enter an appropriate CDR call up diary (DCM 8.5.2 and 8.5.3), if it is warranted, using the CDR call up program (DCM 12.3). A copy is placed on the left side of the claims folder.

      NOTE: Existing medical diary call ups in the CDR call up program should be closed and an up-to-date diary entered.

   c. The adjudicating specialist will release one copy of the Reversal Sheet to DBD. A second copy (attached to the USTAR tracking sheet) is placed in the incoming tray of the Chief of Reconsideration Section.

   d. When all is complete, the claims folder is either sent to:

      - Claim Files, or
      - Survivor Benefits Division - Initial Section if a DF has been granted for a deceased railroad employee (DCM 6.9.1).

      NOTE: If the payment of a D/A or O/M is affected such as could occur when an earlier DF onset date is allowed, notify the Retirement Benefits Division via an E-mail.

6.7 Joint Freeze, Unilateral Freeze, and Financial Interchange Disability Determinations

6.7.1 Introduction To Joint And Unilateral Freeze Determinations

Joint RRB/SSA disability freeze (DF) decisions are not required by law or regulation but are the results of interagency policy formed in September 1958 to protect certain railroad employees and their families against the possible adverse effect of independent and/or conflicting DF decisions made by two agencies based on the same provisions of law. Joint freeze (JF) decisions also eliminate any potential administrative problems for both agencies due to uncoordinated decisions.

Although the Railroad Retirement Board (RRB) has independent statutory authority to make DF decisions for our annuitants, there are no provisions of law that requires the Social Security Administration (SSA) to recognize our ratings for benefits under the Social Security Act (SS Act). JF decisions insure that the employee's family will have the advantage of higher survivor benefits after his death.

A JF determination is defined as a disability claim processed jointly by RRB and SSA where there is some likelihood of social security benefits being paid OR cases included in the financial interchange sample. RRB prepares the DF determination and SSA reviews and countersigns the decision.

An application for a disability annuity (D/A) filed with the RRB is also deemed to be an application for a DF under the SS Act. If a claim for D/A **filed with the RRB** meets the criteria (but not an exception) shown in DCM 6.7.3, the RRB is required to attempt to coordinate the DF decision with SSA as a possible JF decision.

- If, at the initial or reconsideration levels of adjudication, the RRB and SSA agree that the claimant is disabled beginning on a specific date, a JF has been established from that date and the disability determination is entered into the RRB system using OLDDS SSA-831 (DCM 12.1.6).

- If, at the initial or reconsideration levels of adjudication, RRB and SSA EITHER

  - disagree that the claimant is disabled

    OR

  - agree that the claimant is disabled but disagree on the date that disability begins

  the RRB may decide to unilaterally conclude that the claimant is disabled for DF purposes. The period of time which the RRB decides to make an independent decision on the claim after the RRB and SSA are unable to reach an agreement through the JF coordination/reconciliation process is considered a unilateral freeze period. Unilateral freeze decisions completed in DBD require supervisory or senior examiner signatory approval. DF decisions denied in DBD but subsequently unilaterally allowed in the Reconsideration Section require authorization by a second Reconsideration specialist.

- The RRB and SSA have agreed that DF claims meeting the criteria in DCM 6.7.3 but completed at the appeals or Board level are considered unilateral freeze decisions. Appeals and Board-level decisions are entered into the RRB systems through OLDDS differently than initial and reconsideration-level decisions.

  NOTE: A courtesy copy of the administrative record and determination rationale are sent to SSA for unilateral DF claims awarded by a hearings officer or three-

member Board which are in the financial interchange sample, as shown in DCM 6.7.3 D.

All JF and unilateral freeze decisions are important for Financial Interchange (FI) purposes. See DCM 6.7.8 for additional information regarding the FI.

6.7.2 SS Definition Of "Career RR Employee"

SSA considers any person to be a career RR employee if the person has:

- 120 months of creditable service under the Railroad Retirement Act (RRA), or
- Completed 60-119 months of creditable service under the RRA with at least 60 months after 1995, or
- Been awarded an RR disability or retirement annuity.

A person who does not meet the conditions mentioned above is termed a "non-career" RR employee.

6.7.3 When A Joint Decision Is Required

Joint disability decisions for an initial disability freeze and continuing entitlement to a disability freeze will be made for career railroad employees when there is potential entitlement to social security benefits. A joint decision will be made when one of the following conditions exist, with exceptions listed at the end of the section:

A. The employee does not have a current connection (C/C).

B. The employee has sufficient wage quarters to be eligible for a DIB as of the alleged quarter of disability onset (AQD).

C. SSA reports wages of over $5,000 but does not identify the quarters of coverage for that year.

D. The case is included in FI sample. The sample consists of employees, widows and children in the following cases:

Those where the claim number is A-979832 or lower and the last two digits of the claim number are 55; or,

Those where the claim number is higher than A-979832 (including terminal digit claim numbers) and the last two digits of the claim number are 30.

Provided an applicant has been disabled for at least five months at the time an RR Act decision is made and we have sufficient medical evidence to make an SS Act disability freeze decision, an attempt should be made to make that decision. Use the information contained on the G-90 record or the REAP program and the DEQY/SEQY earnings

information and report from The Work Number (TWN) in conjunction with data on the application about recent work to determine whether a single or joint decision is required. These items or records must be imaged. Do NOT print as they contain federal tax information and must be properly safeguarded.

EXCEPTIONS: The following types of cases should be excluded from the joint freeze process unless the case is in the FI sample (see item D above). If the case is in the FI sample the exceptions in items 2 through 6 do **NOT** apply. Only item 1 applies for cases in the FI sample:

1. All cases in which the annuity is denied based on the same application

2. All technical denials for lack of insured status or failure to meet the twelve-month duration requirement. This type of denial should be handled as a single disability freeze decision.

3. All cases in which an occupational annuity is being granted, but the disability freeze would be denied for being in SGA. This type of denial should be handled as a single disability freeze decision. However, a facsimile copy of the denial letter should be sent to GLPSC at (312) 575-4701, Attention: Disability Consultant.

4. The employee has a current connection and has died before adjudication.

5. Cases in which the person has filed for either Title II or Title XVI under the Social Security Act.

6. Technical denials for which the annuitant has submitted a statement that he does not want to be granted a DF per DCM 6.3.1

6.7.4 Making Joint And Unilateral Freeze Decisions

All claims for disability annuity (D/A) **filed with the RRB** meeting the criteria in DCM 6.7.3 are considered joint freeze (JF) decisions. Initial JF claims are coordinated with the Social Security Administration (SSA) by examiners in the Disability Benefits Division - Disability Post Section (DBD-DPS). In addition, JF claims initially denied by DBD-DPS but allowed by a claims specialist in the Reconsideration Section (Recon) are coordinated with SSA.

> **NOTE 1:** Affirmations of initially denied JF's are not coordinated with SSA by Recon claims specialists.
>
> **NOTE 2:** If a claim for D/A was denied initially by DBD but reversed by a reconsideration specialist AND the claim meets the criteria for JF coordination (DCM 6.7.3), Recon will return the claims folder back to DBD-DPS to coordinate the JF decision with SSA since it had not been previously attempted.

Disagreements may occur between the RRB and SSA with regards to medical and/or vocational issues as well as, if an allowance, the proposed onset date. Those disability

claims where the RRB makes an independent decision after the RRB and SSA are unable to reach an agreement through the JF reconciliation process are considered unilateral freeze decisions. In addition, disability freeze (DF) decisions meeting the criteria in DCM 6.7.3 but completed at the appeals or Board level are considered unilateral freeze decisions. Appeals and Board-level decisions are entered into the RRB systems through OLDDS differently than initial and reconsideration-level decisions.

NOTE: A courtesy copy of the administrative record and determination rationale are sent to SSA for unilateral DF claims awarded by a hearings officer or three-member Board which are in the financial interchange sample, as shown in DCM 6.7.3 D.

The process that follows is used to coordinate decisions with SSA.

6.7.4.1 Distribution of Incoming Claims

A. DBD Handling

Cases are generally distributed to and adjudicated by DBD examiners according to terminal digits.

DBD sends the claims folder of initially denied JF's to Recon at the time that an individual is rated not disabled in anticipation of a possible request for reconsideration.

B. Reconsideration Section Handling

Incoming requests for reconsideration of a wholly or partially unfavorable JF determination are screened to determine if the request was made timely. Timely requests are logged into USTAR (FOM1 15120) and a letter acknowledging receipt of the request is released. A USTAR tracking sheet is printed and attached to the request and claims folder. (Claims folders not already in Recon are obtained.)

Request for reconsideration are distributed to Recon specialists by date of receipt, the oldest requests being distributed first, except when there is special (i.e. Congressional, Board member, etc) interest.

6.7.4.2 Adjudication and Evidence Development

The DBD-DPS examiner or Recon specialist obtains all information needed to make a DF decision including but not limited to: any pertinent medical and non-medical evidence, vocational reports, earnings record (DCM 6.3.4), application forms, activities of daily living and medical consultant's opinion (MO) of the claimant's residual functional capacity.

NOTE 1: Adjudicating personnel must check to see if an application for Disability Insurance Benefits (DIB; Title II) or Supplemental Security Income (SSI; Title XVI)

was already filed at SSA. Indications that a disability application was filed at SSA can be found in/on:

- Form AA-1 (APPLE and paper);
- Form AA-1d;
- SSA Master Benefit Record (MBR);
- SSI Record;
- DATAQ;
- DEQY (if already in file); and
- Contact Log.

Adjudicators can request a MBR, SSI record, and DEQY from RRB personnel who have been authorized by SSA to access their system. Instructions how to read a MBR can be found in POMS SM 00510. Instructions how to read a SSI record can be found in POMS SM 01601. Adjudicators can also request a report from The Work Number (TWN); see DCM 3.4.205).

If a career railroad employee has also filed a claim with SSA for a DIB or SSI, the DF decision must be processed into the RRB systems as a single freeze (DCM 6.6.4; DCM 12.1.4) **EXCEPT** when a claim is in the Financial Interchange (FI) sample, as shown in DCM 6.7.3 D. If the claim is in the FI sample, the DF decision must be processed into the RRB systems through OLDDS SSA-831 (DCM 12.1.6).

NOTE 2: Affirmations of initially denied JF decisions or JF disability onset dates are not coordinated with SSA by Recon claims specialists. If a Recon specialist affirms a JF which was initially denied or a JF disability onset date, do not follow the instructions in DCM 6.7.4.3 through 6.7.4.5. Disposition of the case shall continue as in DCM 6.7.4.6 A.2.

6.7.4.3 Administrative Actions Before Coordination With SSA

After reviewing all the information and coming to a determination, the DBD examiner or Recon specialist:

1. completes a RRAILS Form G-325.1, *Disability Decision Rationale*, for the proposed decision (DCM 11 G-325.1), and
2. records and signs the JF decision on Form SSA-831-U3, *Disability Determination and Transmittal*.(See DCM 11 SSA-831)

The above information is placed on the top of the left side of the claims folder. (See RCM 5.12.10 for information how a claims folder is organized.)

3. images a copy of the REAP earnings record and/or DEQY/SEQY/ and report from The Work Number (TWN) for documentation (if needed). (Do not send these items to SSA).

6.7.4.4 Sending Claims Folders To SSA

The DBD examiner or Recon specialist places the claims folder in terminal digit order in the T0GL file cabinet located in DBD and logs the folder into AFCS sublocation T0GL (DBD-Cases Going to GLPSC). The claims folder will then be sent by messenger (generally once each week) to SSA's Great Lakes Program Service Center-Disability Program Branch (GLPSC-DPB) for JF coordination efforts.

Folders leaving the Board for GLPSC will be logged into AFCS sublocation T017 (DBD-Joint D/F at SSA).

NOTE: The claims folder with the proposed JF decision may be released to SSA before a D/A award has been paid partial or final by the RRB.

6.7.4.5 Coordination Actions With SSA

The GLPSC claims examiner reviews the decision for concurrence and then sends the claims folder to their doctor(s) to review the evidence and provide a written MO. Any differences between agencies are reconciled before the GLPSC claims examiner **and** SSA doctor certify the decision by each signing Form SSA-831-U3.

A. SSA agrees with the proposed RRB JF determination (i.e. medical and/or vocational issues as well as disability onset date)

   The GLPSC disability examiner will keep a photocopy of the certified Form SSA-831-U3 for their records, leave any MO's and other related paperwork in the claims folder, complete and staple SSA Form GLPSC-38 to the front of the file, and return the claims folder to the RRB.

   Disposition of the case shall continue as in DCM 6.7.4.6 A.1 (DBD-DPS) or DCM 6.7.4.6 A.2 (Recon).

B. SSA disagrees with the proposed RRB JF determination

   Neither the GLPSC disability examiner nor their doctor will certify Form SSA-831-U3. The GLPSC disability examiner will leave the MO's and other related paperwork in the claims folder, complete and staple SSA Form GLPSC-38 to the front of the claims folder with an explanation for the disagreement, and return the claims folder to the RRB.

   Upon return of the claims folder, the DBD-DPS examiner or Recon specialist will review all of the evidence and any supporting rationale that SSA has provided.

1. If the DBD-DPS examiner proposed a JF allowance or denial but now agrees with SSA's proposed denial or allowance, (s)he will complete a new RRAILS Form G-325.1, *Disability Determination Rationale*, and Form SSA-831-U3, *Disability Determination and Transmittal*, and place them above the original G-325.1 and SSA-831-U3 forms. (A large "X" shall be written on the original G-325.1 and SSA-831-U3 forms and each form will be left in file for documentation purposes.) A "GLPSC Conflict Case" label shall be stapled to the front of the claims folder to alert the GLPSC representative that they have previously reviewed the file. The claims folder will then be resubmitted to SSA. Follow the instructions in DCM 6.7.4.3.

   If the Recon specialist proposed a JF allowance but now agrees with SSA's proposed denial, (s)he will follow normal Reconsideration section procedures to affirm the denial. Disposition of the case shall continue as in DCM 6.7.4.6 A.2.

2. If the DBD-DPS examiner or Recon specialist disagrees with SSA's proposed determination, a judgment should be made as to the next course of action. If necessary, the examiner or specialist must make reasonable attempts to reconcile vocational issues and differences in medical opinions including but not limited to attempting to obtain any additional medical and/or vocational evidence and scheduling consultative examinations requested by SSA.

   If the examiner or specialist continues to feel that the evidence is sufficient, (s)he can resubmit the claims folder with additional information and/or supporting rationale for its decision to SSA. In addition, DBD-DPS examiners may refer the claim to the DBD-DPS supervisor or senior examiner with a written request for advice. The request should briefly summarize the case and suggest a course of action. The DBD-DPS supervisor or senior examiner will review the evidence and provide a written opinion regarding what further action, if any, should be taken to reconcile the possible conflict. Both the request for advice and opinion must remain documented in the claims folder.

   A new RRAILS Form G-325.1, *Disability Determination Rationale*, and/or Form SSA-831-U3, *Disability Determination and Transmittal*, may need to be completed and placed in the left side of the claims folder if it is resubmitted to SSA. A "GLPSC Conflict Case" label shall be stapled to the front of the claims folder each time it is returned to SSA to alert the GLPSC claims examiner that they have already reviewed the case. The claims folder will be resubmitted to SSA. Follow the instructions in DCM 6.7.4.3.

   If, after reasonable attempts to reconcile the differences, a disagreement still exists between the RRB and SSA, the RRB may decide to make an independent determination, referred to as a unilateral freeze decision. All unilateral freeze decisions completed by a DBD-DPS examiner require supervisory or senior examiner signatory approval. Unilateral freeze periods allowed in the Reconsideration Section require signatory approval by a second Recon specialist.

Unilateral freeze decisions proposed by a DBD-DPS examiner or Recon specialist require a written explanation (separate from the determination rationale) of the reason(s) for the decision. The rating DBD-DPS examiner shall give the claims folder and explanation to his/her supervisor or senior examiner for review. The rating Recon specialist shall give the claims folder and explanation to a second Recon specialist for review. The supervisor, senior examiner, or Recon specialist will review the proposed decision and either approve or deny it by signing the explanation (and including any additional explanation when necessary). The original approval/explanation shall be filed on the right side of the claims folder. (Unilateral freeze decisions completed as a result of an appeal do not require any approval.)

Disposition of the case shall continue as in DCM 6.7.4.6 B.1 (DBD-DPS) or DCM 6.7.4.6 B.2 (Recon) after signatory approval has been obtained.

See DCM 12.1.4 for proper OLDDS coding for item 24 for unilateral freeze cases on the G-325 screen.

After OLDDS processes, the claims folder shall be returned to the DBD-DPS supervisor or senior examiner who approved the unilateral freeze decision. Similarly, the claims folder shall be returned to the Recon specialist who proposed the unilateral freeze decision

The DBD-DPS supervisor or senior examiner who approved the decision OR Recon specialist who proposed the decision is responsible to formally advise the SSA of the unilateral freeze decision, including any additional evidence or supporting rationale (s)he may choose to provide. The notification should be made by E-mail to: CHI.ARC.PCO.DPB@ssa.gov.

C. SSA agrees with a JF allowance but not with the proposed disability onset date or Medical-Vocational rule

SSA may or may not certify Form SSA-831-U3. If Form SSA-831-U3 is certified, the GLPSC will cross out the entries to be changed and write in the revised information. Regardless of whether it is certified, the GLPSC claims examiner should leave the MO's and other related paperwork in the claims folder, complete and staple SSA Form GLPSC-38 to the front of the claims folder (with a brief explanation of the changes), and return the claims folder to the RRB.

NOTE 1: In these situations, be alert to the possibility of an earlier onset date for the D/A determination **or** a unilateral freeze request for the period prior to the onset date SSA agrees to.

NOTE 2: RRB and SSA regulations specify that a person reaches a particular age on the day before his or her birthday. (See RCM 4.2.3) Consideration of an individual's age does not take place until step 5 of the sequential evaluation process for disability onset date purposes. Although the Medical-Vocational

rules (DCM 5.6) are not to be applied mechanically, in borderline age situations (see DCM 5.3.6 and POMS DI 25015.005), a DF onset date based on the attainment of a particular age as shown in the Medical-Vocational rules is normally established as the day before the claimant's birthday.

Upon return of the claims folder, the DBD-DPS examiner or Recon specialist will review all of the evidence and any supporting rationale that SSA has provided.

1. <u>If the DBD-DPS examiner or Recon specialist agrees with SSA's proposed changes</u>, (s)he will complete a new RRAILS Form G-325.1, *Disability Determination Rationale*, and place it above the original Form G-325.1. (A large "X" shall be written on the original Form G-325.1 and it shall be left in file for documentation purposes.) No changes are to be made to Form SSA-831-U3, *Disability Determination and Transmittal*.

   Disposition of the case shall continue as in DCM 6.7.4.6 A.1 (DBD-DPS) or DCM 6.7.4.6 A.2 (Recon).

2. <u>If the DBD-DPS examiner or Recon specialist disagrees with SSA's proposed changes</u>, a judgment should be made as to the next course of action. If necessary, the examiner or specialist must make reasonable attempts to reconcile vocational issues and differences in medical opinions.

   (S)he may resubmit the claims folder with additional information and/or supporting rationale to SSA. In addition, DBD-DPS examiners may refer the claim to the DBD-DPS supervisor or senior examiner with a written request for advice. The request should briefly summarize the case and suggest a course of action. The DBD-DPS supervisor or senior examiner will review the evidence and provide a written opinion regarding what further action, if any, should be taken to reconcile the possible conflict. Both the request for advice and opinion must remain documented in the claims folder.

   If the claims folder is resubmitted to SSA, a new RRAILS Form G-325.1, *Disability Determination Rationale*, and/or SSA-831-U3, *Disability Determination and Transmittal*, shall be printed and placed on the left side of the claims folder. A "GLPSC Conflict Case" label shall be stapled to the front of the claims folder each time it is returned to SSA to alert the GLPSC claims examiner that they have already reviewed the case. The claims folder will then be resubmitted to SSA as in DCM 6.7.4.3 above.

   If, after reasonable attempts to reconcile the differences (most likely due to a difference in the disability onset date) a disagreement still exists between the RRB and SSA, the RRB may decide to make an independent determination. The period of time that SSA does not agree with the RRB that the career railroad employee is disabled would be considered as a unilateral freeze. <u>All unilateral freeze decisions completed by a DBD-DPS examiner require supervisory or senior examiner signatory approval. Unilateral freeze periods</u>

allowed in the Reconsideration Section require signatory approval by a second Recon specialist.

All periods of time considered as a unilateral freeze and proposed by a DBD-DPS examiner or Recon specialist require written explanation (separate from the determination rationale) of the reasons(s) for the decision. The rating DBD-DPS examiner shall give the claims folder and explanation to his/her supervisor or senior examiner for review. The rating Recon specialist shall give the claims folder and explanation to a second Recon specialist for review. The supervisor, senior examiner, or Recon specialist will review the proposed decision and either approve or deny it by signing the explanation (and including any additional explanation when necessary). The original approval/explanation shall be filed on the right side of the claims folder. (Unilateral freeze decisions completed as a result of an appeal do not require any approval.)

After signatory approval has been obtained, the case must be properly completed. Disposition of the case shall continue as in DCM 6.7.4.6 B.1 (DBD-DPS) or DCM 6.7.4.6 B.2 (Recon).

See DCM 6.7.5 for proper OLDDS coding in this situation.

After OLDDS processes, the claims folder shall be returned to the DBD-DPS supervisor or senior examiner who approved the unilateral freeze period. In a similar manner, the claims folder shall be returned to the Recon specialist who proposed the unilateral freeze period.

The DBD supervisor or senior examiner who approved the decision OR Recon specialist who proposed the decision is responsible to formally advise SSA that the RRB considered a period of time as a unilateral freeze period. The notification may include any additional evidence or supporting rationale (s)he may choose to provide and should be made by E-mail to: CHI.ARC.PCO.DPB@ssa.gov.

6.7.4.6 Administrative Actions After Coordination With SSA

The DBD-DPS examiner or Recon specialist will take appropriate actions after SSA certifies the proposed JF decision and/or approval for a unilateral freeze decision.

A. Joint Freeze Decisions

1. DBD-DPS Handling

a. OLDDS

Enter and process the certified JF decision on the OLDDS SSA-831 screen (see DCM 12.1.6). Authorization is not required because SSA has approved the decision. (DCM 3.4.304)

EXCEPTION: If a JF allowance ALSO allows an earlier D/A onset date, actions to enter the earlier D/A onset date MUST be completed before actions to enter the JF onset date so that PREH processes correctly. In this situation, complete the following actions as follows:

- DAY 1: Complete OLDDS G-325 to allow the earlier D/A onset date
- DAY 2: After the earlier D/A onset date has processed, complete OLDDS SSA-831 to allow the JF onset date
- DAY 3: After the JF onset date has processed, send the claims folder to the DBD-Disability Post Section senior examiner so that they release an E-mail to RPS about the earlier D/A onset date. Advise the senior examiner if the claims folder needs to be sent to another location rather than to claim files.

Place a printout of all OLDDS screens above Forms SSA-831-U3 and G-325.1 on the left side of the claims folder.

JF decisions must not be authorized on OLDDS until the disability annuity award has been paid partial or final by the RRB.

NOTE: See DCM 6.7.5 for procedure how to enter OLDDS in an onset date conflict.

b. Disability Determination Letter

Compose and release the appropriate RL-210 series or RL-260 series letter. In addition, either the SSA-810 or SSA-813 (with SSA publication No. 05-10058, *Your Right To Question The Decision Made On Your Claim*) must be concurrently released. (See DCM 6.4.6 and DCM 6.7.6)

EXCEPTION: If the JF is allowed and the EE has both a fully insured status (RCM 5.6.5; DCM 6 Appendix 5) under the Social Security Act (SS Act) and a disability insured status (DCM 6.3.2) based on Social Security earnings, (s)he is insured for a Disability Insurance Benefits (i.e. DIB; cash annuity) under the SS Act. In this situation, do not release Form SSA-810 (or SSA publication No. 05-10058) to the EE. SSA will release their SSA-L810 letter and solicit the EE for an application for DIB.

Make a second copy of the RL-210 or RL-260 series letter and place it on the top of the right side of the claims folder. Do not print a copy of the SSA-810 or SSA-813 for the claims folder.

Send all letters to imaging.

c. CDR Call-Up Diary

If necessary, establish an appropriate CDR call-up diary in the CDR Call-Up program. (See DCM 8.5.2 and DCM 8.5.3)

If a CDR call-up diary is established, place a printout on the left side of the claims folder.

d. DF-Only Applications

DF-only applications are manually coded out of KOR. DBD-DPS examiners should enter the appropriate information on the coding sheet. The coding sheet will be E-mailed back to the DBD-DPS senior examiner at the end of each calendar month.

e. Other Miscellaneous Actions Involving the Claims Folder

File the SSA-certified Form SSA-831-U3 on the left side of the claims folder.

File all other documentation received from SSA, including but not limited to Form GLPSC-38 and SSA medical opinion form on the right side of the claims folder.

Send the EE's earning record (REAP or DEQY/SEQY and report from The Work Number (TWN)) electronically to imaging.

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f. Medicare

If the Medicare effective date is in a previous month, the current month, or any of the five months following the award, the DBD-DPS examiner or Recon specialist must notify the Medicare Section of the Medicare entitlement using Form G-405 attached to an Email. (See RCM 11 G405)

It is highly recommended that the examiner or specialist place a photocopy of the E-mail and Form G-405 on the right side of the claims folder.

g. Disposition

Send the claims folder to claim files EXCEPT when a DF has been granted for a deceased railroad employee, in which case the folder should be sent to the Survivor Benefits Division - Initial Section. (See DCM 6.9.1).

2. Reconsideration Section Handling

a. OLDDS

OLDDS is only entered if the Recon examiner revises the JF decision (allowance/denial or disability onset date) originally made by DBD-DPS and

SSA certifies that decision. If this occurs, follow the instructions in DCM 6.7.4.6 A.1.a.

b. Disability Determination Letter

Use RRAILS letter +RECONDEC.

If the initial JF decision is fully or partially reversed, either Recon Section code letter RL-210a (if decision is reversed) or code paragraph RS 807 (if revising a disability onset date) is used. Additional Recon Section code paragraphs and other text may need to be added to the letter. Also, code letter RL-210a.ATTACHMENT is used if a JF decision is reversed. If the claimant is represented by an attorney, the original is released to the claimant and a carbon copy is sent to the claimant's attorney.

If the initial JF decision is affirmed, either Recon Section code paragraph RS 808-1 (if a denial is affirmed) or RS-811 (if affirming a disability onset date) is used. Additional Recon Section code paragraphs and other text may need to be added to the letter. If the claimant is represented by an attorney, the code paragraph RS 809-1 is used if a JF denial is affirmed. Regardless, if a claimant is represented by an attorney, a carbon copy is sent to the claimant and the original is sent to the claimant's attorney.

Send all letters to imaging.

c. CDR Call-Up Diary

Affirmations of initial JF decisions do not require a revised CDR call-up diary. However, if an initial JF denial is reversed or a disability onset date is revised, follow the instructions in DCM 6.7.4.6 A.1.c. to update the CDR call-up diary.

d. Other Miscellaneous Actions Involving the Claims Folder

Follow the instructions in DCM 6.7.4.6 A.1.e.

e. Medicare

Follow the instructions in DCM 6.7.4.6 A.1.f.

f. Disposition

Follow the instructions in DCM 6.7.4.6 A.1.g.

In addition, attach a copy of the Recon tracking sheet to a copy of the letter and place it in the appropriate incoming tray in the office of the Chief of Reconsideration.

B. Unilateral Freeze Decisions

1. DBD-DPS Handling

   a. OLDDS

   Enter and process the unilateral DF decision on the appropriate OLDDS G-325 screens (see DCM 12.1.4, especially for correct coding instructions for item 24). Authorization is not required because the supervisor or senior examiner has approved the decision. (See DCM 3.4.304)

   NOTE: A single OLDDS entry can be completed on the same day if a unilateral freeze allowance ALSO allows an earlier D/A onset date.

   Place a printout of all OLDDS screens above Form G-325.1 on the left side of the claims folder.

   Unilateral freeze decisions must not be authorized on OLDDS until the disability annuity award has been paid partial or final by the RRB.

   NOTE: See DCM 6.7.5 for procedure how to enter OLDDS in an onset date conflict.

   b. Disability Determination Letter

   Compose and release the appropriate RL-210 series or RL-260 series letter. (See DCM 6.4.6)

   Place a printout of the RL-210 or RL-260 series letter on the top of the right side of the claims folder.

   Send the letter to imaging.

   c. CDR Call-Up Diary

   Follow the instructions in DCM 6.7.4.6 A.1.c.

   d. DF-only Applications

   Follow the instructions in DCM 6.7.4.6 A.1.d.

   e. Other Miscellaneous Actions Involving the Claims Folder

   File the original approval/explanation from the supervisor/lead examiner on the right side of the claims folder.

   File all other documentation received from SSA, including but not limited to Form GLPSC-38 and SSA medical opinion form on the right side of the claims folder.

Send the EE's earning record (REAP or DEQY/SEQY and report from The Work Number (TWN)) electronically directly to imaging.

SSA must be notified of the unilateral freeze decision by sending an E-mail to CHI.ARC.PCO.DPB@ssa.gov.

f. Medicare

Follow the instructions in DCM 6.7.4.6 A.1.f.

g. Disposition

Follow the instructions in DCM 6.7.4.6 A.1.g.

2. Reconsideration Section Handling

a. OLDDS

OLDDS is only entered if the Recon examiner revises the DF decision (allowance/denial or disability onset date) originally made by DBD-DPS and SSA does not agree with the decision. If this occurs, follow the instructions in DCM 6.7.4.6 B.1.a.

b. Disability Determination Letter

Use RRAILS letter +RECONDEC.

If the initial DF decision is fully or partially reversed, either Recon Section code letter RL-210a (if the decision is reversed) or code paragraph RS 807 (if revising a disability onset date) is used. Additional Recon Section code paragraphs and other text may need to be added to the letter. Also, code letter RL-210a.ATTACHMENT is used if a DF decision is reversed. If the claimant is represented by an attorney, the original is released to the claimant and a carbon copy is sent to the claimant's attorney.

Send all letters to imaging.

c. CDR Call-Up Diary

Follow the instructions in DCM 6.7.4.6 A.1.c.

d. Other Miscellaneous Actions Involving the Claims Folder

Follow the instructions in DCM 6.7.4.6 B.1.e.

e. Medicare

Follow the instructions in DCM 6.7.4.6 A.1.f.

f. Disposition

Follow the instructions in DCM 6.7.4.6 A.1.g.

In addition, attach a copy of the Recon tracking sheet to a copy of the letter and place it in the appropriate incoming tray in the office of the Chief of Reconsideration.

NOTE: SSA will request by an email to the DBD group mailbox photocopies of the RRB file for any JF case where the employee is insured for an SSA DIB (20/40 insured case) **and** files for a disability benefit at SSA. DBD will retrieve the file from claims files and send the photocopies attached to a G-26f within 3 weeks of receiving the request. Keep a copy of the G-26f in the file as documentation that the photocopies were sent. Requests are handled by the DBD-DPS lead examiners.

6.7.5 RRB/SSA Disability Onset Date Conflict In Joint Freeze Decisions

At times the RRB and SSA may agree to grant a disability freeze (DF), but a conflict exists as to the appropriate disability onset date. Although SSA and RRB will make every effort to reconcile a conflict, the RRB is not bound to accept SSA's onset date. If after reasonable attempts to reconcile the differences, a disagreement still exists between the RRB and SSA, the RRB may decide to make an independent determination for the period of time prior to the date of disability onset that SSA agrees to. That period of time would be considered as a unilateral freeze period.

All unilateral freeze decisions completed by a DBD-DPS examiner require supervisory or senior examiner signatory approval. Similarly, all unilateral freeze decisions completed by a Recon specialist require signatory approval by a second Recon specialist.

The rating DBD-DPS examiner shall give the claims folder and explanation to his/her supervisor or senior examiner for review. The rating Recon specialist shall give the claims folder and explanation to a second Recon specialist for review. The supervisor, senior examiner, or Recon specialist will review the proposed decision and either approve or deny it by signing the explanation (and including any additional explanation when necessary). The original approval/explanation shall be filed on the right side of the claims folder. (Unilateral freeze decisions completed as a result of an appeal do not require any approval.)

In an unreconciled disability onset date conflict, the RRB date will be used for Taxation and Medicare. For any payment adjustment to a claim in this situation, refer to RCM 8.11.15 E.

When all efforts to reconcile the date conflict have been exhausted and the SSA-831 has been returned to DBD, signed off and with SSA's own disability onset date, and DBD supervisory/senior examiner or second Recon specialist signatory approval has been approved for a unilateral freeze period, process the case as follows:

- Enter the information from the form SSA-831 on OLDDS screen SSA-831 as described in DCM 12.1.6. Even though RRB will not use the onset date on this form, the information must be entered for financial interchange purposes. Allow the OLDDS SSA-831 to process on the nightly run;

- After the SSA-831 information has been entered and processed, complete the screen G-325 on OLDDS for a DF only (see DCM 12.1.4). Item 24, Employee Dis Code, should contain a "7." The actual onset date used by the RRB, the RRB date and SSA date must all be completed. In the actual onset date and RRB date of this item enter the disability onset date recognized by the RRB. For the SSA date enter the disability onset date used by SSA. This information must be entered to correctly update PREH and TAX databases with the RRB onset date;

- Prepare allowance notice RL-210C as well as SSA-L810. Enter the RRB DF onset date and Medicare coverage beginning date on the RL-210C. Enter the SSA disability onset date on the SSA-L810 if it is not a 20/40 DIB insured status case. In 20/40 DIB insured status cases, SSA will release the SSA-L810.

6.7.6 Joint Disability Freeze Decision Notices

As agreed by both agencies, two joint decision notices are furnished to the applicant in most instances: one from RRB and one from SSA.

For allowances, DBD prepares RR RL-210, or RL-210b, or RL-210C. SSA-L810 is also prepared and SSA Publication No. 05-10058 (Your Right To Question The Decision Made On Your Claim) is enclosed when the employee does **not** have a 20/40 SSA DIB insured status, and SS notices are entered in item 29 of Form SSA-831-U3. In 20/40 DIB insured status cases, SSA will release the SSA-L810 and SSA Publication No. 05-10058.

DBD examiners prepare RL-260 for RR denials. A copy of RL-260 is filed in the applicant's folder and sent to imaging. In addition, the DPS examiner will prepare a SSA-L813.1 and enclose SSA Publication No. 05-10058. A copy of that letter is furnished to the annuitant and GLPSC-DPB.

No copies of the SS notices are retained for the RR claim folder.

6.7.7 Receipt Of Disability Freeze G-90 In Single Coverage Or Joint Disability Freeze Allowance

A disability freeze G-90 will be requested sometime after Forms G-325 or SSA-831-U3 are entered on OLDDS. Do not control for it. RBD receives the G-90s once a month via the GOLD system. RBD screens them to identify cases requiring additional action.

6.7.8 The Financial Interchange

In 1951, Congress enacted amendments that increased benefit levels under the Railroad Retirement Act (RR Act). This legislation guaranteed that benefits paid under the RR Act would never be less than what would have been payable if the worker's railroad earrings had been credited as Social Security employment instead of RR Act-covered compensation. As part of that same legislative package, Congress established the Financial Interchange (FI) between the Social Security and Railroad Retirement systems as an additional funding source. The FI is one of the major funding sources that supports the RR Act trust fund.

The FI is a collective term that describes a series of legally mandated periodic fund transfers between the Railroad Retirement Board (RRB) and Social Security Administration, the RRB and Centers for Medicare and Medicaid Services, and between the RRB and the Treasury. The amounts transferred are the result of a complex statistical projection based on the scenario "What if the RR Act had never been enacted?"

FI amounts are computed by the Bureau of the Actuary using statistical methods including large samples of RRB beneficiaries and currently employed railroad workers. All calculations are performed under the provisions of the Social Security Act.

When SSA concurs with the RRB's decision to grant a JF, some or all of the benefits awarded are considered Social Security Equivalent Benefits (SSEB). Normally through the FI, the Social Security trust funds bear the cost for any benefits awarded under the RR Act if the benefits are considered SSEB.

When SSA does not concur with the RRB's decision to grant a JF OR agrees to grant a DF but disagrees on the disability onset date, the RRB completes a unilateral freeze decision for the period of time of the disagreement. In these situations, none of the benefits are considered SSEB and, as a result, the Railroad Retirement trust fund bears the entire cost.

The Financial Interchange Division of the Bureau of the Actuary must keep track of the DF cases in the FI sample in addition to joint freeze and unilateral freeze cases. The Financial Interchange Division will make the appropriate queries to obtain the information needed for employees and widows. DBD management will periodically report the disabled children to the Financial Interchange Division, including the following information:

- claim number
- date of birth
- claimant's social security number
- DF code
- disability onset date, and
- date of decision

The FI is based upon the railroad employee's claim number, not a widow's or child's social security number.

6.8 74 Act Medicare and Government Employment

6.8.1 When The 1974 Act Applies

In the 1974 RR Act, a new provision was added which provides that an individual who meets the insured status requirement when their disability annuity begins retains, for Medicare purposes only, that status as long as disability benefits are paid.

In other words any disability annuitant who meets 20/40 as of his ABD, but does not meet 20/40 in the month of disability onset, is not entitled to a disability freeze. The employee can receive a "Medicare only" rating that qualifies that employee only for early Medicare. Under the 1974 RR Act, for Medicare purposes only, a disability annuitant is deemed to have met 20/40 when their condition becomes severe enough to entitle them to a DIB.

6.8.2 When Government Employment Can Be Used To Establish Medicare

A. General - In some cases, claimed Federal, State and local government employment may be used to establish Medicare entitlement only. QCs received for this type of employment are called Government Employment Quarters of Coverage (GEQCs). They cannot be used to establish entitlement to an annuity or a disability freeze.

   Every attempt should be made to establish Medicare based on Railroad Retirement (RR) earnings or Social Security (SS) wages. If this fails and the application shows government employment, an attempt should be made to establish Medicare based on government employment.

B. Federal Employment - Federal QCs awarded January 1983 or later may be used to establish Medicare Coverage.

In addition, a federal employee may be granted QCs for federal employment before January 1983 to establish Medicare coverage if:

- the employee was in an employer-employee relationship with the federal government at anytime during January 1983, and;
- the employee was employed by the federal government prior to January 1983.

C. State and Local Government - State or local government QCs awarded April 1986 or later may be used to establish Medicare only. No quarters may be granted for employment before April 1986.

D. DPS Examiner Action - If Medicare entitlement cannot be established in a disability case based on RR earnings or SS wages, further development may be required. The DPS examiner should check the application for an indication of Federal, State or local government employment. If such employment is indicated, a DEQY and report from The Work Number (TWN) must be requested and sent to Imaging. Upon viewing the DEQY, determine whether the GEQCs will provide Medicare coverage. Refer to RCM 3.2.13 for further details.

6.8.3 Freeze Notice

For cases in which the 1974 Act applies or government employment is used as quarters of coverage and the employee qualifies for early Medicare, letter RL-260b is sent to the employee.

6.8.4 Past Relevant Work in 1974 Act Cases

When adjudicating 1974 Act cases, the 15 year rule used in determining past relevant work (PRW) is to be used from the date of adjudication and not from the date last insured.

6.9 Routing of Disability Freeze Cases

6.9.1 Routing Of Disability Freeze Cases When Employee Is Deceased

In cases where a disability freeze has been granted for a deceased employee and all disability action has been completed, send an email to the SBD-Survivor Benefits Division mailbox, attention: SIS, providing the RRB claim number and deceased employee's name. Route the file to the survivor initial unit. This action is needed to determine if survivor benefits are affected by the disability freeze.

Appendices

Appendix 2 - Deemed Filing Dates Of Freeze Applications

Filed At RRB before 9-7-58

D/A Application Filed	Deemed Filing Date of DF	Employee's Insured Status Requirement
Employee died after 6-30-55 and before 8-2-56. (Employees who died before 7-1-55 could not qualify for DF.)	Latest of: 1-1-55; date D/A application was filed; date disabled under section Title II of SS Act.	Meets 6/13 QC test.
Application had been filed; employee was alive and disabled under Title II on 8-2-56.	8-2-56	Meets 6/20 QC test.
Application filed after 8-2-56 and before 1958.	Latest of: Date D/A application was filed; date disabled under Title II of SS Act.	Meets 6/20 QC test.
Application filed before 1958, and employee was alive on 8-28-58. (Employee who died before 8-28-58 could not qualify for DF under 20/40.)	1-1-58	Does not meet 6/20 QC test – meets 20/40.
Application filed 1-1-58 through 9-6-58.	Later of the following dates which occurred before 7-1-58: Date D/A application was filed; date disabled under Title II of SS Act.	Meets QC test for applicable period of DF; or meets 20/40 QC test.
Employee did not qualify for DF on basis of D/A application filed before 9-7-58.	Latest of: 1-1-55; date D/A application was filed; date following last day engaged in SGA.	Meets QC test for applicable period of DF; or meets 20/40 QC test.

Application filed 7-1-58 through 9-6-58, employee not disabled under Title II before 7-1-58, or application filed after 9-6-58.	Date D/A filed; or if D/A application was filed in advance of eligibility, the date on which a letter or other SAME AS ABOVE document evidencing an intention to apply for D/A was received at an office of the Board.	
D/A previously denied and reapplication for D/A made after 9-6-58.	Date on which the letter or other document evidencing intentions to SAME AS ABOVE reapply for D/A was received at an office of the Board.	

Appendix 3 - Effect Of Filing Date And Insured Status Requirements On DF And DIB-O/M - Application Filed Before 12-2-64

Application Filing Date	**DF or DIB Insured Status**	**Retroactivity of DF Application**	**DIB-O/M Entitlement Date**
DF or DIB filed at SSA before 1958.	20/40 with 6/13 day employee has	DF effective first date ee age insured status and under disability which continued without interruption to date application was filed. No DF can be established beginning earlier than 10-1-41.	DIB effective application (6/20) 50/64, after 6 months waiting period. DIB-O/M cannot begin before 7-1-57

1-1-58 Through 8-27-58.	6/20 - if not met 20/40 can be applied, provided the W/E was alive on 8-28-58, and had not been sent notice of decision by that date; in such cases see eligibility requirement as shown below.	No change.	No change.
8-28-58 through 8-31-60	20/40 and fully insured unless, wage earner (W/E) has 6/20 and possible DIB entitlement or recalculation for months before 9-1958	No change. 6/20 requirement met for DIB entitlement or DF recalculation for months before 9-1958.	9-1--58, unless
9-1-60 through 7-1-62	20/40 and fully insured. If not met before 10-1960, alternate insured status can be applied 20 QC's before quarter of disability with at least 6 quarters after 1950.	No change, unless alternate insured status applied. Earliest date DF can begin under alternate insured status is 7-1-52. Insured status is 10-1960.	No change, unless alternate insured status applied. Earliest DF recalculation or DIB entitlement under alternate

7-2-62 Through 12-1-64	20/40 and fully insured.	DF can begin no earlier than 18 months before the date the application was filed, providing that the W/E has an insured status and is under a disability which continued to the day application was filed. Effective 11-1-64, the above 18-month restriction was removed, as though never in effect, if W/E was alive on 12-1-64 and W/E was continuously disabled from the date of filing until 12-1-64, or the 1st day of the month in which he attained age 65 (whichever was earlier).	No change.

Appendix 4 - DF And DIB (OM) Legislative History

Effective Date	Provisions
7-1-55	O/M increase at age 65, if DF period established.
7-1-55	Insured status for DF set at 6/13 (currently insured).
1-1-57	DIB (OM) increased to disabled employees age 50-64, after 6- month waiting period. Earliest entitlement date for benefits under DIB (OM) 20/40 with 6/13, referred to as 6/20 (fully and currently insured).
1-1-57	Insured status for DF and DIB (OM) 20/40 with 6/13, referred to as 6/20 (fully and currently insured).
9-1-58	Repeal of DIB (O/M) offset for receipt of Workmen's Compensation (WC) and Veterans benefits.
9-1-58	Inclusion of auxiliary beneficiaries in DIB (O/M) for months after 8/58.
9-1-58	Insured status for DF and DIB (O/M) entitlement or recalculation, for months after 9/58, 20/40 and fully insured.

10-1-60	Alternate insured status for W/E under disability before 1956, 10 QC's before quarter of disability, with 6 quarters earned after 1950. The first day a DF could begin under this requirement was 7-1-52. The first month for which DIB could be paid on this requirement was 10-1960.
10-1-60	Trial work period (TWP) under SS Act changed from 3 to 9 months.
10-1-60	DIB (O/M) terminates 2 months after the month in which the disability ends.
11-1-60	DIB (O/M) at any age, after 6-month waiting period. Earliest date of entitlement to DIB (O/M) under this requirement was 11-1-60.
7-1-61	DF could begin no earlier than 18 months before application was filed based on application filed based on application filed on or after 7-2-62.
11-1-64	Removed above 18-month restriction as though it had never been in effect if: W/E was alive on 12-1-64; and he was continuously disabled from the date filing until 12-1-64, or until the first day of the month in which he attained age 65 (whichever is earlier).
9-1-65	Regular definition of disability liberalized.
9-1-65	Special insured status for blindness before age 31.
9-1-65	Change in application requirements. A W/E may file an application for DF or DIB (O/M) could not be paid before 9-1-65.
9-1-65	Offset under DIB (O/M) because of receipt of periodic workmen's compensation, for months after 12-1965, and before the disabled worker attains age 62.
2-1-68	Expanded regular definition of disability and liberalized definition of statutory blindness.
2-1-68	Special insured status requirement for disability before age 31.
2-1-68	Liberalized retroactive filing of an application for closed periods of disability, when failure to file within normal 12-month period is due to physical or mental incapacity (this change does not extend retroactive payments under DIB (O/M) beyond 12 months).
2-1-68	Definition of "average current earnings" for WC offset liberalized.
1-1-75	The RR 1974 Act permits a disability annuitant who meets 20/40 as of his ABD but does not meet 20/40 in the month of disability onset to

	receive a "Medicare Only' ratings that qualifies him only for early Medicare even though he is not entitled to a DF.
12-1-80	Extended Medicare coverage may continue for up to 24 additional months but only if the disability DF is terminated solely due to SGA.
12-1-88	In accordance with SSA's extended period of eligibility (EPE) provisions, and individual may be granted a 36-month entitlement period beginning with the month immediately following the completion of the 9-month TWP.
1-1-91	The Omnibus Budget Reconciliation Act (OBRA) of 1990 repealed the more restrictive definition of disability for entitlement to disabled widow(er)'s benefits under the SS Act. Under the new law, vocational factors can also be considered for widow(er)'s remarried widow(er)'s and surviving divorced spouses when rating these individuals for Medicare under the SS Act.
1-1-92	Section 5112 of OBRA grants a TWP in every period of disability and provides that the disabled annuitant's TWP ends only when he/she has completed 9 service months within a 60 consecutive month period.

Appendix 5 - Wage Quarters Of Coverage Required For SS Fully Insured Status - Disability Cases

Disability Onset

Employee Born Before 1-2-90	**Before Year Age 62 Attained**	**Employee Born After 1-1-30**	**Disability Onset Age 31 or later**
Year of Onset	QC Required	Age at Onset	QC Required
1957	06	31	09
1958	07	32	10
1959	08	33	11
1960	09	34	12
1961	10	35	13
1962	11	36	14
1963	12	37	15

1964	13	38	16
1965	14	39	17
1966	15	40	18
1967	16	41	19
1968	17	42	20
1969	18	43	21
1970	19	44	22
1971	20	45	23
1972	21	46	24
1973	22	47	25
1974	23	48	26
1975	24	49	27
1976	25	50	28
1977	26	51	29
1978	27	52	30
1979	28	53	31
1980	29	54	32
1981	30	55	33
1982	31	56	34
1983	32	57	35
1984	33	58	36
1985	34	59	37
1986	35	60	38
1987	36	61	39
1988	37	62	40

1989	38
1990	39
1991	40

Onset Before Age 31 Attained

An employee born after 1-1-30 who has disability onset before age 31 attained must, to have an SS fully insured status, have acquired wage QC's equal to one-half (1/2) of the quarters that elapsed between the quarter after he attained age 21 and the quarter before his disability began.

Onset In or After Year Age 62 Attained

Refer to calendar year in which age 62 attained to find required QC's.

7.1 Introduction

7.1.1 Scope of Chapter

This chapter focuses on the processing and disposition of requests for reconsideration and appeals of disability rating decisions rendered by the Disability Programs Section (DPS) under the Railroad Retirement Act (RR Act). The Reconsideration Section in Assessment and Training handles all reconsideration requests of disability decisions and appeals of decisions are charged to the Bureau of Hearings and Appeals.

This section contains procedures that are unique to disability reconsideration such as medical development, vocational documentation and preparing a rationale. RCM 6.1.1 contains procedures regarding all non-medical issues pertaining to reconsideration.

7.1.2 Right To Request Reconsideration

Every annuitant has the right to file a request for reconsideration of an initial or post disability decision made by DBD. See RCM 6.1 for exceptions, summary of the reconsideration and appeals process, and filing for reconsideration and appeals.

NOTE: An annuitant may request a reconsideration of a disability annuity onset decision based on Form RL-121f notice. For this reason, RL-121f letters must include information about reconsideration rights, even if additional medical evidence has been requested for a possible earlier onset date. Requests for reconsideration of the ABD or annuity rate must be based on the annuity award letter (RL-20 for retirement cases and RL-43 for survivor cases).

In addition, reconsideration rights are **not** to be included in letters when informing an annuitant that their annuity has been impacted by earnings and impairment related work expenses (IRWE) have been considered. The reconsideration rights will be provided in a letter when the annuity is adjusted by the adjudicating unit.

7.1.3 Types Of Reconsideration

A. Initial Denial Actions - A reconsideration request may be handled for cases where an initial disability annuity under the RR Act and/or "period of disability" (disability freeze) or early Medicare entitlement under the SS Act were denied. The disability denial may be based on service requirement not met, lack of disability severity, insufficient quarters of coverage (QC's) for disability freeze, etc.

The handling of the reconsideration request pertains to the following beneficiary types:

Employee's occupational disability

Employee's total and permanent disability (including DF)

Widow's disability

Child's disability

B. Partially Favorable Decisions - This type of reconsideration request involves disability decisions for each beneficiary where a partially favorable allowance was made. For example, we did not allow the earliest onset date, as claimed by the annuitant since the medical evidence of record did not permit it. Also, another situation is where the occupational disability annuity was allowed but the "period of disability" (disability freeze for early Medicare entitlement) was denied. The medical evidence of record did not support a finding of total and permanent disability.

C. Cessation of Disability Determinations - Regarding this reconsideration request, a CDR was conducted and it resulted in a termination of either disability benefits under the RR Act and/or disability freeze for early Medicare entitlement under the SS Act. The termination was made due to an annuitant's medical recovery, subsequent work for covered railroad carrier, substantial gainful activities (SGA), continued work activity after a trial work period (TWP) or failure to cooperate.

Also, a reconsideration request may be received after we have reopened to deny because a post review uncovered that an erroneous initial determination had been made for him/her.

7.1.4 Third Party Inquiry Relating To Adverse Decisions

If an inquiry is received from someone clearly representing the claimant, which refers to our adverse notice (denial letter) and indicates that the notice was incorrect, this may indicate an attempt by the claimant to ask for a reconsideration.

In such cases, the field office should be advised to contact the claimant to find out if a reconsideration request was intended. If so, the third party letter will preserve his/her appeal as long as the third party letter was received within the 60 day reconsideration/appeal period.

7.1.5 Reconsideration Handling By Reconsideration Examiners

A reconsideration examiner, not involved in the initial determination or post termination decision, performs the case review after Form RL-211a is released to the individual acknowledging the receipt of request for reconsideration.

If it is not already in file, request the field office to secure any medical evidence including evidence from the individual's treating physician(s). This request should also include records from hospitalizations or clinic treatments and/or non-medical evidence (vocational/work records) from him/her and/or employer(s).

It may be necessary to request that the individual undergo a consultative examination (CE) or refer the case to QTC when the medical evidence presented for use at the reconsideration level is in conflict with medical evidence of record.

Based on all the evidence, render a reconsideration decision.

If you determine that the initial denial, partially favorable or cessation decision should be reversed, prepare the appropriate screen(s) on OLDDS and/or paper forms. (G-325, G-325.1, SSA-831-U3, or G-325a).

Also, prepare a letter advising the individual about the wholly/partially favorable allowance or continuance of disability decision.

After the reconsideration decision has been authorized the case should be handled as follows:

- Forward to the Director of the Retirement Benefits Division or the Director of the Survivor Benefits Division. The route slip should indicate the type of action needed by the payment examiner, such as awarding the initial disability annuity, recertifying the disability annuity payment based on an earlier onset date, enrolling for Medicare coverage, etc.

When the reconsideration decision still affirms the initial decision, prepare and release a letter affirming our earlier decision. Unless there is some other action needed after reconsideration action has been taken, forward the folder to BHA.

7.1.6 Reconsideration Request Filed Before The Initial Determination Is Made On An Initial Disability Claim

Under RRB's regulations, a claimant does not have a right to request a reconsideration in advance of an initial determination. For purposes of an appeal, an initial determination is made when the notice of such determination is dated for release.

In instances where a request for reconsideration is filed before the initial determination is made, Disability Initial Section (DIS) will dismiss the reconsideration request on the basis that an initial determination had not been made. Conversely, in those instances when the reconsideration request is filed before receipt of the notification (the denial notification is prepared but not released, or it is in transit), the reconsideration request should be processed as a valid request.

In some situations, the field office will have to telephone DIS to ascertain the status of a claim before taking an action. Any new and material medical evidence submitted at this time should be forwarded to DIS for association and consideration with the pending unadjudicated claim.

An example of the language which may be used in dismissing such a request is as follows, but may have to be modified to fit the particular case involved:

"We have dismissed your request for reconsideration dated ________________ because an initial disability determination has not been made in your case. The RRB regulations provide the right to reconsideration of a disability determination only after an initial determination has been made. You will be advised of this right in the initial disability determination notice.

If you have any questions about your claim, you should get in touch with any RRB field office. Most questions can be handled by telephone or mail. If you visit the field office, please bring this notice with you.

7.1.7 New Disability Applications Filed While A Reconsideration Or Appeal Is Pending

RRB's regulations (20 CFR Section 217.9) states that the effective period of an application ends on the date of the notice of an initial decision denying the claim. Also, Section 217.9 states that if a timely appeal is made, the effective period of the application ends on the date of the notice of the decision of the hearings officer, on the date of the notice of the final decision of the Board or when the court review of the denial has been completed. After the effective period of an application ends, the person must file a new application for any annuity.

Due to varying circumstances, the time period involved in the handling of cases from the initial decision through the entire appeal process can become quite lengthy. For that reason, some claimants file a new application while they are still appealing the decision from the original application.

Section 5(b) of the RR Act provides that an application for any payment under the Act "shall be made and filed in such manner and form as the Board may prescribe." This statute thus expressly grants to the Board the discretion to determine the manner in which applications may be filed.

Based on the above, DBD can receive new applications filed while a reconsideration or appeal before the Board is pending, but should take no development action until the appeal process is completed. No additional development is necessary in those cases where the appeal is ultimately decided in the claimant's favor. Where the appeal is not decided in the claimant's favor, payments are prohibited on the application for the period covered by the initial application only (claimant's potential eligibility for receiving a benefit for up to twelve months prior to the filing date).

This approach conforms with procedures of SSA. See POMS GND1 12045.027 for specifics.

When a claimant files a new application while a reconsideration of an initial determination is pending, process the case as follows:

A. New Application Filed While Initial Denial Being Reconsidered - If the claimant files a new application while the Reconsideration Section is reconsidering an

initial denial, and the new application represents the same issue as the previous claim, combine the application with the reconsideration request. Advise claimant that since his original application is still in an appeal process, it is active so no action will be taken on the second application filed.

B. New Application Filed While Cessation Being Reconsidered - When a Reconsideration examiner is preparing a reconsideration determination affirming a substantial gainful activity (SGA) cessation, and a new application is filed, the new application should be combined with the reconsideration request.

C. Dual Disability Claim Filed While An Initial Denial Or Cessation Is Being Reconsidered

When a claimant files a related claim (dual entitlement exists) while a reconsideration request is pending on another disability claim under the same entitlement, the new claim should be referred to DPS. DPS should complete the disability rating for the new application and then review the claim that had been denied. If this new rating shows that the previously denied rating should be reopened then DPS should take all necessary actions. For example:

An employee was denied a total and permanent disability and files a reconsideration. In the interim the employee files for a disabled widower benefit. When the medical evidence is received for the widower claim, evidence that was unavailable when the denied rating was made, is submitted. This new evidence shows the claimant to be disabled for both a widower and total and permanent annuity. DPS should reopen the denied claim, make the appropriate disability determination, and inform the Reconsideration Section that the decision has been overturned.

However, if the decision on the new application does not affect the denied rating, DPS should complete their action and return the claim to the Reconsideration Section.

Prepare a personalized notice for each claim to include the claimant's right to request a hearing if dissatisfied with the reconsideration decision.

D. Application Filed After Appeal Process Completed

If an application is filed after the appeal process has been completed, the medical determination cannot consider a period covered by the earlier application. To do so would in effect be reopening the original final decision.

NOTE: The appeals process ends 60 days after notification to the applicant of a decision even if no request for reconsideration was filed.

7.2 Jurisdictional Handling Of Reconsideration / Appeals

7.2.1 General

There had been some questions raised about the manner in which a request for reconsideration should be processed. This section incorporates the interim procedure (A-91-05) issued to the disability claims examiners on February 15, 1991 that provided guidelines for the jurisdictional handling of reconsideration/appeals.

Some of the questions being raised referred to notifications advising annuitants of the reconsideration decision, which cases should be referred to hearings and appeals and what type of appeal backing should be on reconsideration letter. Procedure is provided in DCM 7.2.2 with examples on how to handle each issue.

7.2.2 Issues

1. The first issue involves an initial disability denial.

   An employee filed a disability application and his claim for a disability annuity is denied for a lack of medical severity. He disagrees with the decision and files a timely reconsideration request. After the reconsideration review is completed, if the determination affirms that the initial disability denial decision is correct, the employee should be provided an explanation including appeal rights.

2. The second issue involves a difference in the claimed onset date (wholly favorable).

   An employee filed a disability application and claimed an onset date of October 17, 1988. His application was denied for a lack of medical severity. He timely submitted a request for reconsideration along with medical evidence. Based on the new medical evidence, his disability annuity was allowed from October 17, 1988, his alleged onset date. The employee should be sent a letter advising him of the wholly favorable decision. No appeal paragraph is required in this letter since the employee will be given appeal rights on the award letter.

3. The third issue involves a difference in the claimed onset date (partially favorable).

   An employee filed a disability application and claimed an onset date of October 17, 1988. His application was denied for lack of medical severity. He submitted a timely request for reconsideration along with additional medical evidence. Based on the new medical evidence, he was found disabled from October 17, 1989, one year after his alleged onset date. The employee should be sent a letter advising him of the partially favorable decision. The letter should also advise him of his appeal rights if he does not agree with the partially favorable decision and it should advise him that he will receive another notice in the mail with specific details about his annuity rate and beginning date.

4. The fourth issue involves a further protest about the reconsideration decision.

   An employee filed a disability application and claimed an onset date of October 17, 1988. His application was denied for lack of medical severity. He timely submitted a request for reconsideration along with additional medical evidence. Based on the new medical evidence, he was found to be disabled from October 17, 1989. Since the decision was only partially favorable, the employee was sent a letter advising him of the partially favorable decision and his annuity was awarded as stated above in issue 3. He now files a protest about the reconsideration decision and wants his alleged onset date to be established based on his disabling conditions. That protest letter should be treated as an appeal request. The file containing the protest letter is to be sent directly to the Bureau of Hearings and Appeals.

5. The fifth issue involves a request for reconsideration of the earliest onset date and medical evidence is submitted.

   An employee filed a disability application and claimed an onset date of October 17, 1988. A disability annuity and/or a "period of disability" is granted with a later onset date of October 17, 1989. He timely submits a request for a reconsideration of the earliest onset date along with medical evidence. Based on the new medical evidence, no change is warranted. The employee should be advised of his appeal rights if he does not agree with the partially favorable decision. However, if the medical evidence does permit a wholly favorable decision, no appeal paragraph is required in the letter advising him of the reconsideration decision.

7.3 Request For Reconsideration Development

7.3.1 General

The Reconsideration examiner has the responsibility for development of medical evidence in a reconsideration case. Use the general instructions on initial cases for development and tracing of medical evidence (DCM Chapter 4).

The reconsideration examiner will consider the issues of whether a claimant is disabled, the onset of disability and cessation of disability. Nonmedical aspects of disability, e.g., vocational consideration, may be fundamental to a proper decision. Resolve doubts about need for further documentation in favor of obtaining such documentation.

The primary requirement of a reconsideration determination is that it be legally and factually proper. A well documented folder gives sufficient evidence at higher appeal levels for validity of determination.

Reconsideration examiners will concentrate on the following for a reconsideration determination:

A. Examine file for all essential elements and proper documentation of all pertinent allegations.

B. Secure additional evidence if evidence is incomplete, insufficient, conflicting, subject to different conclusions, or subject to questionable assumptions.

C. Analyze total evidence in file. Check and resolve conflicts or discrepancies. Weigh the complete evidence and set forth in the determination, the findings, rationale and conclusion.

NOTE: When evaluating an occupational disability reconsideration with a filing date prior to January 1, 1998, use the Provisional Occupational Disability Rating Schedule (PODRS) (See DCM 3.4.2). If the filing date is January 1, 1998 or later use the Occupational Disability Standards a described in the Disability Manual. (See DCM 13.)

7.3.2 Development Techniques

Reconsideration examiners should use any development technique for handling reconsideration that will provide the best documentation such as mail, telephone calls and contact with field offices. To handle expedited cases, it may be necessary to call the field office, claimant, physician, employers, or other individuals knowledgeable about the claimant's situation.

The following is a suggested outline to resolve the problems presented in a case for reconsideration development.

A. Analyze the information obtained in the initial development and any new information obtained by any source as it relates to the claimant's disability determination.

B. Solicit medical evidence from prior or newly identified sources which could document the claimant's condition.

C. Secure a consultative examination (CE) and/or work history to fill in any remaining gaps in the medical and/or vocational evidence.

D. Have the field office arrange for a face-to-face interview whenever doubts remain about any fact which could affect the decision if the Reconsideration examiner believes that direct contact would help resolve the issue(s).

E. Follow instructions in DCM 4.3.8 when tracing for evidence necessary to complete the reconsideration decision.

7.3.3 New Medical Documentation Needed

A. Claimant's Medical Sources - The claimant for a disability annuity is responsible for providing evidence of the claimed disability. The Board will assist the claimant, when necessary, in obtaining medical evidence. All medical sources

from which the claimant has received examination or treatment since the initial decision should be obtained. Also any medical evidence not developed as part of the initial decision should be requested. These sources of evidence should be developed in the most expeditious manner.

B. Worsening of Condition or New Allegations - Often new allegations are made or new evidence presented on reconsideration which indicates a worsening of the claimant's condition. When this occurs, Reconsideration examiner should obtain the additional information needed to provide a clear picture of the claimant's current condition. This information may be available from the claimant's medical sources or through a CE.

C. Consultative Examination - CE's should be obtained when needed, but not routinely. A CE should not, if possible, be performed by the same physician used in the initial claim.

D. Signing of Medical Reports - If reconsideration permits allowance, the case can be paid while the signature is being obtained. Medical evidence obtained by telephone during the reconsideration process must be sent to the medical source(s) for confirming signature. Unsigned reports secured in connection with the initial decision which are material to the reconsideration determination must also be sent to the medical source(s) for signature. The confirming signatures are necessary to perfect the record in case of future appeal if the reconsideration determination affirms an initial denial or cessation (including partial denials such as disability onset established later than alleged).

7.3.4 Vocational Documentation Required

In cases in which the severity of an impairment does not meet a "D" finding in the Occupational Disability Tables (January 1, 1998 or later) or meet or equal the disqualifying criteria for the claimant's appropriate family group as identified in the PODRS (prior to January 1, 1998) or the Listings or Impairments, as shown in RRB or Social Security Administration (SSA) regulations, a finding of "disabled" cannot be made on medical considerations alone. When this occurs, full consideration must be given to the vocational factors. (See DCM 4 for a discussion of sequential evaluation.)

The folder should always contain complete vocational development including a full description of the claimant's work history during at least the 15 years prior to alleged onset (or past the alleged onset date if the claimant is still working). The information secured should include the job titles, types of business (both railroad or non-railroad), dates worked, usual job in the last 5 years (both railroad or non-railroad), which job claimed as regular railroad occupation, physical demands, basic duties, nature and extent of supervision, independent judgment required and the types of tools, machinery and equipment used, if any.

If more than one job was performed during this 15-year period, separate descriptions of each job must be secured. Use Form G-251 (Vocational Report) for obtaining additional vocational history.

See DCM Chapter 5 for additional information about vocational development.

7.4 Reconsideration Determinations

7.4.1 Preparation Of The Reconsideration Determination

When the development of the reconsideration request has been finished, prepare a new determination revising or affirming the original determination as appropriate. This requires careful attention to the following:

A. Examination of the file in detail to ensure that all required elements are present and all pertinent allegations are properly documented.

B. Determination that evidence in file is sufficient, without conflict and not subject to different conclusions.

C. Analysis of the total evidence, resolving conflicts and discrepancies, weighing the complete evidence and setting forth the findings and conclusions in the disability decision rationale.

7.4.2 Affirming A Previous Determination

A previous denial determination may be affirmed as written if any of the following conditions are satisfied:

A. There is no allegation of a worsening of any previously documented impairment;

B. There is no allegation of any new impairment;

C. There has been no treatment of any impairment subsequent to the prior determination;

D. The prior denial determination was substantively and technically correct;

E. The rationale for the prior denial determination was correctly presented and it resolved all the pertinent issues to be adjudicated.

F. The applicant failed to submit additional evidence.

In the event a previous denial determination is affirmed and the rationale for the reconsideration determination would merely be a verbatim repetition, the following statement may be considered as an adequate rationale for the file:

The original (or prior) determination of ___(date)___ for ___(claimant)___ is hereby affirmed as written.

The letter should also include railroad retirement claim number, date of affirmation and name of disability examiner involved in decision.

7.4.3 Revision Of Prior Determinations

In the event the reconsideration examiner revises any part of a prior determination, the revision must be explained in the rationale or letter to the claimant. The criteria for reconsideration case rationale are generally the same applicable criteria for initial case rationale.

The rationale may include the following elements:

A. A review of the claimant's allegations, including his/her basis for requesting a reconsideration. This should include worsening of documented impairments; new impairment; different onset date; no medical recovery; sheltered employment; new evidence, etc.

B. A discussion of any technical issues which have arisen since the prior determination.

C. A discussion of the findings produced by the sequential evaluation process.

D. A statement of the basis for the revised disability determination (cite any specific listing, standard, rule, etc. that supports the revision).

7.4.4 Points To Consider In The Reconsideration Process

A. Treating Source Opinion Differs - When the total evidence does not support an opinion furnished by the claimant's treating physician that he or she is "unable to work," "disabled," etc., cite the findings or evidence which rebut(s) the treating source opinion.

B. Inconsistencies Material to the Decision - Explain any inconsistencies material to the decision, i.e., evidence which might indicate a different decisional outcome.

C. Pain-Related Issues - Any allegation(s) or report(s) of pain must be considered in (1) determining whether the claimant has a severe impairment, and (2) at each step in the sequential evaluation process. If there are inconsistencies in the evidence concerning pain, i.e., the claimant alleges limitations or restrictions greater than that reasonably expected based on the objective medical findings, there are conflicts in the evidence, etc. Then these differences must be reconciled and explained in the file.

D. Closed Period Cases - In closed periods of disability, explain how medical improvement is demonstrated.

E. Vocational Rule - In a medical vocational decision, if no vocational rule is met, but the vocational rules are used as a framework for the decision, explain what rules have been considered.

F. Consideration of Jobs and Incidence - In unfavorable decisions, a citation of jobs may be stated. For example, "You are considered able to perform your past work..." or "You are considered able to perform medium..." etc.

G. Court Cases - Explain any specific issues as required by court decision that impacts either positively or negatively on reconsideration determination, e.g., RRB's legal opinion on alcoholism L79-232.

7.5 Reconsideration Rationale Preparation

7.5.1 General

The rationale is a statement of the fundamental reasons serving to account for the reconsideration determination of disability. It is used as a supporting statement for a disability decision and contains a complete, concise discussion of the analysis and opinions used as a basis for a decision. It also includes citation of applicable rules and codes. The rationale for a disability reconsideration decision must be written, keeping the audience that will be reading it in mind, so that a clear picture of the case can be obtained. The rationale should follow an orderly pattern and show clearly how specific evidence leads to a conclusion. Any significant inconsistencies in medical and non-medical factors must be reconciled. Reasonable inferences may be drawn, but presumptions, speculations and suppositions must not be used.

If a reconsideration request results in a reversal of a disability determination a formal rationale should be prepared on the form G-325.1. If the initial disability decision is being sustained the rationale for sustaining that decision is included in the letter to the annuitant.

The purpose of the disability determination/reconsideration decision rationale is multi-fold: to identify all the medical and non-medical factors which have been considered; to explain the thought process which was used to arrive at the determination; and to provide a permanent evidentiary record of the reasons underlying the conclusion. The rationale further serves to inform subsequent reviewers, including quality assessment groups, of the basis for the determination.

When a favorable determination or decision is based on meeting a "D" in the Tables of the Occupational Disability Standards, or equaling the disqualifying criteria in the PODRS, or the listing of impairments, the applicable criteria must be cited. Also, state the medical findings that support that decision.

If the reconsideration determination is based on medical vocational rules, the rationale should include the claimant's age, education level, work experience and the impairment severity level (i.e. heavy, medium, light or sedentary work). The impairment severity

level is determined by the claimants RFC and must be supported by objective medical evidence.

A reversal based on a mere conclusion that the claimant is "not able to perform a regular railroad job or to engage in SGA" is insufficient. The rationale must state fully the reasons that the claimant cannot perform his/her regular railroad occupation or engage in SGA and it must be based on the evidence of record, the applicable regulations and the determinative step in the sequential evaluation process.

If a decision is sustained no rationale is provided. However, a letter to the applicant, or his representative, provides the rationale for the decision to be sustained. In this letter a conclusion that "the applicant's impairment(s) is not severe enough to prevent him or her from performing a regular railroad occupation or from engaging in SGA" is insufficient. If the evidence establishes that the impairment(s) is "not severe," the rationale must show that the impairment(s) would not significantly affect the performance of a regular railroad job or a basic work-related function. If a denial may not be made on this basis, the rationale must reflect the remainder of the sequential evaluation process.

Remember that you are to consider the effect of all the claimant's medically documented impairments in a disability determination.

7.5.2 Processing Of Joint Freeze Cases Involving Reconsideration

A. No formal action will be taken by the agency that did not receive the request for reconsideration or appeal, unless the other agency decides that its previous decision should be revised. In the event, before a final decision is made, the other agency will be given an opportunity to review its decision in the light of new evidence or information received at whatever level the "protest" is being handled.

B. The Great Lakes Program Service Center (GLPSC) - Disability Review Section (DRS) has the responsibility for handling claims of career railroad workers who request reconsideration of initial and continuing disability determinations on claims filed through any SSA district office and on those claims which were jointly coordinated and rated. CE may be obtained from SSA.

   We should coordinate our reconsideration decision with SSA before our decision is finalized. While they are not bound by our decision, nor are we bound by theirs, an attempt to coordinate is required.

7.6 Personalized Reconsideration Disability Letters

7.6.1 General

The law requires that when a totally or partially unfavorable disability decision is rendered, the determination letter must be written in understandable language discussing the evidence and stating the RRB's determination and the reasons for it.

Where a written personalized explanation has been provided explaining why the individual is not or will no longer be entitled to disability benefits and/or disability freeze - early Medicare entitlement (e.g., disability cessation, adverse reopenings), it will not be necessary to repeat the same information in the initial determination notice. Personalized letters should be brief and understandable to the claimant or his/her representative.

7.6.2 Personalized Explanation Requirements

A. Basic Tests - A personalized explanation sent to annuitants must meet two basic tests. First, it must be legally sufficient and secondly, it must not be offensive in any way.

1. The first test will be consistently met by following the instructions contained in this chapter for preparation of personalized explanations in the various claims affected.

2. The second test involves what is written and how it is written. Abbreviations, acronyms, jargon, technical terms and complex medical phrases must not be used unless they are properly qualified. The information provided must be relevant, concise and meaningful. Dates may be abbreviated numerically (e.g., 12/14/92), if necessary, to save space. The reconsideration examiner must be sensitive to the claimant or annuitant's feelings and needs. Information in the personalized explanations must not be offensive to the applicant in any manner. The personalized explanations should be written in the third person when it is to a person filing on behalf of a claimant or a representative payee for an annuitant.

B. Clarity - In addition to meeting the two basic tests it is equally important that the personalized explanation be written as simply and clearly as possible, i.e., understandable to anyone with a least a 6th grade education. Proper wording is also important to avoid conveying an unintended negative message to the claimant or annuitant. Poorly written letters can have a negative impact on RRB and impair its ability to serve the railroad public interest.

C. Impairments Addressed - The personalized explanation should address alleged impairments and other impairments which are discovered during the course of the evaluation provided that the impairments are known by the claimant. Closely related impairments may be grouped by body system.

D. Letter Preparation

1. The reconsideration examiner is responsible for preparing the personalized explanation for reconsideration since they are responsible for making the reconsideration determination.

2. The personalized explanation may be typewritten from the Form G-835 (PC Assembly Form for Disability Notices), or a personal computer.

3. The reconsideration disability determination rationale will continue to be prepared based on instructions in DCM 7.5.

7.6.3 Explanations In Reconsideration Denials

A. General

1. The reconsideration examiner will prepare a personalized explanation with a denial letter for reconsideration based on medical and/or medical/vocational issues.

2. When an insured status or a prescribed period is last met prior to the date of the determination, the explanation should reflect the period of time considered and specify the date through which the insured status or the prescribed period was met.

3. Medical reports and non-medical reports listed on the initial personalized explanation do not need to be repeated.

4. The wording of a personalized reconsideration explanation should not be the same as that of the initial notice even if the denial is sustained on the same basis. The wording should be rephrased to avoid the erroneous impression that the claim was not independently review on the reconsideration level.

5. The Reconsideration examiner will notate in the decision notice that all medical evidence in the file has been reviewed;

6. When the medical sources were unresponsive, a disclaimer statement may be provided, e.g., additional reports were not obtainable; however, we had enough information to evaluate the claimant's condition;

7. (Optional) Give a statement that "the determination on your claim was made by the RRB. It was not made by your own doctor or by other people, hospitals, or agencies writing reports about you. However, any evidence they gave the RRB was used in making this determination. Doctors and other people employed by the RRB who are trained in disability evaluations reviewed the evidence and made the determination according to the Railroad Retirement law and regulations;"

8. Provide a list of the impairments evaluated. Do not use technical terms unless the claimant or annuitant uses and appears to understand them. When information in file suggests that the claimant or annuitant has terminal illness, mental impairment or is unaware of the exact nature of his or her condition, the reconsideration examiner will use good judgment as

to what will be listed in the explanation concerning the impairments. If the claimant or annuitant is unaware of an impairment, use general terms such as the reports do not show any other conditions which would significantly limit your ability to work;"

9. Furnish a brief description of medical severity as of the month of cessation in closed period of disability allowances or a brief description of the medical or medical/vocational basis for the established onset date in unfavorable onset date allowances. However, care must be taken in discussing medical evidence (address unconfirmed allegations by stating that evidence does not reveal any other disabling condition).

10. When vocational factors are considered in a closed period of disability allowance, a brief description must be given of the job the railroad claimant can return to, or a statement must be provided advising that although the person cannot do any of the work he or she did during the period evaluated he or she still has the capacity to do other work which is less demanding (exertion, mental, skill levels) or has the ability to do less physical work (specify in general terms, e.g., lighter work) based on his or her age, education and past work experience. Do not cite other jobs;

11. When vocational factors were considered in an unfavorable onset date allowance, explain why the vocational factors permit the claimant to work prior to the onset date; and

12. If the claimant's work activity is the reason for the closed period of disability or unfavorable onset determination, that information must be covered in the letter.

B. Special Situations

1. Insufficient evidence, failure/refusal to submit to a CE, does not wish to continue development of claim.

   You will prepare a personalized explanation based on the instructions in DCM 7.5.4.A (items 6-8). The explanation should also include:

   a. A brief description of the evidence needed to adjudicate the claim; and

   b. A brief description of the attempts to obtain evidence and the response received (if any).

2. Failure to follow prescribed treatment, which can restore the claimant's ability to work, without good reason.

   You will prepare a personalized explanation based on the instructions in DCM 7.5.4.A (items 6-8). The explanation should also include:

a. A description of vocational limitations (e.g., age, education) if vocational factors are considered; and

b. A description of the prescribed treatment the claimant refuses to follow and what the treatment will allegedly accomplish.

Appendices

Appendix 1 - AB-25 Reconsideration And Appeal Rights

If you believe that this decision is not correct, you may request that the decision be reconsidered. If you wish this reconsideration, you must request it in writing and your request must be received by the Board within 60 days from the date of this notice. You may file your request at any district office of the Board. If you wish any additional evidence to be considered, please include it with your request.

If you disagree with the reconsideration decision, you may then appeal to the Bureau of Hearings and Appeals within 60 days from the date of the reconsideration decision.

If you do not request a reconsideration within 60 days from the date of this notice, you may not file an appeal at a later date.

Appendix 2 - RECON - Initial Denial Affirmed

Sample Letter

In reply refer to

R.R.B. No.

(EE's Name)

Dear

This refers to your letter requesting reconsideration of the denial of (insert 1).

We have again carefully reviewed all of the medical evidence in your file and are still of the opinion that you are not disabled for (insert 2).

(Narrative insert)

If you disagree with this decision, you have the right to appeal to the Bureau of Hearings and Appeals. If an appeal is made, it must be submitted on Form HA-1 and must be received at an office of the Railroad Retirement Board (RRB) within 60 days from the date of this notice. A Form HA-1 may be obtained from any field office of the RRB or by writing directly to the Director of Hearings and Appeals at the following address:

Railroad Retirement Board, Bureau of Hearings and Appeals, 844 North Rush Street, Chicago, Illinois 60611.

If you need to personally visit one of our field offices, you are urged to call for an appointment. You will not be refused service if you do not have an appointment, but Railroad Retirement Board representatives can serve you better when an appointment is made. Most Railroad Retirement Board offices are open to the public from 9:00 a.m. to 3:30 p.m., Monday through Friday.

Very truly yours,

John R. Feldheim

Director of Disability

and Medicare Operations

cc: Field Office

G-835 Items To Complete

A-1 Recon . . . Denial

Check RECON box at top.

Check DENIAL box in RECON section

Enter the name/address of any other party that will be sent a copy of this letter next to OTHER.

Enter employee's name next to EE NAME.

Enter the addressee's name to ADDRESSEE NAME if other than the employee.*

Enter the address in the lines below ADDRESS.

Enter claim number next to RRB CLAIM NO.

Enter the salutation next to DEAR.

INSERT 1 - Enter the type of claim that is being reconsidered, e.g., an occupational disability annuity, a total and permanent disability annuity, a "period of disability," etc.

INSERT 2 - Enter either "your regular railroad occupation" or "all regular work."

Check the box next to NARRATIVE INSERT ON REVERSE and write your personalized rationale for sustaining denial decision on the reverse side of the worksheet. Note that this narrative will appear as the third paragraph in your denial letter.

Enter your name under DPS-EXAMINER NAME on the reverse side.

Enter the date under DATE on the reverse side.

* This letter can only be addressed directly to the claimant and cannot be addressed to a representative of the claimant. However, a carbon copy could be sent to the representative, if appropriate.

Appendix 3 - RECON - Allowance Wholly Favorable

Sample Letter

In reply refer to

R.R.B. No.

(EE's Name)

Dear

This is to advise you that we have reconsidered our decision regarding your disability application. Based on the evidence in file, you qualify for (insert 1) effective (insert 2). You will receive another notice in the mail with specific details about your annuity rate and beginning date.

Very truly yours,

John R. Feldheim

Director of Disability

and Medicare Operations

cc: Field Office

G-835 Items To Complete

A-3 Recon . . . Allowance (Wholly Favorable)

Check RECON box at top.

Check ALLOWANCE (Wholly Favorable) box in RECON section.

Enter the name/address of any other party that will be sent a copy of this letter next to OTHER.

Enter employee's name next to EE NAME.

Enter the addressee's name to ADDRESSEE NAME if other than the employee.*

Enter the address in the lines below ADDRESS.

Enter claim number next to RRB CLAIM NO.

Enter the salutation next to DEAR.

INSERT 1 - Enter the type of annuity claimant qualifies for, e.g., an occupational disability annuity, a total and permanent disability annuity, etc. . .

INSERT 2 - Enter the effective date (annuitant's alleged onset date).

Enter your name under DPS-EXAMINER NAME on the reverse side.

Enter the date under DATE on the reverse side.

* This letter can only be addressed directly to the claimant and cannot be addressed to a representative of the claimant. However, a carbon copy could be sent to the representative, if appropriate.

Appendix 4 - RECON - Partially Favorable Decision

Sample Letter

In reply refer to

R.R.B. No.

(EE's Name)

Dear

This refers to your letter requesting reconsideration of the denial of (insert 1).

We have carefully reviewed all of the medical evidence in your file and are now of the opinion that you are disabled for (insert 2) effective (insert 3).

(Narrative insert)

If you disagree with this decision, you have the right to appeal to the Bureau of Hearings and Appeals. If an appeal is made, it must be submitted on Form HA-1 and must be received at an office of the Railroad Retirement Board (RRB) within 60 days from the date of this notice. A Form HA-1 may be obtained from any field office of the RRB or by writing directly to the Director of Hearings and Appeals at the following address: Railroad Retirement Board, Bureau of Hearings and Appeals, 844 North Rush Street, Chicago, Illinois 60611.

You will receive another notice in the mail with specific details about your annuity rate and beginning date.

If you need to personally visit one of our field offices, you are urged to call for an appointment. You will not be refused service if you do not have an appointment, but Railroad Retirement Board representatives can serve you better when an appointment is made. Most Railroad Retirement Board offices are open to the public from 9:00 a.m. to 3:30 p.m., Monday through Friday.

Very truly yours,

John R. Feldheim

Director of Disability

and Medicare Operations

cc: Field Office

G-835 Items To Complete

A-4 Recon . . . Allowance (Partially Favorable)

Check RECON box at top.

Check ALLOWANCE (Partially Favorable) box in RECON section.

Enter the appropriate field office below FIELD OFFICE.

Enter the name/address of any other party that will be sent a copy of this letter next to OTHER.

Enter employee's name next to EE NAME.

Enter the addressee's name to ADDRESSEE NAME if other than the employee.*

Enter the address in the lines below ADDRESS.

Enter claim number next to RRB CLAIM NO.

Enter the salutation next to DEAR.

INSERT 1 - Enter the type of annuity claimant qualifies for, e.g., an occupational disability annuity, a total and permanent disability annuity, etc. . .

INSERT 2 - Enter either "your regular railroad occupation" or "all regular work."

INSERT 3 - Enter the effective date (other than annuitant's alleged onset date).

Check the box next to NARRATIVE INSERT ON REVERSE and write your personalized rationale advising why a partially favorable decision was made regarding the effective date on the reverse side of the worksheet.

Enter your name under DPS-EXAMINER NAME on the reverse side.

Enter the date under DATE on the reverse side.

* This letter can only be addressed directly to the claimant and cannot be addressed to a representative of the claimant. However, a carbon copy could be sent to the representative, if appropriate.

Appendix 5 - RECON - No Change In Initial Decision Based On New Evidence -

Sample Letter

In reply refer to

R.R.B. No.

(EE's Name)

Dear :

This refers to your letter requesting reconsideration of your annuity beginning date of (insert 1) and/or your disability freeze onset date of (insert 2).

We have carefully reviewed all of the medical evidence in your file and are still of the opinion that you are disabled for (insert 3) and/or disability freeze as of (insert 4).

(Narrative insert)

If you disagree with this decision, you have the right to appeal to the Bureau of Hearings and Appeals. If an appeal is made, it must be submitted on Form HA-1 and must be received at an office of the Railroad Retirement Board (RRB) within 60 days from the date of this notice. A Form HA-1 may be obtained from any field office of the RRB or by writing directly to the Director of Hearings and Appeals at the following address: Railroad Retirement Board, Bureau of Hearings and Appeals, 844 North Rush Street, Chicago, Illinois 60611.

If you need to personally visit one of our field offices, you are urged to call for an appointment. You will not be refused service if you do not have an appointment, but Railroad Retirement Board representatives can serve you better when an appointment is made. Most Railroad Retirement Board offices are open to the public from 9:00 a.m. to 3:30 p.m., Monday through Friday.

Very truly yours,

John R. Feldheim

Director of Disability

and Medicare Operations

cc: Field Office

G-835 Items To Complete

A-5 Recon . . . Allowance (Wholly Favorable)

Check RECON box at top.

Check ALLOWANCE NO CHANGE IN ONSET DATE box in RECON section.

Enter the appropriate field office below FIELD OFFICE.

Enter the name/address of any other party that will be sent a copy of this letter next to OTHER.

Enter employee's name next to EE NAME.

Enter the addressee's name to ADDRESSEE NAME if other than the employee.*

Enter the address in the lines below ADDRESS.

Enter claim number next to RRB CLAIM NO.

Enter the salutation next to DEAR.

INSERT 1 - Enter the disability date used for allowance (other than annuitant's alleged onset date.)

INSERT 2 - Enter the established onset date based on initial medical evidence.

INSERT 3 - Enter the type of annuity, e.g., an occupational disability, a total and permanent disability annuity, etc.

INSERT 4 - Enter the disability date based on all medical evidence.

Check the box next to NARRATIVE INSERT ON REVERSE and write your personalized rationale advising why a partially favorable decision was made regarding the effective date on the reverse side of the worksheet.

Enter your name under DPS-EXAMINER NAME on the reverse side.

Enter the date under DATE on the reverse side.

* This letter can only be addressed directly to the claimant and cannot be addressed to a representative of the claimant. However, a carbon copy could be sent to the representative, if appropriate.

10.1 Introduction

10.1.1 Scope of Chapter

This chapter discusses an annuitant's continued entitlement to a disability annuity. Statutory requirements necessitate that continued entitlement to an annuity must be reviewed periodically until the employee or child reaches age 65 and the widow(er) reaches age 60, unless the impairment has been classified as so severe that medical improvement is not expected (MINE). (See DCM 8.5.2 for additional information on medical improvement classifications.)

The two major factors that are considered in deciding whether a disability continues are work and medical improvement. These factors are defined in the disability regulations. These regulations have been included with existing procedure and form the basis for this chapter.

10.1.2 Regulations Governing Continuance Or Termination Of Disability

The Disability Benefits Division (DBD) makes disability decisions for all claims of disability under the Railroad Retirement Act. These decisions are based either on the rules contained in the Board's regulations or the rules contained in the regulations of the Social Security Administration, whichever is controlling.

In addition to making initial disability decisions, DBD is required to periodically review those claimants that have been granted benefits to determine whether they continue to be disabled, unless the impairment upon which the disability is based is classified as so severe that medical improvement is not expected (MINE). (See DCM 8.5.2 for additional information on medical improvement classifications.) Subpart O, Sections 220.175 through 20.187 of the Board's revised regulations describes the process under which the Board makes these determinations. These regulations parallel the regulations of the Social Security Administration found in Subpart P, Part 404, of Title 20 (Determining Disability and Blindness).

10.1.3 Responsibility To Notify The Board Of Events Which Affect Disability

If the annuitant is entitled to a disability annuity, the annuitant should promptly tell the Board if -

(a) His or her impairment(s) improves;

(b) He or she returns to any type of work;

(c) He or she increases the amount of work; or

(d) His or her earnings increase.

10.1.4 Circumstances Which Raise A Question Of Continuing Disability

Various situations occur which may indicate a need for a continuing disability investigation to determine whether an issue of continuing eligibility exists. Any one of the following situations warrants a continuing disability investigation.

A. Disability Monitoring System - DBD is required to conduct periodic reviews of an annuitant's continued entitlement to a disability until an employee or child reaches age 65 and until a widow(er) reaches age 60, unless the impairment upon which the disability is based is classified as so severe that medical improvement is not expected (MINE). (See DCM 8.5.2 for additional information on medical improvement classifications.) This requirement has led to the development of the disability monitoring system which includes the following four categories. (See DCM 8.5 Detailed Benefit Monitoring.)

- Medical Improvement Expected (MIE) - These are medical examination diary cases in which the individual's impairment(s) is expected to improve.
- Medical Improvement Possible (MIP) - Refers to a medical examination diary case in which medical improvement is possible.
- Medical Improvement Not Expected (MINE) - These are cases in which the individual's impairment is so severe that medical improvement is not likely.
- Administrative Appeal - These are any disability cases that were awarded on the basis of a decision by a hearings officer, the Board members or a Federal court.

B. Third Party Reports - A notice is received from someone, in a position to know, indicating one of the following:

- The annuitant's physical or mental condition has improved, or;
- The annuitant returned to work, or;
- The annuitant is not following prescribed treatment, or;
- The annuitant is failing to follow the provisions of the Social Security Act, the Railroad Retirement Act or Regulations.

C. Earnings Involved - Substantial earnings are reported to the annuitant's wage record.

D. Return to Work - The annuitant returns to work and successfully completes a trial work period.

E. Annitant Report - The annuitant tells DBD that he or she has recovered from his or her disability or that he or she has returned to work.

F. Current Medical Evidence - Advances in medical technology or a change in vocational therapy requires current medical evidence to see if the annuitant's disability continues.

G. State Vocational Rehabilitation Notice - A State Vocational Rehabilitation Agency tells DBD that:

- The services have been completed; or
- The annuitant is now working; or
- The annuitant is able to work.

H. Questions Regarding Continuance - Evidence DBD receives raises a question as to whether the annuitant's disability continues.

10.1.5 Suspension Of Disability Annuity (DA)

A. Non-Payment Months - A D/A is not payable for any month in which an annuitant:

- Works for a railroad or other employer in the RR industry; or,
- Earns more than the current monthly disability earnings limit after deduction of disability related work expenses in employment or self-employment of any type. See DCM 10.8 for an explanation of disability related work expenses. Refer to the chart in FOM 1125.5.2 for the monthly and annual earnings limits.

Examiners should immediately suspend payments upon receiving notice from the EE that he/she is currently doing any of the above events. If the report is from a third party, due process notification is required prior to suspension. However, no appeal rights should be given on the suspension notice.

NOTE: Payments should not be suspended when the annuitant is engaged in VISTA sponsored activity. Refer these cases to P&S.

B. Administrative Suspensions - D/A payments are to be suspended by DBD if the annuitant fails to report for a medical examination scheduled by DBD for policing purposes.

10.1.6 Diaries For Suspended Disability Employee Annuitants Due To Earnings

A disability annuity is not payable for any month in which an annuitant works for an employer covered under the Railroad Retirement Act. In addition, an employee's disability annuity is not payable for any month in which the employee earns over the current monthly disability earnings limit (after deduction of impairment-related work expenses) in employment or self-employment of any kind. Refer to the chart in FOM 1125.5.2 for the monthly and annual earnings limits.

When a disabled employee's annuity is suspended due to work, two diaries will need to be established.

A. Employee end-of-year adjustment diary:

If the employee's yearly earnings are less than $11,875 (computed as $950 x 12 months + 50% of $950) in 2019, all annuity payments and penalties withheld during the year because of earnings are payable. Therefore, when an employee's disability annuity is suspended due to reported earnings over the current monthly disability earnings limit per month, set a call-up for a possible end-of-year adjustment using Form G-65b (Reason Code 50 - Section 2(e) 4 Refund and Section Code 06 - Retirement Post Section). In the remarks section of Form G-65b enter, "possible end-of-year adjustment."

B. Trial Work Period Diary (See DCM 10.5.4 and 10.5.5):

Using CDR PC call-up program, establish a call-up for the trial work period using earnings or return to RR service as the call-up reason.

10.1.7 Termination Causes

Entitlement to railroad retirement disability benefits may be terminated by the following causes:

- Death of the beneficiary;
- Medical recovery;
- Demonstration of ability to work.

Before a disability annuity is stopped for reasons other than death, the annuitant must be given a chance to explain why it should not be terminated. DCM 10.6.1 explains the requirements of the termination notice.

10.1.8 Termination Of Disability And Termination Of Entitlement To A Disability Annuity

A. Determining the Month Disability Ends

1. In Medical Improvement Cases

The month disability ends in medical improvement cases is as follows:

The month DBD mails the annuitant a notice saying that DBD finds that he or she is no longer disabled based on evidence showing there has been medical improvement in the annuitant's impairments related to the ability to work. The annuitant has the capacity to engage in substantial gainful work (SGA) as described in DCM 10.3.3 and 10.3.4.

The month in which the annuitant returns to full-time work, with no significant medical restrictions and acknowledges that medical improvement has occurred, and DBD expected the annuitant's impairment(s) to improve;

The first month the annuitant was told by his or her physician that he or she could return to work provided there is not substantial conflict between the physician's and the annuitant's statements regarding the annuitant's awareness of his or her capacity for work and the earlier date is supported by the medical evidence.

The month the evidence shows that the annuitant is no longer disabled under the rules set out in DCM 10.3, sections 3, 4, 5 and 6, and he or she was disabled only for a specified period of time in the past.

2. In Other Than Death and Medical Improvement Cases

In non-medical improvement cases, a disability will end:

The month DBD mails the annuitant a notice saying that DBD finds that he or she is no longer disabled based on evidence showing there has been no medical improvement in the annuitant's impairments related to the ability to work but the annuitant has the capacity to engage in substantial gainful work and one of the exceptions to medical improvements set out in DCM 10.3.5 applies.

The month in which the annuitant actually does substantial gainful activity where such annuitant is not entitled to a trial work period;

The first month in which the annuitant failed without good cause to do what DBD asked, when the rule set out in DCM 10.3.5(B) (2) applies;

The first month in which the question of continuing disability arose and DBD could not locate the annuitant after a suitable investigation (see DCM 10.3.5(B) (3));

The first month in which the annuitant failed without good cause to follow prescribed treatment (see DCM 10.3.5(B) (4));

B. Termination of Entitlement to and Payment of a Disability Annuity

1. Death

2. Medical Improvement

In medical improvement cases, entitlement to a disability annuity ends on the last day of the second month following the month in which disability ceased. Payment of the disability annuity will stop on the last day of the second month following the month in which disability ends or on the last day of the first month following the month the initial cessation notice is sent by DBD, whichever date is later. Any payment received after the payment termination date is considered an overpayment.

EXAMPLE 1: The employee recovered from his or her disability in February 1990, the month the initial cessation letter was released. No work was involved. The last day of the second month following the month in which recovery occurred in this case is April 30, 1990. Therefore, no annuity is payable for any month after April 1990. The check dated May 1, 1990 is payable because it represents the April 1990 payment. Benefits should be terminated effective May 1, 1990.

EXAMPLE 2: The employee recovered from his or her disability in November 1989. The initial cessation letter was released in February 1990. Payment of the disability annuity ends on the last day of the month following the month in which the letter was released. Therefore, no annuity is payable for any month after March 1990. The check dated April 1, 1990, is payable because it represents the March 1990 payment.

NOTE: See DCM 10.6 for termination procedure. Any annuity suspended for an indefinite period or termination cases involving an overpayment should be referred by the CDR examiner to the appropriate post section (retirement or survivor) for determination of

overpayments. In employee termination or indefinite suspension cases which do not involve an overpayment, the CDR examiner should refer the case to the DBD-RASI examiner who will notify the Sickness and Unemployment Benefits section of the termination (see RCM 5.9.4B).

3. Reason Other Than Death or Medical Improvement

If the annuitant demonstrates the ability to perform the duties of his or her regular railroad occupation or is able to engage in substantial gainful activity, or fails to cooperate with the Board, entitlement to a disability annuity will end on the last day of the second month following the month in which disability ceased. Payment of the disability annuity will stop on the last day of the second month following the month in which disability ends.

C. Converting A Disability Annuity To An Age and Service Annuity

The Social Security Administration converts disability annuities to age and service annuities in order to effect a change in trust funds.

Under the Railroad Retirement Act, we do not switch from a disability annuity to an age and service (A&S) annuity for trust fund reasons. However, at full retirement age (FRA), a disability annuity ends and the individual is deemed to have filed an application for an A&S annuity. At that time, the annuity will be treated the same as a regular FRA annuity. This is a continuous entitlement with no disruption in payments. DBD does not have to police these cases, and we do not change our coding.

NOTE: See RCM 2.2.20 regarding earnings restrictions on widow(er)s over age 60.

10.2 Occupational Disabilities

10.2.1 Effects Of Work On Occupational Disability

A. Adjusting disability onset when the employee works despite impairment - An employee who has stopped work in his or her regular railroad occupation due to a permanent physical or mental impairment(s) may make an effort to return to work in his or her regular railroad occupation. If the employee is subsequently forced to stop that work after a short time because of his or her impairment(s), DBD will generally consider that work as an unsuccessful work attempt. (See DCM 10.5.3) In this situation, DBD may determine that the employee became disabled for work in his or her regular railroad occupation before the last date the employee worked in his or her regular railroad occupation. No annuity will be payable, however, until after the last date worked.

B. Occupational disability annuitant work restrictions - The restrictions which apply to an annuitant who is disabled for work in his or her regular railroad occupation are found in DCM 10.1.5.

10.2.2 Evaluation For Recovery From Disability For Work In The Regular Railroad Occupation

In evaluating annuitants receiving an occupational disability, there must be significant medical improvement related to the beneficiary's ability to return to his regular railroad occupation, rather than the ability to engage in substantial gainful activity (SGA). Some examples of improvement in an individual's impairment, but not to the point where the employee could return to his regular railroad occupation are:

- An individual who has had a laryngectomy with a stoma. Although he may be able to use artificial devices for speech, he could not work in a dusty environment because of the risk of infection.

- An individual with a hip or knee replacement. Although the artificial joint may relieve pain and stabilize the joint to some extent, he may be forever precluded from work that requires kneeling, crawling and other movements requiring acute flexion of the joint.

- An individual with a seizure disorder that may have responded to drug therapy. Although the number of seizures may be reduced, he may be forever precluded from working at heights, on ladders, and on scaffolds.

- An individual with an impairment caused by exposure to environmental factors that are inherent to his railroad job. Although he may improve if no longer exposed to these factors, his condition will continue to affect his ability to work in specific occupations.

EXAMPLE 1: The individual has allergies which cause contact dermatitis when exposed to creosote (a railroad track tie preservative). Such an individual could not work as a track laborer even if his condition cleared up when he quit working.

EXAMPLE 2: The individual has a respiratory problem resulting from exposure to welding fumes or diesel exhaust. Such an individual could not work as a welder or an engineer even if his condition cleared up when he quit working.

Such cases may be classified as Medical Improvement Not Expected (MINE) cases.

NOTE: Administrative factors, such as carrier disqualification, must also be considered.

A. General - Disability for work in the regular railroad occupation will end if:

1. There is medical improvement in the annuitant's impairment(s) to the extent that the annuitant is able to perform the duties of his regular railroad occupation; or

2. The annuitant demonstrates the ability to perform the duties of his regular railroad occupation. RRB regulations provide for unsuccessful work attempts, trial work periods, and re-entitlement periods before terminating a disability annuity because of the annuitant's return to work. See DCM 10.5 for procedure on unsuccessful work attempts, trial work periods, and re-entitlement periods.

B. Payment of the disability annuity during the trial work period and the re-entitlement period

1. The employee who is entitled to an occupational disability annuity will not be paid an annuity for each month in the trial work period or re-entitlement period in which he or she

- Works for an employer covered by the Railroad Retirement Act; or

  - Earns more than the current monthly disability earnings limit after deduction of disability related work expenses in employment or self-employment. Refer to the chart in FOM 1125.5.2for the monthly and annual earnings limits.

2. If the employee's occupational disability annuity is stopped because of work during the trial work period or re-entitlement period, and the employee discontinues that work before the end of either period, the disability annuity may be started again without a new application and a new determination of disability.

C. Notice that an annuitant is no longer disabled - The procedures explaining DBD's responsibilities in notifying the annuitant, and the annuitant's rights when the disability annuity is stopped are found in DCM 10.6.

10.2.3 Initial Evaluation Of A Previous Occupational Disability

A. In some cases, DBD may determine that a claimant is not currently disabled for work in his or her regular railroad occupation but was previously disabled for a specified period of time in the past. This can occur when

- The disability application was filed before the claimant's occupational disability ended, but DBD did not make the initial determination of occupational disability until after the claimant's disability ended; or

- The disability application was filed after the claimant's occupational disability ended but no later than the 12th month after the month the disability ended.

B. When evaluating a claim for a previous occupational disability, DBD follows the steps of initial occupational disability rating to determine whether an occupational disability existed, and follows the steps in 10.2.1 and 10.2.2 to determine when the occupational disability ended.

EXAMPLE 1: The claimant sustained multiple fractures to his left leg in an automobile accident that occurred on June 16, 1982. For a period of 18 month following the accident the claimant underwent 2 surgical procedures which restored the functional use of his leg. After a recovery period following the last surgery, the claimant returned to his regular railroad job on February 1, 1984. The claimant, although fully recovered medically and regularly employed, filed an application on December 3, 1984, for a determination of occupational disability for the period June 16, 1982 through January 31, 1984. A disability annuity is payable to the employee only for the period December 1, 1983 through January 31, 1984. An annuity may not begin an earlier than the 1st day of the 12th month before the month in which the application was filed.

EXAMPLE 2: The claimant is occupationally disabled using the same medical facts disclosed above, beginning June 16, 1982 (the date of the automobile accident). The claimant files an application for an occupational disability annuity, dated December 1, 1983. However, as of February 1, 1984, and before DBD makes a disability determination, the claimant returns to his regular railroad job and is no longer considered occupationally disabled. DBD reviews the claimant's application in May of 1984 and finds him occupationally disabled for the period June 16, 1982 through January 31, 1984. A disability annuity is payable to the employee from December 1, 1982 through January 31, 1984.

10.3 Disability For Any Regular Employment

10.3.1 Determining Whether Disability Annuity Continues Or Ends

The RRB is under a statutory duty to periodically review every annuitant's disability until the employee or child annuitant reaches age 65 and the widow(er) annuitant reaches age 60. Please note that widow(er) medicare entitlement is under review until age 65. During these periodic reviews, there are a number of factors to be considered. First, consider whether the annuitant has worked and by doing so, demonstrated the ability to engage insubstantial gainful activity. If so, the disability will end. Next consider whether there has been any medical improvement in the annuitant's impairment(s) and, if so, whether this medical improvement is related to the ability to do work. If the impairments have not medically improved, the examiner must consider whether one or more of the

exceptions to medical improvement applies. (See DCM 10.3.5.) If medical improvement related to ability to work has not occurred and no exception applies, the disability will continue.

NOTE: Even when medical improvement related to work has occurred or an exception applies, the examiner must show that the annuitant is currently able to engage in substantial gainful activity before he or she can find that the annuitant is no longer disabled.

10.3.2 The Sequential Evaluation Process

The continuing disability review may cease and the disability may be continued at any point if the examiner determines that there is sufficient evidence to find that the annuitant is still unable to engage in substantial gainful activity. The review consists of an eight-step process. Each step of the process taken must be documented.

The steps are as follows:

1. Is the annuitant engaging in substantial gainful activity? If he is (and any applicable trial work period has been completed), find the disability to have ended;

2. If the annuitant is not engaging in substantial gainful activity, does he have an impairment or combination of impairments which meets or equals the severity of an impairment listed in Appendix 1. If the annuitant's impairment(s) does meet or equal the level of severity of an impairment listed in Appendix 1, find his disability to continue;

3. If the annuitant's impairment(s) does not meet or equal the level of severity of an impairment listed in Appendix 1, has there been medical improvement as defined in DCM 10.3.3(A)? If there has been medical improvement as shown by a decrease in medical severity, see step 4. If there has been no decrease in medical severity, then there has been no medical improvement. (See step 5);

4. If there has been medical improvement, the examiner must determine whether it is related to the annuitant's ability to do work in accordance with paragraphs A through D of DCM 10.3.3, (i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination). If medical improvement is not related to the annuitant's ability to do work, see step 5. If medical improvement is related to the annuitant ability to do work, see step 6;

5. If the examiner found at step 3 that there has been no medical improvement or if he found at step 4 that the medical improvement is not

related to the annuitant's ability to work, the examiner must consider whether any of the exceptions in DCM 10.3.5 apply. If none of them apply, disability continues. If one of the first group of exceptions to medical improvements applies, the disability ends. The second group or exceptions to medical improvement may be considered at any point in this process;

6. If medical improvement is shown to be related to the annuitant's ability to do work or if one of the first groups of exceptions to medical improvement applies, determine whether all of the annuitant's current impairments in combination are severe. This determination will consider all current impairments and the impact of the combination of those impairments on the ability to function. If the residual functional capacity assessment in step 4 above shows significant limitation of ability to do basic work activities, see step 7. When the evidence shows that all current impairments in combination do not significantly limit physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature, and the annuitant will no longer be considered to be disabled;

7. If the annuitant's impairment(s) is severe, assess his current ability to engage in substantial gainful activity. That is, assess the annuitant's residual functional capacity based on all of his current impairments and consider whether he can still do work that was done in the past. If he can do such work, disability will be found to have ended; and

8. If the annuitant is not able to do work he has done in the past, consider one final step. Given the residual functional capacity assessment and considering the annuitant's age, education and past work experience, can he do other work? If the annuitant can do other work, disability will be found to have ended. If he cannot do other work, disability will be found to continue.

In cases that are not of listing severity, medical improvement may permit work at a lower level of exertion, but not at a higher level of exertion. If the individual's past relevant work (PRW) was low-exertion work, any significant improvement may result in a decision supporting termination based on an ability to return to the low-exertion PRW.

Conversely, medical improvement may occur, but not to the point at which the annuitant would be found no longer disabled on a medical vocational basis.

EXAMPLE: An amputee unable to wear a prosthetic device was initially rated with a listing level impairment. After a passage of time, enough healing occurred to permit ambulation with prosthesis. This may permit an RFC for light or sedentary work. But if the individual is age 55 or older, this RFC will still result in a finding of disability.

10.3.3 Terms And Definitions Applicable In Disability For Any Regular Employment Situations

A. Medical improvement - Medical improvement is any decrease in the medical severity of an impairment(s) which was present at the time of the most recent favorable medical decision that the annuitant was disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on a comparison of prior and current medical evidence showing changes (improvement) in the symptoms, signs or laboratory findings associated with the impairment(s).

EXAMPLE 1: The annuitant was awarded a disability annuity due to a herniated disc. At the time of the DPS's prior decision granting the annuity, he had had a laminectomy. Postoperatively, a myelogram still shows evidence of a persistent deficit in his lumbar spine. The was pain in his back, and a burning sensation in his right foot and leg. There were no muscle weaknesses or neurological changes and a modest decrease in motion in his back and leg. When DPS reviewed the annuitant's claim to determine whether his disability should be continued, his treating physician reported that he had seen the annuitant regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. The annuitant's doctor further reported a moderately decreased range of motion in the annuitant's back and right leg, but again no muscle atrophy occurred because there has been no decrease in the severity of the annuitant's back impairment as shown by changes in symptoms, signs or laboratory findings.

EXAMPLE 2: The annuitant was awarded a disability annuity due to rheumatoid arthritis. At the time, laboratory findings were positive for this impairment. The annuitant's doctor reported persistent swelling and tenderness of the annuitant's fingers and wrists and that he complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, the annuitant's impairment has responded favorably to therapy so that for the last year his fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of the annuitant's impairment as documented by the current symptoms and signs reported by his physician. Although the annuitant's impairment is subject to temporary remission and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. DPS would then determine if this medical improvement is related to the annuitant's ability to work.

B. Medical improvement not related to ability to do work - Medical improvement is not related to the annuitant's ability to work if there has been a decrease in the severity of the impairment(s) (as defined in

paragraph A of this section) present at the time of the most recent favorable medical decision, but no increase in that annuitant's functional capacity to do basic work activities as defined in paragraph D of this section. If there has been any medical improvement in an annuitant's impairment(s), but it is not related to the annuitant's ability to do work and none of the exceptions applies, the annuity will be continued.

EXAMPLE: An annuitant was 65 inches tall and weighed 246 pounds at the time his disability was established. He had venous insufficiency and persistent edema in his leg. At the time, the annuitant's ability to do basic work activities was affected because he was able to sit for 6 hours, but was able to stand or walk only occasionally. At the time of DPS's continuing disability review, the annuitant had undergone a vein stripping operation. He now weighed 220 pounds and had intermittent edema. He is still able to sit for 6 hours at a time and to stand or walk only occasionally although he reports less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by his weight loss and the improvement in his edema. This medical improvement is not related to his ability to work, however, because his functional capacity to do basic work activities (i.e., the ability to sit, stand and walk) has not increased.

C. Medical improvement that is related to ability to do work - Medical improvement is related to an annuitant's ability to work if there has been a decrease in the severity (as defined in paragraph A of this section) of the impairment(s) present at the time of the most recent favorable medical decision and an increase in the annuitant's functional capacity to do basic work activities as discussed in paragraph D of this section. A determination that medical improvement related to an annuitant's ability to do work has occurred does not, necessarily, mean that such annuitant's disability will be found to have ended unless it is also shown that the annuitant is currently able to engage in substantial gainful activity as discussed in paragraph E of this section.

EXAMPLE 1: The annuitant has a back impairment and has had a laminectomy to relieve the nerve root impingement and weakness in his left leg. At the time of DPS's prior decision, basic work activities were affected because he was able to stand less than 6 hours, and sit no more than 1/2 hour at a time. The annuitant had a successful fusion operation on his back about 1 year before DPS's review of his entitlement.

At the time of DPS's review, the weakness in his leg has decreased. The annuitant's functional capacity to perform basic work activities now is unimpaired because he now has no limitation on his ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of his impairment as demonstrated by the deceased weakness in his leg. This medical improvement is related to his

ability to work because there has also been an increase in his functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on his ability to sit, walk, or stand. Whether or not his disability is found to have ended, however, will depend on DPS's determination as to whether he can currently engage in substantial gainful activity.

EXAMPLE 2: The annuitant was injured in an automobile accident receiving a compound fracture to his right femur and a fractured pelvis. When he applied for disability annuity 10 months after the accident his doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. The annuitant's doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of the continuing disability review 6 months later, solid union had occurred and the annuitant had been returned to full weight-bearing for over a month. His doctor reported this and the fact that his prior fractures no longer placed any limitation on his ability to walk, stand, and lift, and, that in fact, he could return to full-time work if he so desired.

Medical improvement has occurred because there has been a decrease in the severity of the annuitant's impairments as shown by X-ray and clinical evidence of solid union had his return to full weight-bearing. This medical improvement is related to his ability to work because he no longer meets the same listed impairment in Appendix I. Whether or not the annuitant's disability is found to have ended will depend on the DPS's determination as to whether he can currently engage in substantial gainful activity (see step D).

D. <u>Functional capacity to do basic work activities</u>

1. Under the law, disability is defined, in part, as the inability to do any regular employment by reason of a physical or mental impairment(s). "Regular employment" is defined as "substantial gainful activity". In determining whether the annuitant is disabled under the law, DPS will measure, therefore, how and to what extent the annuitant's impairment(s) has affected his or her ability to do work. DPS does this by looking at how the annuitant's functional capacity for doing basic work activities has been affected. Basic work activities mean the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and non exertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes in a work setting and dealing with both supervisors and fellow workers. The annuitant who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited

functional capacity to do basic work activities. Depending on its nature and severity, an impairment(s), is called his or her residual functional capacity. Unless an impairment is so severe that it is deemed to prevent the annuitant from doing substantial gainful activity (i.e., the impairment(s) meets or equals the severity of a listed impairment in Appendix 1), it is this residual functional capacity that is used to determine whether the annuitant can still do his or her past work or, in conjunction with his or her age, education and work experience, do any other work.

2. A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the annuitant can stand or walk for longer periods. When new evidence showing a change in medical findings established that both medical improvement has occurred and the annuitant's functional capacity to perform basic work activities, or residual functional capacity, has increased, DPS will find that medical improvement which is related to the annuitant's ability to do work has occurred. A residual functional capacity assessment is also used to determine whether an annuitant can engage in substantial gainful activity and, thus, whether he or she continues to be disabled (see paragraph E of this section).

3. Many impairment-related factors must be considered in assessing an annuitant's functional capacity for basic work activities. Age is one key actor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminished with age. Other changes related to sustained periods o inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

4. Studies have also shown that the longer the annuitant is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if the annuitant is age 50 or over and has been receiving a disability annuity for a considerable period of time, consider this factor along with his or her age in assessing the residual functional capacity. This will

ensure that the disadvantages resulting from inactivity and the aging process during a longer period of disability will be considered. In some instances where available evidence does not resolve what the annuitant can or cannot do on a sustained basis, DPS can provide for special work evaluations or other appropriate testing.

E. Ability to engage insubstantial gainful activity - In most instances, the examiner must show that the annuitant is able to engage in substantial gainful activity before terminating his or her annuity. When doing this, consider all of the annuitant's current impairments not just that impairment(s) present at the time of the most recent favorable determination. If the examiner cannot determine that the annuitant is still disabled based on medical considerations alone, use the new symptoms, signs and laboratory findings to make an objective assessment of functional capacity to do basic work activities (or residual functional capacity) and consider vocational factors.

F. Evidence and basis for the decision - Decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that the annuitant had previously be determined to be disabled. Consider all of the evidence the annuitant submits, as well as all evidence obtained from treating physician(s) and other medical or nonmedical sources. What constitutes "evidence" and DPS procedures for obtaining it will be set out in DCM Chapter 3 . DPS's determination regarding whether a disability continues will be made on the basis of the weight of the evidence."

G. Point of comparison - For purposes of determining whether medical improvement has occurred, compare the current medical severity of that impairment(s), which was present at the time of the most recent favorable medical decision that the annuitant was disabled or continued to be disabled, to the medical severity of that impairment(s) at that time. If medical improvement has occurred, compare the annuitant's current functional capacity to do basic work activities (i.e., his or her residual functional capacity) based on this previously existing impairment(s) with the annuitant's prior residual functional capacity in order to determine whether the medical improvement is related to his or her ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether the annuitant was disabled or continued to be disabled which became final.

10.3.4 Determining Medical Improvement And Its Relationship To The Annuitant's Ability To Do Work

A. General - Paragraphs A, B, and C of Chapter 10.3.3 discuss what is meant by medical improvement, medical improvement not related to the ability to work and medical improvement that is related to the ability to

work. How DPS will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed in paragraphs B and C of this section.

B. Determining that medical improvement is related to ability to work - If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, the rating examiner must then determine if it is related to the annuitant's ability to do work. In determining whether medical improvement that has occurred is related to the annuitant's ability to do work, the examiner should assess the annuitant's residual functional capacity (RFC) based on the current severity of the impairment(s) which was present at the annuitant's last favorable medical decision. Unless the increase in the current RFC is based on changes in the signs, symptoms, or laboratory findings, any medical improvement that has occurred will not be considered to be related to the annuitant's ability to work.

C. Additional factors and considerations

1. RFC not previously determined - If the most recent favorable decision was based on the fact that the annuitant's impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments, an assessment of his or her RFC would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing, find that the medical improvement was related to the annuitant's ability to work. This is because meeting or equaling the listing level of severity is evidence that the annuitant is unable to work. Since meeting or equalling the level of severity of the listing deems an annuitant unable to work, not meeting the level of severity of the listing deems an annuitant potentially able to work. Being deemed "potentially able to work" simply means that the rating examiner can make the determination as to whether the annuitant can currently engage in gainful activity. The examiner must, of course, also establish that the annuitant can currently engage in gainful activity before finding that his or her disability has ended.

2. Prior RFC assessment made - Compare the RFC assessment used in making the most recent favorable medical decision with the RFC assessment based on current evidence to determine whether an annuitant's functional capacity for basic work activities has increased. Do not attempt to reassess the prior RFC.

3. Prior RFC should have been assessed but wasn't - In cases where an RFC assessment should have been made for the prior most favorable decision but wasn't either because this assessment is missing from the annuitant's file or because it was not done, the

doctor or medical consultant must reconstruct the residual functional capacity. In reconstructing the RFC, assign the maximum functional capacity consistent with an allowance. This reconstructed RFC should accurately and objectively assess the annuitant's functional capacity to do work.

EXAMPLE: The annuitant was previously found to be disabled on the basis that while his impairment did not meet or equal a listing, it did prevent him from doing his past or any other work. The prior examiner did not, however, include a residual functional capacity assessment in the rationale of that decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, i.e., medical improvement, has occurred, the residual functional capacity based on the current level of severity of the annuitant's impairment will have to be compared with his residual functional capacity based on its prior severity in order to determine if the medical improvement is related to his ability to do work. In order to make this comparison, the medical consultant must review the prior evidence and make an objective assessment of the annuitant's residual functional capacity at the time of its most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

4. Impairment subject to temporary remission - If the evidence shows that the annuitant's impairment(s) is subject to temporary remission, carefully consider the history of the impairment(s), including the occurrence of any prior remissions, and the prospects for future worsening. A remission that is only temporary, that is, less than one year, will not warrant a finding of medical improvement.

5. When the prior file cannot be located - If the prior file cannot be located, determine whether the annuitant is able to engage in substantial gainful activity. If the annuitant can engage in SGA, do not attempt to reconstruct prior evidence. If the annuitant is not able to engage in SGA, his or her disability will continue unless one of the second group of exceptions applies (see 10.3.5(B)).

10.3.5 Exceptions To Medical Improvement

A. The First Group of Exceptions to Medical Improvement - General - The law provides for certain limited situations when the annuitant's disability can be found to have ended even though medical improvement has not occurred. These exceptions to medical improvement are intended to provide a way of finding that the annuitant is no longer disabled in those limited situations where, even though there has been no decrease in the severity of the impairment(s), evidence shows that the annuitant should no

longer be considered disabled or never should have been considered disabled.

For one of these exceptions to apply, the examiner must also show that taking all of the annuitant's current impairment(s) into account, not just those that existed at the time of the most recent favorable medical decision, the annuitant is now able to engage in SGA before his or her annuity can be found to have ended.

As part of the exception review process, ask the annuitant about any medical or vocational therapy that he or she has received or is receiving. The examiner should use these answers, the evidence gathered and all other evidence as the basis for finding that an exception applies.

1. Substantial evidence shows that the annuitant is the beneficiary of advances in medical or vocational therapy or technology (related to his or her ability to work) - Advances in medical or vocational therapy or technology are improvements in a treatment or rehabilitative methods which have increased the annuitant's ability to do basic work activities. To apply this exception, the examiner has to show by substantial evidence that the annuitant has been the beneficiary of services which reflect these advances and they have favorably affected the severity of his or her impairment (s) or ability to do basic work activities.

   This decision must always be based on new medical evidence and a new RFC assessment. Since, in many instances, an advance medical or vocational technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement, this exception will see very limited application.

2. Substantial evidence shows that the annuitant has undergone vocational therapy (related to his or her ability to work) - Vocational therapy (related to the annuitant's ability to work) may include, but is not limited to, additional education, training, or work experience that improves his or her ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. If, at the time of the continuing disability review the annuitant has not completed vocational therapy which could affect the continuance of his or her disability, review such annuitant's claim upon completion of the therapy.

   EXAMPLE 1: The annuitant was found to be disabled because the limitations imposed on him by his impairment(s) allowed him to only do work that was at a sedentary level of exertion. The annuitant's

prior work experience was work that required a medium level of exertion with no acquired skills that could be transferred to sedentary work. His age, education, and past work experience at the time did not qualify him for work that was below this medium level of exertion. The annuitant enrolled in and completed a specialized training course which qualifies him for a job in data processing as a computer programmer in the period since he was awarded a disability annuity. On review of his claim, current evidence shows that there is no medical improvement and that he can still do only sedentary work. As the work of a computer programmer is sedentary in nature, he is now able to engage in substantial gainful activity when his new skills are considered.

EXAMPLE 2: The annuitant was previously entitled to a disability annuity because the medical evidence and assessment of his residual functional capacity showed he could only do light work. His prior work was considered to be of a heavy exertional level with no acquired skills that could be transferred to light work. His age, education, and past work experience did not qualify him for work that was below the heavy level of exertion. The current evidence and residual functional capacity show there has been no medical improvement and that he can still do only light work. Since he was originally entitled to a disability annuity, his vocational rehabilitation agency enrolled him in and he successfully completed a trade school course so that he is now qualified to do small appliance repair. This work is light in nature, so when his new skills are considered, he is now able to engage in substantial gainful activity even though there has been no change in his residual functional capacity.

3. Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the annuitant's impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision - Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that the annuitant's impairment(s) is not as severe as was determined at the time of the most recent favorable medical decision, such evidence may serve as a basis for finding that the annuitant can engage in substantial gainful activity and is no longer disabled. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of DPS's most recent favorable medical decision.

The RRB will determine which methods and techniques are new and improved and when they become generally available. The RRB will learn about these new techniques when they are presented as evidence in specific cases and when they are discussed in medical literature by medical professional groups and other governmental entities. The RRB will develop a listing of new techniques and publication of this listing in the Federal Register will determine the date the duty to inform our annuitant of these changes through this listing and its publication in the Federal Register.

EXAMPLE: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of the annuitant's last favorable medical decision. Current evidence shows that the annuitant's impairment, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all his current impairments into account, the annuitant is now able to engage in substantial gainful activity, this exception would be used to find that he is no longer disabled even if medical improvement has not occurred.

4. Substantial evidence shows that the prior disability decision was in error - There are three situations in which an exception to medical improvement will be found based on error. The three situations are: (a) when substantial evidence on its face shows that the decision should not have been made, (b) when required and material evidence of the severity of the annuitant's impairment(s) was missing, and (c) when new evidence relating to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence. Apply this exception to medical improvement if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to a disability annuity was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error.

   a. Errors on the face of the evidence - Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in file such as pulmonary function study values was misread or an adjudicative standard such as a listing in Appendix 1 or a medical/vocational rule in Appendix 2 was misapplied).

      EXAMPLE 1: The annuitant was granted a disability annuity when it was determined that his epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more

frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history f the frequency of his seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether the annuitant was still considered to e disabled would be based on whether he could currently engage insubstantial gainful activity.

EXAMPLE 2: The annuitant's prior award of a disability annuity was based on vocational rule 201.14 in Appendix 2. This rule applies to a person age 50-54 who has at least a high school education, whose previous work was entirely at semiskilled level, and who can do only sedentary work. On review it is found that at the time of the prior determination the annuitant was actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of his claim and the prior decision is found to have been in error. Continuation of his disability would depend on a finding of his current inability to engage in substantial gainful activity.

b. <u>Required and material evidence is missing</u> - This situation arises when at the time of the prior evaluation, required and material evidence of the severity of the annuitant's impairment(s) was missing. This evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

EXAMPLE: The annuitant was found disabled on the basis of chronic obstructive pulmonary disease. The severity of his impairment was documented primarily by pulmonary function testing results. The evidence showed that he could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracing. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that the annuitant's impairment does not limit his ability to perform basic work activities in any way. Error is found based on the fact that required material evidence, which was originally missing,

now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

c. New evidence contradicts the conclusions of prior evidence - This situation arises when substantial evidence, which is new evidence relating to the prior determination (of allowance or continuance), refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign.) Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the disability would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

EXAMPLE: The annuitant was previously found entitled to a disability annuity on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that the annuitant has "brittle" diabetes for which he was taking insulin. The annuitant's urine was 3+ for sugar, and he alleged occasional hypoglycemic attacks caused by exertion. His doctor felt the diabetes was never really controlled because he was not following his diet or taking his medication regularly. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that the annuitant's impairment clearly does not equal the severity contemplated by the listings. Error cannot be found because it would represent a substitution of current judgment for that of the prior adjudicator that the annuitant's impairment equaled a listing. The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision are met.

5. The annuitant is currently engaging in substantial gainful activity - If the annuitant is currently engaging in substantial gainful activity, before DPS determines whether he or she is no longer disabled because of his or her work activity, DPS will consider whether he or she is entitled to a trial work period as set out in DCM 10.5.4. DPS will find that the annuitant's disability has ended in the month in which he or she demonstrated the ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether the

annuitant continues to have a disabling impairment(s) for purposes of deciding his or her eligibility for a reentitlement period.

B. The Second Group of Exceptions to Medical Improvement - General - In the second group of exceptions, the continuance decision will be made without a determination that the annuitant has medically improved or can engage in SGA.

1. A prior determination was fraudulently obtained - If DPS finds that any prior favorable determination was obtained by fraud, it may find that the annuitant is not disabled. In addition, DPS may reopen the claim.

2. Failure to cooperate - If there is a question about whether the annuitant continues to be disabled and DPS requests that he or she submit medical or other evidence or go for a physical or mental examination by a certain date, DPS will find that the annuitant's disability has ended if he or she fails (without good cause) to do what is requested. The month in which the annuitant's disability ends will be the first month in which he or she failed to do what was requested.

3. Inability to locate the annuitant - If there is a question about whether the annuitant continues to be disabled and DPS is unable to find him or her to resolve the question, DPS will suspend annuity payments. If, after a suitable investigation, DPS is still unable to locate the annuitant, DPS will determine that the annuitant's disability has ended. The month such annuitant's disability ends will be the first month in which the question arose and the annuitant could not be found.

4. Failure of the annuitant to follow prescribed treatment which would be expected to restore the ability to engage in substantial gainful activity - If treatment has been prescribed for the annuitant which would be expected to restore his or her ability to work, he or she must follow that treatment in order to be paid a disability annuity. If the annuitant is not following that treatment and he or she does not have good cause for failing to follow the treatment, DPS will find that his or her disability has ended. The month such annuitant's disability ends will be the first month in which he or she failed to follow the prescribed treatment.

10.3.6 If The Annuitant Becomes Disabled By Another Impairment During The Continuance Determination

If a new severe impairment begins in or before the month in which the last impairment ends, DPS will find that the disability is continuing. The impairment

need not be expected to last 12 months or to result in death, but it must be severe enough to keep the annuitant form doing substantial gainful activity, or severe enough so that he or she is still disabled.

10.4 Substantial Gainful Activity

10.4.1 General

The work that a claimant has done during any period in which the claimant believes he or she is disabled may show that the claimant is able to do work at the substantial gainful activity (SGA) level. If a claimant is able to engage in SGA, find that the claimant is not disabled for any regular employment under the Railroad Retirement Act. Even if the work the claimant has done was not SGA, it may show that the claimant is able to do more work than he/she actually did. Consider all medical and vocational evidence in the claimant's file to decide whether or not the claimant has the ability to engage in SGA.

10.4.2 Substantial Gainful Activity Defined

Substantial gainful activity is work activity that is both substantial and gainful.

A. Substantial work activity - Substantial work activity is work activity that involves doing a significant physical or mental activities. The annuitant's work may be substantial even if it is done on a part-time basis or if the annuitant does less, gets paid less, or has less responsibility than when the annuitant worked before.

B. Gainful work activity - Gainful work activity is work activity that the annuitant does for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

C. Some other activities - Generally, do not consider activities like taking care of one's self, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

10.4.3 General Information About Work Activity

A. The nature of the claimant's work - If the claimant's duties require use of the claimant's experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that the claimant has the ability to work at the substantial gainful activity level.

B. How well the claimant performs - Consider how well the claimant does his or her work when determining whether or not the claimant is doing substantial gainful activity.

If the claimant's performance is satisfactory, this may be evidence that his or her work is SGA.

If the claimant is unable to work at a satisfactory level of performance because of his or her impairment, this is evidence that the work is not SGA.

If the claimant's work involves only minimal duties, this may be evidence that the work is not SGA.

C. The claimant's work is done under special conditions - Even though the work the claimant is doing takes into account his or her impairment, such as work done in a sheltered workshop or as a patient in a hospital, it may still show that the claimant has the necessary skills and ability to work at the substantial gainful activity level.

D. The claimant is self-employed - Supervisory, managerial, advisory or other significant personal services that the claimant performs as a self-employed person may show that the claimant is able to do substantial gainful activity.

E. Time spent in work - While the time the claimant spends in work is important, do not decide whether or not the claimant is doing substantial gainful activity only on that basis. Evaluate the work to decide whether it is substantial and gainful regardless of whether the claimant spends more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

10.4.4 Evaluation Guides For An Employed Annuitant

A. General - Evaluating SGA consists of 3 steps:

1. Developing for gross earnings, employer subsidies, and impairment related work expenses;
2. Subtract the subsidies and IRWE's from the gross earnings; and
3. Determine the net earnings from employment. The net earnings are then compared with the earnings table in section B.2.

   The earnings test is not applied mechanically. When making SGA evaluation, keep the following points in mind:

   a. The claimant's earnings may show the annuitant has done substantial gainful activity - The amount of the claimant's earnings from work the claimant has done may show that he or she has engaged in substantial gainful activity. Generally, if the claimant worked for substantial earnings, this shows that he or she is able to do substantial gainful

activity. On the other hand, the fact that the claimant's earnings are not substantial does not necessarily show that the claimant is not able to do substantial gainful activity. Generally, consider work that the claimant is forced to stop after a short time because of his or her impairment(s) as an unsuccessful work attempt (See DCM 10.5.3) and the claimant's earnings from that work will not show that the claimant is able to do substantial gainful activity.

b. Consider only the amounts the claimant earns

(i) If the claimant's earnings are subsidized, the amount of the subsidy is not counted when determining whether or not the claimant's work is substantial gainful activity. Thus, where work is done under special conditions, consider only the part of the claimant's pay which the claimant actually "earns." For example, where a handicapped person does simple tasks under close and continuous supervision, do not determine that the person worked at the substantial gainful activity level only on the basis of the amount of pay. A railroad or non-railroad employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If the claimant's work is subsidized and the claimant's railroad and non-railroad employer does not set the amount of the subsidy or does not adequately explain how the subsidy was figured, investigate to see how much the claimant's work is worth.

(ii) The following circumstances indicate a subsidy might exist:

A. The employment is sheltered, or

B. Childhood disability is involved, or

C. Mental impairment is involved, or

D. There appears to be a marked discrepancy between the amount of pay and the value of the services, or

E. The employer, employee, or other interested party alleges that the employee does not fully ear his or her pay (e.g., the employee receives unusual help from others in doing the work, or

F. The nature and severity of the impairment indicate that the employee receives unusual help from others in doing the work, or

G. The employee is involved in a government sponsored job training and employment program.

c. If the claimant is working in a sheltered or special environment - If the claimant is working in a sheltered workshop, the claimant may or may not be earning the amounts he or she is being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that the claimant is not earning all he or she is being paid. Persons in military service being treated for a severe impairment usually continue to receive full pay. Therefore evaluate work activity in a therapy program while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

B. Earnings guidelines

1. How to determine "Countable Earnings." *

a. First determine gross earnings i.e., the total earnings reported for work activity. Gross earnings include payments in kind (e.g., room and board) which are made for the performance of work in lieu of cash

* "Countable earnings" are that portion of an individual's earnings representing the actual value of the work he or she performed. See worksheet IV of Appendix E for a summary sheet that can be used in making this determination.

b. Once gross earnings are determined, deduct:

(i) The amount of any subsidized earnings provided by the employer (See Sec. A.2) and

(ii) The amount of any impairment-related work expenses paid by the employee. (See 10.4.6)

c. Finally, compare the claimant's net or countable earnings with the applicable amounts shown in sec. 2, below. If a claimant's average "countable earnings" exceed the earnings guidelines, he or she will be found to engage in SGA.

NOTE: In those cases in which the earnings or work activity vary somewhat from month to month, the claimant's earnings will have to be averaged. (See Appendix D.)

2. Table of SGA earnings guidelines and effective dates

a. All RRB Annuitants and all SSA Title II Blind and Non-blind Beneficiaries

YEAR(S)	"Countable Earnings" of employees indicate SGA if the amount averages more per month than the (primary) amount of:	"Countable Earnings" usually do not indicate SGA if they average less per month than the (secondary **) amount of:
1975 and before	$200	$130
1976	$230	$150
1977	$240	$160

b. RRB and SSA Title II Non-blind Beneficiaries. Amounts begin January 1st of the year unless otherwise indicated.

YEAR(S)	"Countable Earnings" of employees indicate SGA if the amount averages more per month than the (primary) amount of:	"Countable Earnings" usually do not indicate SGA if they average less per month than the (secondary **) amount of:
1978	$260	$170
1979	$280	$180
1980 through 1989	$300	$190
January 1990 through June 1999	$500	$300
July 1999 through December 2000	$700	$300
2001	$740	N/A
2002	$780	N/A
2003	$800	N/A
2004	$810	N/A

2005	$830	N/A
2006	$860	N/A
2007	$900	N/A
2008	$940	N/A
2009	$980	N/A
2010	$1000	N/A
2011	1000	N/A
2012	$1010	N/A
2013	$1040	N/A
2014	$1070	N/A
2015	$1090	N/A
2016	$1130	N/A
2017	$1170	N/A
2018	$1180	N/A
2019	$1220	N/A

NOTE: Beginning in January 2001, the secondary substantial gainful activity amount is discontinued.

** The lower (secondary) amounts apply only to employees, not to self-employed individuals. (See DCM 10.4.5(A)(2)).

c. RRB and SSA Title II Blind Beneficiaries. Amounts begin on January 1st of the year unless otherwise indicated.

1978	$334
1979	$375
1980	$417

1981	$459
1982	$500
1983	$550
1984	$580
1985	$610
1986	$650
1987	$680
1988	$700
1989	$740
1990	$780
1991	$810
1992	$850
1993	$880
1994	$930
1995	$940
1996	$960
1997	$1000
1998	$1050
1999	$1110
2000	$1170
2001	$1240
2002	$1300
2003	$1330
2004	$1350

2005	$1380
2006	$1450
2007	$1500
2008	$1570
2009	$1640
2010	$1640
2011	$1640
2012	$1690
2013	$1740
2014	$1800
2015	$1820
2016	$1820
2017	$1950
2018	$1970
2019	$2040

d. If the claimant's earnings fall between the primary and secondary amounts - Consider other information in addition to the claimant's earnings, such as whether:

- The disability application was filed after the claimant's occupational disability ended but no later than the 12th month after the month the disability ended; or
- The claimant's work, although significantly less than that done by unimpaired persons, is clearly worth the amounts shown in the earnings guidelines according to pay scales in the claimant's community.

If the work meets either of these tests, it is SGA.

10.4.5 Evaluation Guides For A Self-Employed Annuitant

A. General - DBD will consider the following three tests, two of which concern the amount of income received, when dealing with self-employed persons. This is because the amount of income the annuitant actually receives in self-employment may depend upon a number of different factors like capital investment and profit sharing that tend to decrease the amount of current income. Consider that the annuitant has engaged in SGA if:

1. The comparability of work test - The annuitant's work activity, in terms of factors such as hour, skills, energy output, efficiency, duties, and responsibilities, is comparable to that of unimpaired persons in the annuitant's community who are in the same or similar businesses as their means of livelihood; or

2. The worth of work test - The annuitant's work activity, although not comparable to that of unimpaired persons, is clearly worth the amount shown in DCM10.4.4 B.2 when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employed person to do the work the annuitant is doing; or

3. The significant services and substantial income test - The annuitant renders services that are significant to the operation of the business and receives a substantial income from the business.

   (i) "Significant Services."

   Annuitants who are not farm landlords - If the annuitant is not a farm landlord and the annuitant operates a business entirely by himself or herself, and services that the annuitant renders are significant to the business. If the annuitant's business involves the services of more than one person, consider the annuitant to be rendering significant services if he or she contributes more than half the total time required for the management of the business or he or she renders management services for more than 45 hours a month regardless of the total management time required by the business.

   Claimants who are farm landlords - If the claimant is a farm landlord consider the claimant to be rendering significant services if he or she materially participates in the production or the management of the things raised on the rented farm.

   Material Participation means that:

   1. The claimant furnishes a large portion of the material stock i.e., the machinery, tools, and livestock used on the farm, or

2. The claimant furnishes the monies or assumes financial responsibility for the farm. Advising or consulting with the farm tenant or inspecting the farm's production is strong evidence that the annuitant is materially participating.

   NOTE: If the claimant was given social security wage credits based on his or her activity as a farm landlord and he or she continues in these activities: consider the claimant to be rendering significant services.

   Production means the physical work performed and the expenses incurred in producing the things raised on the farm. It includes activities like the actual work of planting, cultivating, and harvesting of crops, and the furnishing of machinery, implements, seed, and livestock.

   Management of the production refers to services performed in making managerial decisions about the production of the crop, such as when to plant, cultivate, dust, spray or harvest. It includes advising and consulting, making inspections, and making decisions on matters, such as rotation of crops, the type of crops to be grown, the type of livestock to be raised, and the type of machinery and implements to be furnished.

(ii) "Substantial Income - Substantial income is net income after deductions are made for the reasonable value of any unpaid help, soil bank payments included as farm income, and any impairment-related work expenses. Consider this net income to be substantial if:

- It average more than the primary amounts described in DCM 10.4.4 B.2; or
- It averages less than the primary amounts described in DCM 10.4.4 B.2 but the livelihood which the annuitant gets from the business is either comparable to what it was before the annuitant became severely impaired or is comparable to that of unimpaired self-employed persons in the claimant's community who are in the same or similar businesses as their means of livelihood.

B. Blind Persons Operating Vending Machines

The Randolph-Sheppard Act (R-S Act) established a program for blind persons to operate vending facilities as a business on Federal property. Various states have established similar programs for blind persons to operate vending facilities as a business on state and local government property. A blind vendor who operates a vending facility may also receive income from

vending machines that are located on the same property even though he/she does not service, operate, or maintain the vending machines.

Social Security Ruling (SSR) 12-1p provides that income that blind self-employed vendors receive under the R-S Act and similar state programs from vending machines that are located on the same property but are not serviced, operated, or maintained by the blind vendor should not be counted toward SGA purposes.

On a case-by-case basis, if the evidence suggests that a blind applicant/annuitant may be a licensed vendor at a Federal, state, or other facility and a DEQY and/or report from The Work Number (TWN) shows that that income is likely to be SGA, the responsible adjudicating unit shall attempt development to find out if at least some of the total income is from vending machines. If at least some of the total income is from vending machines, then attempt to determine how much of the income was from vending machines which he/she services, operates, and maintains and how much was from vending machines which he/she does not service, operate, or maintain.

SSR 12-1p only applies to disability freeze and Medicare claims under the Social Security Act. After developing for the information in the previous paragraph, refer any case to Policy and Systems - RAC for a determination how that income should be treated for SGA purposes for disability claims under the Railroad Retirement Act.

10.4.6 Impairment Related Work Expenses

A. General - When figuring the claimant's earnings in making an SGA test, subtract the reasonable costs to the claimant of certain items and services which, because of his or her impairments, the claimant needs to be able to work. The costs are deductible even though the claimant also needs or uses the items and services to carry our daily living functions unrelated to his or her work. (See DCM 10.8 for Disability Related Work Expenses.)

B. Requirements for Deducting Impairment-Related Work Expenses - Deduct IRWE's if -

1. The claimant is disabled for any regular employment and not occupationally disabled;

2. The severity of the claimant's impairment(s) requires the claimant to purchase (or rent) certain items and services in order to work;

3. The claimant pays the cost of the item or service. No deduction will be allowed to the extent that payment has been, could be or will be made by another source. No deduction will be allowed to the extent that the claimant has been, could be, or will be reimbursed

for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if the claimant purchases crutches for $80 but the claimant was, could be, or will be reimbursed $64 by some agency, plan, or program, deduct only $16.

4. The claimant pays for the item or service in a month he or she is working (in accordance with paragraph (D) of this section); and

5. The claimant's payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

C. <u>What Expenses may be Deducted</u>

1. <u>Payments for attendant care services</u>

(i) If because of the claimant's impairment(s) the claimant needs assistance in traveling to and from work, or while at work the claimant needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments the claimant makes for those services may be deducted.

(ii) If because of the claimant's impairment(s) the claimant needs assistance with personal functions (e.g., dressing administering medications) at home in preparation for going to and assistance in returning from work, the payments the claimant makes for those services may be deducted.

(iii) Deduct payments the claimant makes to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

Consider a family member to be anyone who is related to the claimant by blood, marriage or adoption, whether or not that person lives with the claimant.

(iv) If only part of the claimant's payment to a person is for services that come under the provisions of this section, deduct that part of the payment that is attributable to those services. For example, an attendant gets the claimant ready for work and helps the claimant in returning from work, which takes about 2 hours a day. The rest of the attendant's 8 hour day is spent cleaning the claimant's house and doing the claimant's laundry, etc. Deduct one-fourth of the

attendant's daily wages as an impairment-related work expense.

2. Payment for medical devices - If the claimant's impairment(s) requires that the claimant utilize medical devices in order to work, the payments the claimant makes for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment that can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

3. Payments for prosthetic devices - If the claimant's impairment(s) requires that the claimant utilize a prosthetic device in order to work, the payments the claimant makes for that device can be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

4. Payments for equipment

   (i) Work-related equipment - If the claimant's impairment(s) requires that the claimant utilize special equipment in order to do his or her job, the payments the claimant makes for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, vision aids, sensory aids for the blind, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

   (ii) Residential modifications

   If the claimant is employed away for home, only the cost of changes made outside of the claimant's home to permit the claimant to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the claimant's home will not be deducted.

   If the claimant works at home, the costs of modifying the inside of the claimant's home in order to create a working space to accommodate the claimant's impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which the claimant works. Examples of such changes are the enlargement of a doorway leading into the

workspace or modification of the workspace to accommodate problems in dexterity. However, if the claimant is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) Non-medical appliances and equipment - Expenses for appliances and equipment that the claimant does not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is for the control of the claimant's disabling impairment(s), thus enabling the claimant to work. To be considered essential, the item must be of such a nature that if it were not available to the claimant there would be an immediate adverse impact on the claimant's ability to function in his or her work activity. In this situation the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner by a person with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If an exercycle is prescribed and used as necessary treatment to enable the claimant to work, deduct payments the claimant makes toward its cost.

5. Payments for drugs and medical services

(i) If the claimant must use drugs or medical services (including diagnostic procedures) to control his or her impairment(s), the payments the claimant makes for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of the claimant's impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are:

- anticonvulsant drugs to control epilepsy or anticonvulsant blood level monitoring;

- antidepressant medication for mental impairments;
- medication used to allay the side effects of certain treatments;
- radiation treatment or chemotherapy for cancer patients;
- corrective surgery for spinal impairments;
- electroencephalograms and brain scans related to a disabling epileptic impairment;
- tests to determine the efficacy of medication on a diabetic condition; and
- immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) Deduct only the costs of drugs or services that are directly related to the claimant's impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

6. Payments for similar items and services

(i) General - If the claimant is required to utilize items and services not specified in paragraphs (C)(1) through (5) of this section, but which are directly related to his or her impairment(s) and which the claimant needs to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, the purchase and maintenance of a guide dog that the claimant needs to work, and transportation.

(ii) Medical supplies and services not described above - Deduct payments the claimant makes for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. Also deduct payments the claimant makes for physical therapy which the annuitant requires because of his or her impairment(s) and which the claimant needs in order to work.

(iii) Payments for transportation costs - Deduct transportation costs in these situations:

(a) The claimant's impairment(s) requires that in order to get to work the claimant needs a vehicle that has structural or operational modifications. The modifications must be critical to the claimant's impairment(s). Deduct the cost of the modifications, but not the cost of the vehicle. Also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs. (See Appendix G).

(b) The claimant's impairment(s) requires the claimant to use driver assistance, taxicabs or other hired vehicles in order to work. Deduct amounts paid to the driver and, if the claimant's own vehicle is used, also deduct a mileage allowance for the trip to and from work.

(c) The claimant's impairment(s) prevents the claimant from taking available public transportation to and from work and the claimant must drive his or her (unmodified) vehicle to work. If DPS can verify through the claimant's physician or other sources that the need to drive is caused by the claimant's impairment(s) (and not due to the unavailability of public transportation), deduct a mileage allowance for the trip to and from work.

7. Payments for installing, maintaining, and repairing deductible items - If the device, equipment, appliance, etc., that the claimant utilizes qualifies as a deductible item as described in paragraphs (C)(2), (3), (4) and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs that are associated with modifications to a vehicle are deductible. Except for a mileage allowance, the costs that are associated with the vehicle itself are not deductible.)

D. When expenses may be deducted

1. Effective date - To be deductible, an expense must be incurred after November 30, 1980. An expense may e considered incurred after that date if is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

2. Payments for services - A payment the claimant makes for services may be deducted if the services are received while the claimant is

working and the payment is made in a month the claimant is working.

3. Payments for items - A payment the claimant makes toward the cost of a deductible item (regardless of when it is acquired) may deducted if payment is made in a month the claimant is working. See paragraph (E)(4) of this section when purchases are made in anticipation of work.

E. How expenses are allocated

1. Recurring expenses - The claimant may pay for services on a regular periodic basis, or the claimant may purchase an item on credit and pay for it in regular periodic installments or the claimant may rent an item. If so, each payment the claimant makes for the services and each payment the claimant makes toward the purchase or rental (including interest) is deductible in the month it is made.

   EXAMPLE: B starts work in October 1981, at which time she purchases: a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No down payment is made. The monthly allowable deduction for the item would be $115 ($5.20 divided by 48) for each month of work during the 48 months.

2. Non-recurring expenses - Part or all of the claimant expenses may not be recurring. For example, the claimant may make a one-time payment in full for an item or service or make a down payment. If the claimant is working when he or she makes the payment, either deduct the entire amount in the month the claimant pays it or allocate the amount over a 12 consecutive month period beginning with the month of payment, whichever the claimant selects.

   EXAMPLE: A begins working in October 1981 and earns $525 a month. In the same month, he purchases and pays for a deductible item at a cost of $250. In this situation, allow a $250 deduction for October 1981, reducing A's earnings below the substantial gainful activity level for that month.

   If A's earnings had been $15 above the substantial gainful activity earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981 - September 1982, giving A an allowable deduction of $20.83 a month for each month of work during that period. This deduction

would reduce A's earnings below the substantial gainful activity level for 12 months.

3. Allocating down payments - If the claimant makes a down payment, make a separate calculation for the down payment in order to provide for uniform monthly deductions, if the claimant chooses. In this situation, determine the total payment that the claimant will make over a 12 consecutive month period beginning with the month of the down payment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if the claimant's regular monthly payments will extend over a period of less than 12 months.

EXAMPLE 1: C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200 down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns $500 a month. He chooses to have the down payment allocated. In this situation, allow a deduction of $205.42 a month for each month of work during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of $115 for each month of work during the remaining installment period.

Explanation:

Down payment in October 1981. . . . .$1,200

Monthly payments:

November 1981 through September 1982.. $1,265

12/ $2,465 = $205.42

EXAMPLE 2: D, while working, buys a deductible item in July 1981, paying $1,450 down. However, his first monthly payment of $125 is not due until September 1981. D chooses to have the down payment allocated. In this situation, allow a deduction of $225 a month for each month of work during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work.

Explanation:

Down payment in July 1981. . . . .$1,450

Monthly payments:

September 1981 through June 1982. . . . $1,250

12/$2,700 = $225

4. Payments made in anticipation of work - A payment made toward the cost of a deductible item that the claimant made in any of the 11 months preceding the month he or she started working will be taken into account in determining the claimant's impairment-related work expenses. When an item is paid for in full during the 11 month preceding the month the claimant started working, the payment will be allocated over the 12 consecutive month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9).

   Installment payments (including a down payment) that the claimant made for a particular item during the 11 months preceding the month he or she started working, will be totaled and considered to have been made in the month of the annuitant's first payment for that item within this 11 month period. The sum of these payments will be allocated over the 12 consecutive month period beginning with the month of the claimant's first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased three months before the month work and it is being paid for in three monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, three months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9).

   The amount, as determined by these formulas is to be considered to have been paid in the first month of work. Deduct either this entire amount in the first month of work or allocate it over a 12 consecutive month period, beginning with the first month of work, whichever the claimant selects. In the above example, the claimant would have the choice of having the entire $450 deducted in the first month of work or having $37.50 a month ($450 divided by 12) deducted for each month that he or she works over a 12 consecutive month period, beginning with the first month of work. To be deductible, the payment must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, non-medical appliances and vehicle modifications.

Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for the purpose of this paragraph.

F. Limits on deductions

1. Deduct the actual amounts the claimant pays towards his or her impairment-related work expenses unless the amounts are unreasonable. Consider the amount the claimant pays to be reasonable if it does not exceed the standard or normal charge for the same or similar item or service in the claimant's community.

2. Impairment-related work expenses are not deducted in computing the claimant's earnings for purposes of determining whether the claimant's work was "services" as described in 10.5.4 - The Trial Work Period.

3. The decision as to whether the claimant performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for the claimant to work will be based generally upon the claimant's "earnings" and not on the value of "services" the claimant rendered. This is not necessarily so, however, when the claimant is in a position to control or manipulate his or her earnings, i.e., a self-employed individual.

4. No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent than the claimant has been, could be, or will be reimbursed for payments he or she made. (See paragraph (B)(3) of this section.)

G. Verification - Verify the claimant's need for items or services for which deductions are claimed, and the amount of the charges for those items or services. The claimant will also be asked to provide proof that he or she paid for the items or services.

10.5 Work Incentives

10.5.1 Return To Work Less Than One Year From Disability Onset

When a beneficiary returns to work less than one year after onset, the issue is raised as to whether the 12-month duration requirement for disability is met. To determine the correct action to be taken, the examiner must know:

- Whether the work was SGA (or regular railroad occupation or had similar duties), and whether the return to work occurred on, before, or after the date of the final determination. The date of the final determination is the date that the determination notice is received by the annuitant. The date of the receipt of notice is presumed to be the fifth day following the date of the mailing of the determination notice. For purposes of disability determination and onset date, the "determination notice" is the RL-121f. (All RL-121f letters must contain the onset date and reconsideration paragraph.)

- In cases where the return to work occurred on or before the final determination, whether the notice of the work was received on, before, or after the date the final disability determination was made, and

- In cases where the return to work occurred after the final determination, whether the work began during or after the five-month waiting period.

NOTE: Any time a notice is received that a disability annuitant has returned to railroad service or an employee disability annuitant has returned to any work for more than the current monthly disability earnings limit, the annuity must immediately be suspended. Refer to the chart in FOM 1125.5.2 for the monthly and annual earnings limits.

10.5.1.1 Return to Work Occurred On or Prior to Date of Final Determination

Determine whether the work information was **received** on, before, or after the date of final determination.

A. Information Received Before the Final Determination

If the claimant returned to work within 12 months of the disability onset and prior to the final determination date, and the return to work information is received before the final determination, there are two possible actions:

1. Deny the disability based on not meeting the duration requirement if the claimant returns to SGA (or to regular railroad or similar occupation for employee occupational disabilities) and the work continues.

   EXAMPLE: The claimant alleges an onset date of 5/1/2005. No decision has yet been made when DBD receives a notice that the claimant has returned to work in SGA on 12/31/2005 and continues to work. Deny the claim.

2. Grant the disability if it is determined that:

   - The work activity was not SGA (or regular railroad or similar occupation for employee occupational disabilities), or

EXAMPLE: The claimant alleges an onset date of 5/1/2005. No decision has yet been made when DBD receives a notice that the claimant has returned to non-railroad work on 12/31/2005 and continues to work. The work is not SGA and is not similar to railroad duties. The work will not affect the decision.

- If the work was SGA (or regular railroad or similar occupation for employee occupational disabilities) but was later stopped. Consider granting with possible later onset date than the claimed onset date or applying an unsuccessful work attempt (UWA). (See DCM 10.5.3 for UWA criteria.)

  EXAMPLE: The claimant alleges an onset date of 5/1/2005. No decision has yet been made when DBD receives a notice that the claimant has returned to non-railroad work on 12/31/2005. The work stopped on 2/5/2006. Consider UWA.

B. Information Received After the Final Determination Date

If the claimant returned to work within 12 months of the disability onset and prior to or on the final determination date, but the return to work information is received after the final determination date, there are three possible actions:

1. Re-open and deny the disability based on not meeting the duration requirement if the claimant returns to SGA (or to regular railroad or similar occupation for employee occupational disabilities) and the work continues, and it has been at least six months since the claimant returned to work. Check payment status to determine whether the case needs to be dumped from RASI or payments terminated.

   EXAMPLE: The final decision date is 3/1/2006 to grant disability with an onset date 2/4/2005. On 3/15/2006, DBD receives a notice that the claimant returned to work in SGA on 8/13/2005 and the work continues. Re-open and deny claim.

   If it has been less than six months since the claimant returned to work, set a call-up for six months after the return to work date. Check payment status to determine whether the case needs to be dumped from RASI or payments suspended. When the call-up expires, determine whether claimant has stopped working. If yes, go to 3. If no, re-open and deny based on not meeting the duration requirement.

   EXAMPLE: The final decision date is 3/1/2006 to grant disability with an onset date of 2/4/2005. On 3/15/2006, DBD receives a

notice that the claimant returned to work in SGA on 12/1/2005. Suspend payments and set call-up for 6/1/2006. If the claimant has stopped work, consider UWA. If the work continues, re-open and deny claim; or,

2. Uphold the original grant decision if the work activity was not SGA (or similar to regular railroad occupation for employee occupational disabilities).

   EXAMPLE: The final decision date is 3/12/2006 to grant disability with an onset date of 2/4/2005. On 3/15/2006 DBD receives a notice that the claimant returned to non-railroad work on 1/13/2006. The work is not SGA. Uphold grant; or.

3. If the work activity was SGA (or regular railroad or similar occupation for employee occupational disabilities) but was later stopped, consider applying an unsuccessful work attempt (UWA). (See DCM 10.5.3 for UWA criteria) or consider re-opening to revise to a later onset than the claimed onset date..

   EXAMPLE: The final decision date is 3/1/2006 to grant disability with an onset date of 2/4/2005. On 3/15/2006, DBD receives a notice that the claimant returned to work in SGA on 12/13/2005. The work stopped on 2/3/2006. Consider UWA.

C. Information Received On the Final Determination Date

If the claimant returned to work within 12 months of the disability onset and prior to or on the final determination date, but the return to work information is received on the final determination date,

1. Re-open and deny the disability based on not meeting the duration requirement if the claimant returns to SGA (or to regular railroad or similar occupation for employee occupational disabilities) and the work continues, and it has been at least six months since the claimant returned to work. Check payment status to determine whether the case needs to be dumped from RASI or payments terminated.

   EXAMPLE: The final decision date is 3/1/2006 to grant disability with an onset date 2/4/2005. On 3/1/2006, DBD receives a notice that the claimant returned to work in SGA on 7/13/2005 and the work continues. Re-open and deny claim.

   If it has been less than six months since the claimant returned to work, set a call-up for six months after the return to work date. Check payment status to determine whether the case needs to be

dumped from RASI or payments suspended. When the call-up expires, determine whether claimant has stopped working. If yes, go to 3. If no, re-open and deny based on not meeting the duration requirement.

EXAMPLE: The final decision date is 6/20/2006 to grant disability with an onset date of 8/8/2005. On 6/20/2006, DBD receives a notice that the claimant returned to work in SGA on 6/19/2006. Suspend payments and set call-up for 1/1/2007. If the claimant has stopped work, consider UWA. If the work continues, re-open and deny claim; or,

2. Uphold the original grant decision if the work activity was not SGA (or similar to regular railroad occupation for employee occupational disabilities).

   EXAMPLE: The final decision date is 6/20/2006 to grant disability with an onset date of 8/8/2005. On 6/20/2006, DBD receives a notice that the claimant returned to non-railroad work on 3/20/2006. The work is not SGA. Uphold grant; or.

3. If the work activity was SGA (or regular railroad or similar occupation for employee occupational disabilities) but was later stopped, consider applying an unsuccessful work attempt (UWA). (See DCM 10.5.3 for UWA criteria) or consider re-opening to revise to a later onset than the claimed onset date.

   EXAMPLE: The final decision date is 6/20/2006 to grant disability with an onset date of 8/5/2005. On 6/20/2006, DBD receives a notice that the claimant returned to work in SGA on 3/1/2006. The work stopped on 5/31/2006. Consider UWA or revision to later onset date.

10.5.1.2 Return to Work Occurred After Date of Final Determination

If the return to work occurred after the date of final determination, determine whether the return to work **occurred** during or after the waiting period.

A. Return to Work Occurred During the Waiting Period

When a claimant returns to work at the SGA level (or to regular railroad or similar occupation for employee occupational disabilities) during the waiting period and after the final determination, the action to be taken depends upon whether this work continues or has stopped.

1. If this work continues, the determination of allowance on the claim must be re-opened and revised to a denial.

EXAMPLE: The final decision date is 2/15/2005 to grant disability with onset date of 12/1/2004. On 3/2/2006, DBD receives notice that the claimant returned to work in SGA on 3/2/2005, and the work continues. Re-open and deny claim.

2. When a claimant returns to work during the waiting period but this work later stops, the claim must be reviewed to determine whether a UWA can be established. A UWA during the waiting period will not preclude a finding of disability. (See DCM 10.5.3 for UWA criteria.)

   EXAMPLE: The final decision date is 2/15/2005 to grant disability with onset date of 12/1/2004. On 3/2/ 2006, DBD receives notice that the claimant returned to work in SGA on 3/2/2005, but the work stopped on 5/30/2005. Consider UWA.

3. When a claimant returns to work at the SGA level during the waiting period and later stops this work and the criterion for a UWA are not met, determine whether a later disability onset date can be granted

   EXAMPLE: The final decision date is 2/15/2005 to grant disability with onset date of 12/1/2004. On 3/2/2006, DBD receives notice that the claimant returned to work in SGA on 3/2/2005. The work stopped on 2/5/2006. Consider a later onset date.

B. Return to Work Occurred After the Waiting Period

In cases where the return to work occurred after the date of the final determination and after the waiting period, the appropriate action will depend on whether an MIE diary is indicated. (See DCM 8.5.3 for diary criteria.)

1. Medical Improvement Expected (MIE) Diary Established - If the claimant returns to SGA (or to regular railroad or similar occupation for employee occupational disabilities) after the waiting period and after the date of the final determination, and an MIE diary has been established or would be set based on the diary call-up criteria, develop for possible medical recovery. While this claimant gets a TWP, if it is determined that medical recovery has occurred, terminate the D/A irrespective of any remaining TWP months.

   EXAMPLE: The final decision date is 2/15/2005 to grant disability with onset date of 12/1/2004. On 3/2/2006, DBD receives notice that the claimant returned to work in SGA on 8/2/2005. A MIE diary was set.

2. No MIE Diary Established - If the claimant returns to SGA (or to regular railroad or similar occupation for employee occupational

disabilities) after the waiting period, and after the date of the final determination, and no MIE diary has been established or would be set based on the diary call-up criteria, apply the TWP provisions.

EXAMPLE: The final decision date is 2/15/2005 to grant disability with onset date of 12/1/2004. On 3/2/2006, DBD receives notice that the claimant returned to work in SGA on 8/2/2005. A MIP diary was set. Apply TWP provisions.

10.5.1.3 Actions to Be Taken When a Case is Re-opened for Denial

When a decision is made to re-open a disability rating to deny, take the following actions:

A. The disability examiner shall:

- Write rationale for decision.
- Enter the decision onto OLDDS G-325. Use code 2 in items 22a and 28. Explain in the REMARKS section why the case is reopened for denial.
- Compose a disability custom denial letter.

  NOTE: The disability decision must be authorized. (See DCM 3.4.300 through DCM 3.4.302) After the case is authorized, the reviewer/authorizer shall:

- Release the disability custom denial letter.
- Enter a FAST termination action to terminate the annuity, using code 08 for employees or code 42 for survivors. Use the ABD as the termination date.
- Log the claim folder into the AFCS location of the DBD-DPS supervisor or senior examiner that the reviewer is assigned to and place it in that person's cubicle.

B. The senior or supervisory disability examiner shall:

- Notify RBD or SBD by electronic mail message of denial action and that overpayment must be calculated.
- Notify Policy and Systems - RAC by electronic mail message to the group mailbox: RAC – Return to Work (Disability Denial), that the disability annuity (and disability freeze, if applicable) information must be removed from PREH, as the annuity (and DF) was adjusted to a denial based on additional information being provided. The E-mail should contain the name. RRA claim number, and the type of benefit(s) being adjusted.

- Notify the Sickness and Unemployment Benefits Section (SUBS) via e-G-115 RR/UI that there is no disability annuity entitlement. See RCM 5.9.4.

- Place a copy of all E-mails in the claim folder.

10.5.1.4 Actions to Be Taken When a Case is Re-opened to Set a Later Onset Date

If the decision is revised to a later onset, take the following actions:

- Enter the decision on OLDDS G-325 using code 2 in Item 22. If DF onset date is also being revised, use code 2 in item 28. (PREH will be automatically updated for the new onset date.)

- Notify the annuitant by letter of the change in onset; and

- The case should be routed to the Supervisor or Senior Examiner to notify RPS or SBD by electronic mail of the change in onset and/or possible change in ABD/OBD and annuity rate and possible overpayment.

10.5.2 Return to Work More Than One Year After Disability Onset Date

The appropriate action will depend on whether the return to work occurred before or after the date of the final determination.

10.5.2.1 Return to Work Prior to Date of Final Determination

In these cases, the appropriate action will depend on whether an MIE diary is indicated. (See DCM 8.5.3 for diary criteria.)

1. MIE Diary Scheduled - If the case is diaried for an MIE review, or an MIE diary would be set based on the call-up criteria, develop for and make an SGA (or regular railroad or similar occupation for employee occupational disabilities) determination.

2. No MIE Diary Schedule - If the case is not diaried for an MIE review, or a MIP or MINE diary would be set based on the call-up criteria, and the TWP is not excluded, a trial work diary must be established. Handle the case following regular TWP provisions.

For more information on how to handle Occupational and Total and Permanent cases when the return to work is more than one year after the disability onset date (meets 12 month duration) and prior to final determination click here:

DBD Initial and Post Examiner Action When 12 month Duration is met

<u>10.5.2.2 Return to Work After Date of Final Determination</u>

If the final determination has been made, the issue involved is strictly one of continuing disability. Handle the case under medical recovery or SGA procedures.

10.5.3 Unsuccessful Work Attempts

A. Definition of Unsuccessful Work Attempt - An "Unsuccessful work attempt" is an effort to do substantial work in employment or self-employment, which was discontinued after a short time (no more than 6 months) by the individual for reasons relating to his ability to work or the removal of special conditions related to the impairment that are essential to the further performance of work.

B. Beginning and Ending Dates - There must be a significant breaking the continuity of an individual's regular employment before he can be considered to have a work attempt that later proved unsuccessful. Such a break in continuity would occur when, because of impairment or the removal of conditions essential to further performance, the individual was out of work for 30 consecutive days, or was forced to change to another type of work or another employer.

After the initial "significant break in continuity," the subsequent period of work should be considered continuous until a similar change occurs, i.e., there is an absence from work of 30 days or a change to another type of work or another employer, which is caused by the impairment or the removal of conditions essential to further performance. Each continuous period, separated by significant breaks in continuity, may constitute an "unsuccessful work attempt." provided that the criteria related to duration and conditions of work, described in D below, are met. (However, as indicated in C. below, seasonal and other types of patterned, recurring work should not be regarded as a series of unsuccessful work attempts.

C. Unsuccessful Work Attempt Distinguished From Seasonal and Other Patterned, Recurring Work - Seasonal and other types of patterned, recurring work should not be regarded as a series of "unsuccessful work attempts," since the termination of each period of work is unrelated to the impairment and does not give rise to an inference that the individual is unable to repeat the work.

The nature and amount of work performed in seasonal and other types of patterned, recurring work may indicate that the individual has the ability to perform SSA substantial gainful activity annuitant, even if he is not actually performing SGA. DPS will resolve issues of this type by taking into

account all vocational and medical factors relevant to a decision of ability to engage in SGA.

D. Criteria - Duration and Conditions of Work - The following requirements must be met in order for a period of work to be considered an unsuccessful work attempt:

1. Claimant Worked 3 Months or Less - The work must have terminated within 3 months due to impairment or the removal of conditions essential to further performance; or

2. Claimant Worked Between 3 and 6 Months - If the work lasted more than 3 months, it must have terminated within 6 months due to impairment or the removal of conditions essential to further performance; and

   There must have been frequent absences due to impairment; or

   The work must have been unsatisfactory due to impairment; or

   The work must have been done under special conditions; or

   The work must have been done during a period of temporary remission of the impairment.

3. Claimant Worked More Than 6 Months - Ordinarily, a period of substantial work carried on for more than 6 months will be regarded as successful regardless of the reason for its termination. When unusual circumstances indicate that it should be regarded as an unsuccessful work attempt, DPS will make its determination accordingly.

NOTE: To illustrate how UWA time periods are figured, work from November 5, 1982, through at least February 5, 1983, but through a date no later than May 4, 1983, to obtain a period that is "between 3 and 6 months."

E. Performance of Work Under Special Conditions - One situation under which SGA-level work may have ended or may have been reduced to the non-SGA level, as set out above, is "the removal of special conditions related to the impairment that are essential to the further performance of work." That is, a severely impaired person may have worked under conditions especially arranged to accommodate his or her impairment or may have worked through an unusual job opportunity, such as in a sheltered workshop. Special or unusual conditions may be evidenced in many ways. For example, the person:

1. Required and received special assistance from other employees in performing the job; or

2. Was allowed to work irregular hours or take frequent rest periods; or

3. Was provided with special equipment or was assigned work especially suited to the impairment; or

4. Was able to work only within a framework of especially arranged circumstances, such as where other persons helped him or her prepare for or get to and from work; or

5. Was permitted to perform at a lower standard of productivity or efficiency than other employees; or

6. Was granted the opportunity to work, despite his or her handicap, because of family relationship, past association with the firm, or other altruistic reason.

10.5.4 The Trial Work Period

A. Definition - The trial work period is a period during which the annuitant may test his or her ability to work and still be considered occupationally disabled or disabled for any regular employment. The trial work period begins and ends as described in paragraphs F. and G. of this section. During this period, the annuitant may perform "services" (see paragraph B. of this section) in as many as nine months, but these months do not have to be consecutive. DPS will not consider those services as showing that the annuitant's disability has ended until the annuitant has performed services in at least nine months. However, after the trial work period has ended, DPS will consider the work the annuitant did during the trial work period in determining whether the annuitant's disability has ended at any time after the trial work period. Effective January 1992, the trial work period is complete only when the disabled annuitant completes 9 service months on or after January 1992 and within 60 consecutive months (see DCM 10.5.5).

B. "Services"

1. Services for an occupational disability - When used in occupational disability situations, "services" means any activity which, even though it may not be substantial gainful activity as defined in DCM 10.4, is

(i) Done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit; and

(ii) The activity is a return to the same duties of the annuitant's regular railroad occupation or the activity so closely approximates the duties of the regular railroad occupation as to demonstrate the ability to perform those duties.

2. <u>Service for annuitants disabled for any regular employment</u> - When used in total and permanent disability situations, "services" means any activity, even though it is not substantial gainful activity, which is done by the annuitant in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. If the annuitant is employed, DPS will consider his or her work to be "services" if in any calendar year the annuitant earns more than the allowable amount in the chart below.

1-1-2019 or later	$880
1-1-2018 through 12-31-2018	$850
1-1-2017 through 12-31-2017	$840
1-1-2016 through 12-31-2016	$810
1-1-2015 through 12-31-2015	$780
1-1-2014 through 12-31-2014	$770
1-1-2013 through 12-31-2013	$750
1-1-2010 through 12-31-2012	$720
1-1-2009 through 12-31-2009	$700
1-1-2008 through 12-31-2008	$670
1-1-2007 through 12-31-2007	$640
1-1-2006 through 12-31-2006	$620
1-1-2005 through 12-31-2005	$590
1-1-2004 through 12-31-2004	$580
1-1-2003 through 12-31-2003	$570
1-1-2002 through 12-31-2002	$560

1-1-2001 through 12-31-2001	$530
1-1-1990 through 12-31-2000	$200
1-1-1979 through 12-31-1989	$75
Prior to 1-1-1979	$50

3. Services in Self-Employment - If the annuitant is self-employed, DPS will consider his or her activities "services" if the annuitant's net earnings are based on the chart below:

1-1-2019 or later	$880
1-1-2018 through 12-31-2018	$850
1-1-2017 through 12-31-2017	$840
1-1-2016 through 12-31-2016	$810
1-1-2015 through 12-31-2015	$780
1-1-2014 through 12-31-2014	$770
1-1-2013 through 12-31-2013	$750
1-1-2010 through 12-31-2012	$720
1-1-2009 through 12-31-2009	$700
1-1-2008 through 12-31-2008	$670
1-1-2007 through 12-31-2007	$640
1-1-2006 through 12-31-2006	$620
1-1-2005 through 12-31-2005	$590
1-1-2004 through 12-31-2004	$580
1-1-2003 through 12-31-2003	$570
1-1-2002 through 12-31-2002	$560
1-1-2001 through 12-31-2001	$530

1-1-1990 through 12-31-2000	$200
1-1-1979 through 12-31-1989	$75
Prior to 1-1-1979	$50

or the annuitant works more than 80 hours a month in the business (40 hours a month is the figure for any calendar year before 2001 and 15 hours a month is the figure for calendar years before 1990). Do not consider work to be "services" when it is done without remuneration or merely as therapy or training, or when it is work usually done in a daily routine around the house or in self-care.

NOTE: Activity performed by an annuitant for which payment in excess of the amounts shown in this chart

1-1-2019 or later	$880
1-1-2018 through 12-31-2018	$850
1-1-2017 through 12-31-2017	$840
1-1-2016 through 12-31-2016	$810
1-1-2015 through 12-31-2015	$780
1-1-2014 through 12-31-2014	$770
1-1-2013 through 12-31-2013	$750
1-1-2010 through 12-31-2012	$720
1-1-2009 through 12-31-2009	$700
1-1-2008 through 12-31-2008	$670
1-1-2007 through 12-31-2007	$640
1-1-2006 through 12-31-2006	$620
1-1-2005 through 12-31-2005	$590
1-1-2004 through 12-31-2004	$580
1-1-2003 through 12-31-2003	$570

1-1-2002 through 12-31-2002	$560
1-1-2001 through 12-31-2001	$530
1-1-1990 through 12-31-2000	$200
1-1-1979 through 12-31-1989	$75
Prior to 1-1-1979	$50

does not constitute "services" if the activity, although resembling services in employment for remuneration or gain, is:

(i) part of a prescribed program of medical therapy; and

(ii) carried out in a hospital under the supervision of medical and administrative staff; and

(iii) not performed in an employer/employee relationship; and

(iv) not normally performed for remuneration or gain.

4. Impact of Impairment Related Work Expenses (IRWE's) and Vocational Rehabilitation Programs on the Assessment of Trial Work Service Months

(i) Impairment Related Work Expenses- The IRWE deduction for items or services necessary for work does not apply for the purpose of determining whether a month of service is chargeable for TWP. In other words, deductions will not be made to determine whether a person's monthly earnings can be reduced based on the chart below:

1-1-2019 or later	$880
1-1-2018 through 12-31-2018	$850
1-1-2017 through 12-31-2017	$840
1-1-2016 through 12-31-2016	$810
1-1-2015 through 12-31-2015	$780
1-1-2014 through 12-31-2014	$770

1-1-2013 through 12-31-2013	$750
1-1-2010 through 12-31-2012	$720
1-1-2009 through 12-31-2009	$700
1-1-2008 through 12-31-2008	$670
1-1-2007 through 12-31-2007	$640
1-1-2006 through 12-31-2006	$620
1-1-2005 through 12-31-2005	$590
1-1-2004 through 12-31-2004	$580
1-1-2003 through 12-31-2003	$570
1-1-2002 through 12-31-2002	$560
1-1-2001 through 12-31-2001	$530
1-1-1990 through 12-31-2000	$200
1-1-1979 through 12-31-1989	$75
Prior to 1-1-1979	$50

(ii) Vocational Rehabilitation Programs - The earnings derived from work in a vocational rehabilitation program is chargeable for TWP purposes.

C. Limitations on the number of trial work periods - An employee may have only one trial work period during each period in which he or she is occupationally disabled or disabled for any regular employment.

D. Entitlement to a Trial Work Period

1. Generally, the annuitant is entitled to a trial work period if he or she is entitled to an annuity based on disability.

2. Prior to January 1992, an annuitant is not entitled to a trial work period if he or she is in a second period of disability for which he or she did not have to complete a waiting period before qualifying for a disability annuity. The annuitant is entitled to a TWP in a second period of entitlement for which no waiting period was served if entitlement exists as of January 1992 or later (see DCM 10.5.5D).

NOTE: There are cases, however, where a person becomes re-entitled to DIB within 5 years after a prior termination but is not paid for the full number of months of disability. This can occur where the subsequent application is not filed until 17 or more months after the onset of the subsequent disability; since benefits can be paid retroactively for only 12 months, a beneficiary in this situation will have a period of 5 or more months after onset in which benefits are not payable. This period of 5 or more nonpayment months constitutes a "deemed" waiting period, thus, the TWP provisions would apply.

3. A disabled child annuitant whose disability has been suspended because of SGA following completion of a trial work period, and who subsequently becomes re-entitled to a disabled child's annuity (DCIA) based on a disability which began before age 22, or within 84 months following the month in which the most recent entitlement to a DCIA terminated is again entitled to a trial work period.

E. <u>Payment of the Disability Annuity During the Trial Work Period</u>

1. The disability annuity of an employee, child, or widow(er) will not be paid for any month in the trial work period in which the annuitant works for an employer covered by the Railroad Retirement Act.

2. The disability annuity of an employee will not be paid for any month in this period in which the employee annuitant earns more than:

1-1-2019 or later	$950
1-1-2018 through 12-31-2018	$920
1-1-2017 through 12-31-2017	$910
1-1-2016 through 12-31-2016	$880
1-1-2015 through 12-31-2015	$850
1-1-2014 through 12-31-2014	$840
1-1-2013 through 12-31-2013	$810
1-1-2012 through 12-31-2012	$790
1-1-2010 through 12-31-2011	$780
1-1-2009 through 12-31-2009	$770

1-1-2008 through 12-31-2008	$730
1-1-2007 through 12-31-2007	$700
1-1-1989 through 12-31-2006	$400
Prior to 1-1-89	$200

All amounts are after deduction of disability related work expenses in employment or self-employment.

3. If a disability annuity for an employee, child, or widow(er) is suspended because of work during the trial work period, and the disability annuitant discontinues that work before the end of the trial work period, the disability annuity may be reinstated again without a new application and a new determination of disability.

F. When the trial work period begins and how trial work months are counted

1. When the TWP begins - The trial work period begins with whichever of the following calendar months is the later -

   (i) The annuity beginning date; or

   (ii) The month the application for disability is filed.

1a. In the case of a disabled child annuitant, who has attained age 18, the entitlement to a trial work period begins with the later of the month in which age 18 is attained or the month entitlement to a disabled child annuity is attained.

1b. A person entitled to a disabled widow(er) annuity is not entitled to a trial work period prior to December 1980

2. When to begin counting TWP service months - The months of trial work will be counted beginning with the first month within the TWP in which the annuitant, who has not recovered medically, performs services as defined in DCM 10.5.3B.

EXAMPLE 1: An annuitant becomes entitled to a disability annuity effective November 1984, based on an application filed in November 1984 and begins work in March 1988. The entitlement to a TWP begins in November 1984, and the counting of trial work months begins in March 1988.

EXAMPLE 2: An annuitant becomes entitled to a disability annuity effective January 1985 based on an application filed in January

1985. An onset date of July 15, 1984, was established. After the award, it was discovered that she returned to work for one month in December 1984 (during the waiting period). However, the work during the waiting period was determined not to be SGA. The TWP and the counting of months of trial work begin in January 1985.

EXAMPLE 3: An annuitant becomes entitled to a disability annuity effective July 1983 based on an application filed in July 1984. The annuitant started work in April 1984 earning only $80 per month (non-SGA) and continued this work through July 1985. Since TWP service months cannot begin prior to date of application, the TWP began July 1984 and ended March 1985.

3. Counting TWP Service Months - It is very important to determine how many months in the TWP are service months since the case processing in work activity cases is dependent upon distinguishing between those situation where 9 service months have been completed, thus ending the TWP, and those situations where 9 service months have not been completed.

Non-discrepant earnings from any reliable source, are sufficient for TWP purposes. However, such information cannot be used as the sole basis for determining if a person engaged in SGA. A continuing disability review should be done at the end of the TWP to verify if medical recovery has occurred.

Counting the number of service months in a TWP is not very complicated when only one period of work activity is involved. However, since the 9 service months need not be consecutive, work in several periods over several years may have to be considered. Thus, it may be necessary to combine the findings from a current review with the findings of previous reviews to arrive at the total service months expired in the TWP. The claim folder should always contain evidence as well as a G-325a, OLDDS printout documenting a monthly breakdown so that the 9 service months can be properly established as composing the TWP. Effective January 1992, the TWP is complete only when the annuitant completes 9 service months on or after January 1992 and within 60 consecutive months (see DCM 10.5.4G).

G. When the trial work period ends and how work activity is evaluated

1. When the TWP ends - The trial work period ends with the close of whichever of the following calendar months is the earlier

(i) The ninth month (whether or not the months have been consecutive) in which the annuitant performed services

effective January 1992, the 9 months must be completed within a 60 consecutive month period (see DCM 10.5.4.F); or

(ii) The month in which new evidence, other than evidence relating to any work the annuitant is not disabled, even though he or she has not worked a full nine months. DPS may find that the annuitant's disability has ended at any time during the trial work period if the medical or other evidence shows that the annuitant is no longer disabled.

EXAMPLE 1: An annuitant became entitled to disability benefits in July 1984 based on an application filed in July 1984 (no medical improvement expected (MIE) diary was established and medical recovery has not occurred): she began work in January 1985 performed and continued services in all succeeding months. The TWP ended with September 1985.

EXAMPLE 2: An annuitant became entitled in July 1984 based on an application filed in April 1984 (no (MIE) diary was established); he began trial work in June 1985. In September 1985 he submitted a medical report from his attending physician indicating recovery (i.e., affirmative evidence). Based on further medical development, cessation of disability was found in October 1985 based upon medical recovery. The TWP ends with October 1985.

EXAMPLE 3: An annuitant became entitled in July 1984 based on an application filed in September 1984 (MIE diary was established for June 1985); he began work in January 1985. Evidence showed medical recovery in January 1985. Disability ceased and the TWP ended with January 1985 based on a current medical cessation.

EXAMPLE 4: An annuitant became entitled in July 1984 based on an application filed in July 1984. An MIE diary was established for June 1985. She began work in January 1985 and continued working in all succeeding months. Since return to work is an indication of possible medical recovery, DPS conducted a CDR but found that she was still disabled and prepared a continuance determination in March 1985. Counting of the TWP service months began in January 1985, the first month in which she performed services, and ended with September 1985 (assuming performed services in all months).

2. Evaluation of Work Activity - After a TWP has ended, it must be decided whether continuing work activity demonstrates an ability to engage in SGA. If it does, disability ceases. If it does not, and there is no medical issue, disability continues. When work activity continues for at least one month at the SGA level following

completion of the TWP, the SGA exception (see DCM 10.3) to medical improvement permits a finding that disability ceased if all the other rules i.e., earnings limitations, subsidies, etc., related to SGA cessations are met. (See DCM 10.4) The individual must actually engage in SGA in the month for which disability is found to have ceased. For example, the 9th TWP month is 12/85 and an SGA decision is made in 01/86. There must be actual performance of SGA in 1/86 before disability can be found to have ceased in 01/86.

If work activity does not continue for at least one month at the SGA level, the SGA exception to medical improvement does not apply, and a DPS medical decision might be needed in order to make a decision that the disability had ceased. Disability ceases when the annuitant demonstrates a continuing ability to engage in SGA. Therefore, the decision must take into consideration whether substantial gainful work is continuing, or, if it has stopped, how long it lasted and the reason it stopped.

If there is no medical issue, the annuitant completes the 9 service months, and the work demonstrates an ability to engage in SGA, cessation should be found effective with the first month of SGA following completion of the TWP. If the beneficiary is not entitled to a TWP, a cessation will be found effective with the first month the annuitant engages in SGA.

10.5.5 The Rolling 60-Month Trial Work Period

A. General - This section contains continuing disability review (CDR) instructions to implement the new rolling 60-month TWP provisions contained in Section 5112 of the Omnibus Budget Reconciliation Act of 1990. Effective January 1992, the Rolling 60-Month TWP provision provides that the TWP is complete only when a disability annuitant completes 9 service months within 60 consecutive months and the TWP provisions apply to subsequent periods of disability for which no waiting period is served. The rolling 60-month trial work period applies to annuitants who are considered occupationally disabled or disabled for any regular employment. Prior to January 1992, an employee or widow(er) disability annuitant was not entitled to a TWP if (s)he was in a 2nd period of entitlement for which (s)he did not have to complete a waiting period (see 10.5.4.D2).

B. The rolling 60-month TWP applies in an initial or subsequent period of disability when:

The disability annuitant completes less than 9 TWP service months as of 1/92 (i.e., 8 or less TWP service months are credited prior to 1/92) and

has not medically recovered (i.e., disability has not been found to have ceased due to medical improvement (MI) or due to work activity).

C. The rolling 60-Month TWP does not apply in an initial or subsequent period of disability when:

1) The disability annuitant completes the TWP under the old rules prior to 1/92 (i.e., completes 9 TWP service months prior to 1/92) or

2) The disability is found to have ceased 1/92 or earlier due to MI or work activity.

D. When the rolling 60-month TWP provision applies in a subsequent period of disability - The rolling 60-month TWP provision applies in a subsequent period of disability for which no waiting period was served if entitlement exists as of 1/92 or later. Therefore, the rolling 60-month TWP applies in a subsequent period of disability when the disability annuitant:

1) Returns to work 1/92 or later, or

2) Returned to work prior to 1/92 but the work was not SGA (i.e., disability continued after 12/91).

E. When the rolling 60-Month TWP provisions does not apply in a subsequent period of disability - The rolling 60-Month TWP provision does not apply in a subsequent period of disability for which no waiting period was served when the disability is found to have ceased 1/92 or earlier due to MI or work activity (e.g., SGA).

F. When the rolling 60-Month TWP begins and ends - January 1992 is the earliest 9th service month that can be credited under the rolling 60-month TWP provisions. Thus, 2/87-1/92 is the earliest 60-month period in which the TWP can be completed and 2/87 is the earliest first service month that can be credited under the new TWP provisions. Therefore, the rolling 60-month TWP begins with the later of the month of entitlement or the month of filing, but no earlier than 2/87. Since the rolling 60-month TWP can begin no earlier than 2/87, months of work prior to 2/87 are disregarded. The TWP ends when 9 service months fall with a 60 consecutive month period ending no earlier than 1/92.

G. Counting the rolling 60-Month TWP months - When a disability beneficiary has worked his or her first 9 service months (the 9th service month occurring no earlier than 1/92 - otherwise the TWP was completed under the old rules), count back 60 consecutive months to see if the 9 service months were completed in that 60-month period. If not, the service months that fall before the 60-month period are disregarded, the service months that fall within the 60-month period are counted, and the TWP

continues. Each time thereafter that a service month is used, count to determine if 9 service months have been completed. When 9 have been completed, count back 60 consecutive months from the 9th service month to determine whether the 9 months were completed within 60 months. When 9 service months are identified within a 60-month period, the TWP has been completed. Some examples of counting the rolling 60-month TWP months are as follows:

EXAMPLE 1 - In February 2014, a disabled employee annuitant reports that he returned to work in November 2013, continues to work, and earns $770 per month. Review of the file reveals that the annuitant previously worked for two months in 2011. Since the annuitant has less than 9 service months as of January 2014, he is entitled to the rolling 60-month provisions. A TWP diary call-up is established for May 2014 in anticipation of the completion of the 9th TWP service month. If the annuitant works through May 2014, he completes 9 TWP months as of May 2014 (2 months were completed in 2011, 2 months completed in 2013 and 5 months completed in 2014). The TWP ending date would be May 2014. Counting 60 months back from May 2014 reveals that the rolling 60-month TWP begins June 2010. Since the 9 months are completed within the 60 consecutive month period, the TWP is completed.

EXAMPLE 2 - In February 1992, a disabled child reports that he returned to work in August 1991, stopped work in February 1992, and earned $800 per month. Review of the file reveals that he previously work for 2 months in February and March of 1987. Since he completed less than 9 months of trial work under the old TWP provisions as of January 1992, he is entitled to the rolling 60-month TWP provisions. The 9th TWP is completed in February 1992. Counting back 60 months reveals that the beginning date of that 60-month period is March 1987. Counting the service months within the period March 1987 - February 1992, we find that this disabled child only has 8 service months (March 1987 and August 1991 thru February 1992). Therefore in this case, the TWP has not been completed. The service month February 1987 is not counted under the rolling 60-month TWP provisions.

EXAMPLE 3 - In February 1992, a disabled widow report that she started work in July 1991, continues to work and earns $800 per month. Review of the file reveals that the disabled widow previously worked from July 1990 through October 1990 earning $250 per month. Since the disabled widow completed 9 TWP service months prior to January 1992 (July 1990 through October 1990 and July 1991 through November 1991), the rolling 60 month TWP provisions do not apply and the TWP ends November 1991.

EXAMPLE 4 - In February 1992, a disabled employee annuitant reports that he returned to work in September 1991, is continuing to work, and

earns $250 per month. A review of the folder reveals that this is a subsequent period of entitlement prior to January 1992. It is determined that the annuitant's most recent work activity beginning in September 1991 is below SGA; therefore, disability continues September 1991 on. Because the annuitant's subsequent period of entitlement continues through January 1992, he is entitled to a TWP under the new provisions. A TWP diary call-up is established for May 1992 in anticipation of the completion of the 9th TWP service month.

EXAMPLE 5 - In March 2015, disabled employee annuitant reports that he returned to work November 2014, continues to work, and earns $780 per month.

A review of the folder reveals that this annuitant is in a subsequent period of entitlement. A counting disability review determines that the disability has ceased due to SGA. Since the work was SGA as of January 2014, or earlier, this annuitant is not entitled to TWP and a disability cessation applies.

10.5.6 The Re-entitlement Period

A. General

1. The re-entitlement period is an addition period after the nine months of trial work during which the annuitant may continue to test his or her ability to work if he or she has a disabling impairment(s).

1a. Effective 1/92 the re-entitlement period (EPE) begins the month after the 9th service month completed within 60 consecutive months.

2. The disability annuity of an employee, child, or widow(er) will not be paid for -

   (i) Any month, after the third month, in this period in which the annuitant does substantial gainful activity; or

   (ii) Any month in this period in which the annuitant works for an employer covered by the Railroad Retirement Act.

3. The disability annuitant of an employee will not be paid for any month in this period in which the employee annuitant earns more than the current monthly disability earnings limit (refer to the chart in FOM1 1125.5.2 for the monthly and annual earnings limits).

4. If the disability annuity of any annuitant is suspended because of work during the trial work period or re-entitlement period, and the disability annuitant discontinues that work before the end of either period, the disability annuity may be reinstated again without a new application or a new determination of disability.

B. When the re-entitlement period begins and ends - The re-entitlement period begins with the first month following completion of nine months of trial work but cannot begin earlier than December 1, 1980. Effective January 1992, the re-entitlement period (EPE) begins the month after the 9th service month completed within 60 consecutive months. It ends with whichever is earlier:

1. The month before the first month in which the annuitant's impairment(s) no longer exists or is not medically disabling; or

2. The month before the first month of SGA earnings after the 36th month following the TWP.

If the annuitant employee does not perform any SGA after the 36-month period, the extended period of eligibility continues indefinitely and payment continues if all other eligibility factors are met.

NOTE: If an employee is considered not disabled due to SGA after the TWP, benefits are then placed in suspense for the months of earnings over the current monthly disability earnings limit after deduction of disability related work expenses and reinstated for months with earnings less than the current monthly disability earnings limit during the remaining months of the 36-month period.

Reinstatement of payments can occur only within 37 months following the 9th month of the TWP. If the individual's work attempt does not end until after 37 months following the TWP, he/she would have engaged in SGA in the 37th month and his/her re-entitlement period would have ended.

EXAMPLE: John Smith completes the TWP in December 1987. He was working at an SGA level in December 1987. His re-entitlement period began January 1, 1988 and he continued to perform SGA in each of the first thirty-six consecutive months of the re-entitlement period and each month thereafter. His re-entitlement period ends December 31, 1990 the thirty-sixth month after completion of the TWP.

The old (15 month re-entitlement period) rule still applies if we are processing a retroactive SGA cessation, and:

a. the first month of the extended period of eligibility (EPE is October 1986, or earlier (i.e., the 15th month of the EPE is December 1987, or earlier), and

b. no benefits are payable after December 1987 due to SGA.

10.6 Notices

10.6.1 Content Of Termination Notice

When it has been determined that entitlement to an annuity has ended because of disability cessation, a written notice of the decision to terminate must be released to the annuitant or representative payee within 30 days of the termination decision. This must allow the annuitant a specified period (always a minimum of 30 calendar days) to respond to our notice before the termination is processed.

Each notice must contain the following:

- The date of cessation of disability.
- A detailed summary of the evidence and rationale upon which the decision is based.
- The effective dates of annuity, freeze and/or Medicare termination.
- If applicable, an explanation that any annuity payments received for months after the effective date of termination are erroneous and must be repaid, unless conditions for waiver are met, and will be the subject of a future notice.
- An opportunity for the annuitant or representative payee to submit evidence within a specified period to support continuance of disability before the decision to terminate becomes final.
- The stipulation that, if the annuitant does not respond in writing within the specified period, that the decision to terminate would become final.
- The right to appeal the decision after it becomes final (do not use AB-25 back).

NOTE: In many cases payments will be in suspense at the cessation effective date, so overpayments usually will not exist. However, in the event that there is an overpayment, the folder will be released to the adjudication unit after termination action has been completed for preparation of an overpayment notice according to current procedure.

10.6.2 Special Situations

A. Death of Annuitant Causes Termination

No written notice is needed with an annuitant's entitlement to an annuity ends because of his death. In addition, a written notice of the decision to terminate a spouse's annuity is not required when the employee dies and SSA has jurisdiction of survivor benefits.

B. Coordination of Joint Freeze Decisions with SSA

Take the following action when coordinating a termination decision with the Social Security Administration.

Joint Freeze Cases - The Board is responsible for development and arriving at a decision. The decision is then sent to SSA for coordination. If SSA indicates they do not wish to handle the case at this time, we will finalize our decision and send SSA a copy of the decision and the evidence on which it was based. Use Form G-26F for transmitting this material.

SSA-415 Case - If a case is called-up for review and the decision was based on SSA's evidence, we must ask SSA if their review has been done and if so, to send a copy of their decision. I f no review as been conducted by SSA, we will develop and make our own decision. Once the decision is finalized, we will send SSA a copy of the decision and the evidence on which it was based.

C. Competing Claimants or Third Party Information Causes Termination

When an individual other than the annuitant or his payee submits information which would cause termination of an annuity, have the field attempt to verify the information from the annuitant or payee directly. If the field is able to verify the information, prepare a termination FAST transaction and G-811 if applicable, to stop the next check and release a letter explaining the termination. That letter should be released within 30 days of the termination decision and must have AB-25 appeals backing. If the field is unable to obtain the information from the annuitant or payee directly, handle the case in the manner described below.

Whenever there are competing claimants or third party informants who submit information which would cause the termination of an annuity, a written notice of the decision to terminate must be sent at least 30 days before the annuity is terminated. This 30 day notice should allow the annuitant or representative payee 30 calendar days to respond to our letter before a FAST transaction is processed.

The advance notice should inform the annuitant or representative payee of:

- The reasons for the annuity termination; AND
- The fact that the annuitant or representative payee has 30 days to submit any evidence or writing which he wants the Board to consider in a review; AND
- The fact that payment of the annuity will either cease or a decision to continue payment shall be made after the Board considers any evidence or writing submitted within the 30 day period and if no evidence is received within this time, the annuity will be terminated as scheduled.

This initial notice should not have AB-25 appeals backing. See 10.6.5 below for action to be taken when any significant evidence or writing is submitted as a result of this notice. See 10.6.4 below for action to be taken when no significant evidence or writing is submitted.

10.6.3 Maintenance Of The Folder After Notice Is Released

The DPS examiner will prepare an advance-dated G-811, if appropriate. This form, together with both copies of G-325a, will be held with the folder in DPS. A call-up will be set to allow any evidence the annuitant may have submitted to match the folder UP TO 15 DAYS after the specified period has ended.

10.6.4 Annuitant Does Not Submit Evidence Within Specified Period

If no written request for review or additional evidence is received at the expiration of the call-up, the DPS examiner will process the FAST transaction and release the G-325a and G-811 as scheduled.

10.6.5 Request For Reconsideration Of A Decision To Terminate

When evidence or writing is submitted to the Board as a response to the notice to terminate, take action as described below:

A. Request for Reconsideration Received Before the Payment Termination Date but Reconsideration Determination not Made by Payment Termination Date

If a request for reconsideration is timely received, but a reconsideration determination has not been made by the payment termination date, the following action should be taken:

Terminate the annuity the day after the payment termination date using FAST termination code 08 or 20. No letter to the annuitant is necessary at

this time because the initial cessation letter advised the annuitant that his or her annuity would be terminated if a favorable determination is not made by the payment termination date.

If the reconsideration determination when rendered is favorable, the annuity should be reinstated following the procedure in RCM 8.6 for reinstating an annuity. If the reconsideration is unfavorable, the annuitant should be sent a letter advising of the decision. Appeals code paragraph 189 should be used in the letter.

B. <u>Request for Reconsideration Received After the Payment Termination Date</u>

Payments should be terminated the day after the payment termination date.

If an acceptable request for reconsideration is received after the payment termination date and payments have not been terminated, payments should be terminated pending the reconsideration determination.

If an acceptable request for reconsideration is received after payments have been terminated, <u>do not</u> reinstate payments unless the reconsideration determination, when rendered, is favorable.

If the reconsideration determination is favorable, reinstate the annuity following the procedure for reinstating an annuity. If the reconsideration determination is unfavorable, the annuitant should be sent a letter advising of the decision. Appeals code paragraph 189 should be used in the letter. Also, if the annuity was not timely terminated, take appropriate action regarding the overpayment.

NOTE: The Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460) enacted on October 9, 1984, does provide specified beneficiaries with the option to elect to continue receiving disability benefits and Medicare coverage, if applicable, pending a reconsideration and/or a hearing decision before an Administrative Law Judge (ALJ) on a medical cessation determination. Any continued benefits paid are overpayments subject to recovery if the medical decision is upheld on reconsideration or appeal.

Unlike the Social Security Administration, we cannot allow payments to continue while a reconsideration determination is pending because the Railroad Retirement Act does not have a comparable provision. Payments under the Railroad Retirement Act must be terminated the day after the payment termination date, and subsequently reinstated if the reconsideration determination is favorable.

10.6.6 Notifying DQRRB's Of Termination When TWP, Re-entitlement Period And Extended Medicare Provisions Apply

DPS will prepare an RR and/or SS Act disability termination notice at the time Form G-325a is prepared, recording SS Act disability cessation in the manner outlined in this chapter. When the DQRR's disability ceased because of SGA, DPS will include information in the cessation notice about the TWP, Re-entitlement Period and/or the extended Medicare coverage and its ending date if it is before age 65.

Special language about the reason for adjustment must be included in the adjustment notices when one of these special rules apply. The following are samples of language that could be used to explain these provisions.

A. Inserts for items B, C, D and E

1: the month and year SS Act disability CEASED (item 7b of G-325a)

2: the last month and year of extended Medicare coverage

3: the thirty-sixth month and year of the re-entitlement period

4: the last month and year in the re-entitlement period

5: months after the 3rd month in the re-entitlement period, through the 36th month in the re-entitlement period, in which SGA was performed

6: the first month after the 3rd month in the re-entitlement period but before the 36th month in which SGA ceases to be performed

7: the first month after the 3rd month in the re-entitlement period in which SGA was performed

8: date of notice by DPS that SS Act disability ceased

B. Sample Language for Use by DPS in SS Act Cessation Notices to DQRRB's Not Entitled to a Re-entitlement Period

"Your disability Medicare coverage will continue for up to 24 months after 1 _____ unless your condition improves. This means that your coverage will end after 2 _____. You will be billed every 3 months for your medical insurance premiums; please pay them promptly to avoid duplicate billing or loss of coverage for failure to pay on time."

C. Sample Language for Use by DPS in SS Act Cessation Notices to DQRR's Entitled to a Re-entitlement Period

1. The Re-entitlement Period has not Expired

    a) SGA Causes Suspension During the Re-entitlement Period

    "If your condition forces (you) (_______) to stop or limit working through 3 _______, your annuity may be paid for those months through 3 _______ in which this work stopped or was reduced below a certain level. Notify the nearest district office of the Board if this occurs.

    In addition (your) (_______'s) coverage will continue for up to 24 additional months after 4 _______, unless (your)(his)(her) condition improves. This means that Medicare coverage will end after 2 _______.

    b) No SGA After 3rd Month of Reentitlement Period Prevents Suspension

    "Although (your) (_______'s) disability under the SS Act ceased because of work on 1 _______, an increased amount in your annuity may still be paid through 4 _______, since (you are)(he is)(she is) not working. If (you begin)(he begins)(she begins) working again, notify the nearest district office of the Board.

    In addition, (your) (_______'s) disability Medicare coverage may continue unless (your)(his)(her) condition improves or (you begin)(he begins)(she begins) working after 3 _______."

2. The Re-entitlement Period has Expired

    a) SGA After 3rd Month of Re-entitlement Period

    "Although (you) SS Act disability ceased on 1 _______, because of work, (your)(his)(her) disability Medicare coverage will continue until 2 ______ unless (your)(his)(her) condition improves. You will receive a separate notice if we owe you money of if you are overpaid."

    b) No SGA After 3rd Month of Re-entitlement Period

    "Although (your) (_______'s) SS Act disability ceased on 1 ______, because of work, an increased amount in your annuity was still payable through 3 _______ since (you)(he)(she) had not worked. This amount is no longer payable. You will receive a separate notice if we owe you money or if you are overpaid.

However, (your)(his)(her) disability Medicare coverage will continue through 2 _______, unless (your)(his)(her) condition improves."

3. Miscellaneous IRWE Sample Language For Use by DPS

a) Allow IRWE Insufficient to Reduce Earnings Below SGA Level

"Although (you)(_______) reported impairment related work expenses which we allowed, they were not enough to reduce (your) (_______'s) earnings below the monthly amount usually considered to be substantial gainful work."

b) "Although (you)(_______) reported impairment related work expenses, we cannot allow them because they do not meet the definition of impairment related work expenses."

10.7 Medicare

10.7.1 Termination Of SMI Coverage

A. General Rule - When an annuitant recovers from disability, SMI coverage ends with the later of:

The last month of entitlement to a monthly disability benefit, or

The month after the month the beneficiary is notified in writing of the termination of monthly disability benefits.

B. Extended Medicare Coverage - Beginning December 1, 1980, Medicare coverage may continue for up to 24 additional months but only if disability is terminated solely due to SGA. This provision is part of Public Law 96-265, the SS Disability Amendments of 1980.

10.7.2 How To Apply Extended Medicare Coverage

If the annuitant is not entitled to a TWP, the extended Medicare coverage begins the first month after the disability benefit entitlement ends due to SGA.

If the annuitant is entitled to a re-entitlement period, the extended Medicare coverage begins the first month after the end of the re-entitlement period. (See 10.5.5) In this case, Medicare coverage would run 48 months after the beneficiary returned to SGA. That is the 9-month TWP plus the 15-month re-entitlement period plus the 24 months of extended coverage.

NOTE: If medical recovery occurs at any point during the TWP or Re-entitlement period, Medicare coverage ceases according to the general rule in DCM 10.7.1(A).

10.7.3 Who Is Eligible For Extended Medicare Coverage

All railroad retirement or survivor disability Medicare beneficiaries whose disability terminates under SS Act rules (DQRRB's) because of SGA are entitled.

10.7.4 Mechanical Termination Of Medicare Coverage

The following action is required to ensure that Medicare will terminate mechanically at the end of the applicable extension period:

1) If CHICO shows a disability annuity in current pay status or suspense

Prepare Form G-96, enter termination code "20" in item 7. Enter the last month of disability annuity entitlement in item 12.

Reminder - When terminating a suspended annuity, do not enter an "X" in item 10.

2) If CHICO shows annuity terminated, but either no termination effective date is shown, or the termination effective date is earlier than the one presently on record

Prepare Form G-96 (same as above). Enter termination code "20" in item 7 and last month of disability annuity entitlement in item 12.

3) If CHICO shows annuity terminated and the termination effective date in the record is correct or earlier than the correct effective date

Prepare Form G-811. Enter activity code "51" in item 3. In item 8, enter event code "9" and the last month of disability annuity entitlement.

4) If no record on CHICO

Prepare Form G-811. Enter activity code "51" in item 3. In item 8, enter event code "9" and the last month of disability annuity entitlement.

5) If entitlement of a DQRRB annuitant terminates after the re-entitlement period due to SGA

Prepare Form G-811. Enter activity code "51" in item 3. In item 8, enter event code "9" and the last month of the re-entitlement period.

Following the action created by G-96 or G-811, the MIRTEL system will reflect a future HI/SMI termination date effective the 25th month after the last month f the

re-entitlement period or disability annuity entitlement, and a term code "3". The record status will remain unchanged until the actual termination action processes. At the scheduled time of termination, the following action will occur:

If the beneficiary is an employee or spouse now over age 65 entitlement to Medicare based on the attainment of age 65 will override the scheduled termination. No manual action is necessary in these cases. The record will be mechanically cleared of the termination and entitlement will continue uninterrupted.

If the beneficiary is an employee or spouse not yet 65 or any other type beneficiary (widow(er), child, etc., regardless of age) Medicare will be terminated effective with the 25th month after "the last month of the re-entitlement period or disability annuity entitlement. The record status will become "90". The HI/SMI termination code shown would still be "3". A folder notice will be prepared showing the termination processing action completed. The reason for termination shown on the folder notice will be "cess of DIB".

If for any reason, it is determined that a termination action should not be taken when the record has been set up to do so, sent the case to MPS to remove the scheduled termination from the record.

If a beneficiary scheduled for Medicare termination becomes entitled to an annuity, Medicare premiums will automatically be deducted mechanically. Since the reinstated annuity is possibly not based on disability (e.g., a retirement annuity based on the 60/30 provisions), a referral will be produced for MPS:

"Alert - Annuity Adjusted During Medicare Extension Period."

MPS will determine whether or not Medicare deductions should continue.

10.8 Disability Related Work Expenses

10.8.1 Overview

The SS Act provides that the cost of what a person needs in order to work can be deducted from the earnings used to determine whether a disability annuitant has performed substantial gainful employment. The cost of these items and service, called impairment-related work expenses (IRWE), can be deducted even if the services and items are also needed for non-work activities.

Effective January 1, 1989, the cost of these same items and services can also be deducted from a disability annuitant's earnings which are used to determined whether work deductions must be imposed. Prior to the 1988 Amendments, these expenses were not deductible for this purpose. When these expenses are deducted for work deduction purposes, they are called disability related work expenses (DRWE).

These expenses which include attendant care, medical devices, equipment, prosthesis, or similar items or services are exactly the same as impairment related work expenses (DCM 10.4.6) and are subject to the same limitations.

10.8.2 How To Develop DRWE

Annuitants with DRWE and earnings over the current monthly disability earnings limit are being instructed to contact field offices in order to establish DRWE. Refer field personnel to FOM 310.55.1 which contains instructions on how to develop DRWE and IRWE.

10.8.3 Handling Of DRWE

DPS will use the guidelines in DCM 10.4.6(c) about IRWE to determine the amount deductible for DRWE. Worksheets in Appendix E may be used for both IRWE and DRWE.

11.1 Scope of Chapter

This part of the DCM contains instructions for completing forms used by the Disability Benefits Division (DBD). The forms in this chapter are arranged in alphabetical-numerical order. Some of the disability forms referred to in this DCM chapter have hyperlinks to FOM1 where the actual forms are fully explained. This is because some forms are handled by work units other than DBD such as Field Service (FS). The explanations for these forms are in FOM1. The forms used by DBD are explained in detail in this DCM chapter.

Generally the instructions for a specific form are broken down into the following categories:

- Use: A brief statement of the form's purpose and when it is used.
- Completion: Item by item instructions for normal completion of the form.
- Special Situations: Instructions for completing the form in infrequent or complex situations.
- Disposition: Instructions for disposing of the form, any copies of the form, and the folder for the form.

11.1A "AA" Forms

AA-1D Application For Determination of Employee Disability

Use

An employee uses Form AA-1D, *Application For Determination of Employee's Disability* as a supplement to Form AA-1, *Application for Employee Annuity* when applying for a disability annuity under the Railroad Retirement Act, or a period of disability (disability freeze or DF) under the Social Security Act, or to establish disability for Medicare entitlement.

Completion

See FOM1 1710 AA-1D for more information on how Form AA-1D should be completed.

Adjudication

Disability Benefits Division (DBD) examiners must consider and compare the information provided on the AA-1D to all relevant evidence sources in file when making a disability decision. If there are material inconsistencies on the AA-1D that may impact the outcome of the decision, the disability examiner must resolve the inconsistencies. If explanations are vague or incomplete, the disability examiner must develop for more information.

The disability examiner should pay particular attention to changes in job duties and non-work activities, educational achievement, special training, as well as the applicant's description of how the condition has affected his/her daily activities. Changes in job duties include, but are not limited to, hours worked and how the job was performed. This consideration also applies to forms as part of the adjudication process. See DCM 3.4.301 and 3.4.302 for more information.

NOTE: If any suspicious patterns or inconsistencies are noted, such as use of technical/descriptive terms or copied dialogue, that cannot be resolved while examining the disability claim, the disability examiner should notify his/her lead examiner or supervisor as soon as possible. See DCM 8.8 for more information.

Section 1, *General Instructions*, contains the instructions and information that the applicant must read prior to completing the form.

Section 2, *Identifying Information*, will prefill from RRAILS.

Section 3, *Information About Your Medical Condition*, contains information about the applicant's medical condition. These items are not purely medical in nature, but can assist in the determination as to whether a physical or mental condition exists that prevents the performance of work. The disability examiners should consider the factors relevant to assessing the nature, intensity, persistence, and the limiting effects of the individual's symptoms. In addition, the disability examiner should:

- Consider if the primary and secondary conditions are consistent with and supported by the medical evidence in file:

  For example: Due to alleged knee pain, an individual alleges extreme symptoms that limit his or her ability to stand and walk; however, the medical evidence does not contain objective medical evidence of a medically determinable knee impairment from an acceptable medical source that could reasonably be expected to produce the alleged symptoms.

- Consider dates when the condition began to affect the individual's ability to perform work and whether the medical evidence sufficiently show that the disability began before the dates when the individual states he/she could no longer perform work. This may include any work attempts. See DCM 3.4.9, DCM 3.4.200, and DCM 10.5.3 for more information;

- Check if there is an Activities of Daily Living (ADL) in file if psychological or neurological impairments are listed. If an ADL is not in file, contact the field office to develop one.

Section 4, *Information About Your Medical Care*, contains information about the applicant's medical care, examinations, treatment, and testing. The disability examiner should check to see that medical evidence was requested from all

hospitals, clinics, and treating physicians listed in this section. In addition, the disability examiner should:

- Consider if the claimant documented recent or future surgeries as this may indicate a persistence and intensity of symptoms. Evidence for 3 months post-operative may be necessary;
- Review all medical sources listed. Determine if medical evidence has been received from the source and is sufficient for a determination. If all source medical has not been received and the medical evidence in file is not sufficient to make a determination, contact the field office to develop the additional medical sources;
- In Occupational cases where the individual claims disqualification by his/her railroad employer, note if there is a Form G-3EMP, *Report of Medical Condition by Employers,* or similar notice in file. If so, it is sufficient to make a rating with the medical evidence in file that confirms the impairment. If Form G-3EMP is not in file, contact the field office to develop for the form. See DCM 13.7 and DCM 4.10.1 for more information;
- Identify any claimed restrictions by a medical doctor;
- Review the type and dosage of all prescribed medications listed and consider their effects on the individual;
- Consider treatment, other than medication, that the individual receives or has received for relief of pain or other symptoms; and
- Consider any indication of non-compliance and the reasons given for non-compliance.

Section 5, *Information About Your Education And Training*, asks the applicant to enter the highest grade of school completed, and indicate if he/she is currently attending any technical, specialized, vocational schools to include online courses, or receiving any educational services, etc. The applicant's education will be considered with the residual functional capacity, age, and work experience at step 5 of the sequential evaluation. See DCM 3.6.1 for more information. When considering education and recent vocational training, the disability examiner should consider education level, illiteracy, as well as the ability to communicate in English. See DCM 5.2 and DCM 5.4 for more information. The disability examiner should also consider:

- If the education provides for direct entry into skilled or semiskilled work (whether skills can transfer to other work);

  NOTE: The shorter the period of education and the lesser the skill of the occupation it prepared the claimant for, the shorter time lapse we should consider that the education could provide for direct entry into that occupation.

The longer the period of education and the higher the skill of the occupation it prepared the claimant for, the longer time lapse we should consider that the education could provide for direct entry into that occupation.

Example: An applicant who completed a registered nurse bachelor's degree program two years ago would be more likely to have an education that provided for direct entry than a claimant who completed a six-month travel agent training course two years ago.

- The recency of education and the amount time that has passed between the completion of the education and the date of the adjudication; and
- When direct entry into skilled or semiskilled work is material to the disability determination or not.

NOTE: If any recent education is listed and direct entry into skilled or semiskilled work is material to the case, the disability examiner must develop and resolve any direct entry issues before making a decision. All findings must be documented in the rationale. Remember to cite the corresponding specific skilled or semiskilled occupation.

Rationale documentation example: 58-year-old applicant with a high school education completed an 18 month program for medical coding one year prior to filing and received a medical record coder certification. The RFC permits a full range of light work. The applicant retains the ability to perform light work and is denied by medical vocational rule 202.05. The applicant retains the ability to perform work as a medical record coder.

Section 6, *Information About Your Daily Activities*, asks the applicant about his/her daily activities, volunteer work, and social or recreational activities. This description from the applicant is an account of his/her current daily activities and how they have changed due to the individual's medical condition. During adjudication, the disability examiner should consider:

- If changes in the activities indicated are due to the applicant's medical condition;
- If the activities precipitate or aggravate the symptoms. For example, the applicant indicates that the activity cause them to be fatigued or suffer constant pain;
- If limitations in the daily activities are consistent with alleged impairment. For example, the applicant alleges an injured rotator cuff, but claims ADL limitations in walking; or the applicant lists playing racquet ball or golfing as a recreational activity, but alleges ADL limitations in standing or walking; and

- If reduced or structured activities minimize the symptoms.

<u>Section 7, *Information About Your Work And Earnings*</u>, asks the applicant for information on current work and earnings in addition to the previous year and next 12 months. The disability examiner should compare the information given with the applicant's date last work. If earnings are reported after the applicant's date last work, reconcile the earnings by contacting the employee and/or employer and reviewing the DEQY, SEQY or The Work Number. The disability examiner should also closely review the reported earnings and note:

- Whether there have been large earnings up until the time of the alleged onset date of disability, which may indicate a sudden traumatic injury;
- Cases where chronic impairments lasting over extended periods of time exist, but there is no indication that the applicant lost time or earnings during this chronic disease period;
- If self-employment is Substantial Gainful Activity. If so, use the three earnings test, NOT just gross/net earnings. See DCM 10.4.5 for more information; and
- If an AA-4, *Self-Employment Questionnaire* and/or G-252, *Self-Employment/Corporate Officer Work and Earnings Monitoring* forms are in file in cases where self-employment is indicated. If forms are not in file, develop with field service, if needed. See DCM 8.5.14 for more information.

<u>Section 8, *General Information*</u>, asks the applicant about Self-Employment, Worker's Compensation, Public Disability Benefits, Social Security Benefits, and Criminal Offenses. Examiners should consider statements made in connection with claims for other types of disability, such as private insurance benefits and develop for medical evidence from these sources, if needed.

NOTE: If the applicant is filing an AA-1 at the same time as filing the AA-1D, questions about "Self-Employment", "Worker's Compensation", "Public Disability Benefits", and "Social Security Benefits" will be skipped on the AA-1D. The disability examiner must review the AA-1 to determine if the applicant reported self-employment and verify that an AA-4 is in file. If an AA-4 form is not in file, ask the field office to develop for the form. The disability examiner should also review the AA-4 to determine if the applicant indicated that he/she was a corporate officer or owner/operator. If the applicant indicated corporate officer or owner/operator, verify that a form G-252 is in file. If the G-252 form is not in file, develop for the form. See DCM 8.5.14 for more information.

If the applicant indicates on the AA-1 that he/she has filed or plans to file an application for social security benefits, the disability examiner should check the Social Security Administration's (SSA) queries to determine if the applicant is receiving any type of SSA benefits, including SSI, and release Form RR-5, *Request for SSA Medical Evidence*. See DCM 11.4, RR-5 for more information.

If the applicant has indicated that he/she has been imprisoned or given a sentence of confinement due to a conviction for a criminal offense, and answered 'Yes' that his/her disability is related to confinement, then disability examiner must follow the felony conviction provisions in DCM 6.4.5 in considering conditions that were worsened or newly acquired during the commission of a criminal offense and/or confinement.

Reminder: In an effort to control, prevent, and deter fraud, disability examiners must become familiar with the best practices to consider when examining disability claims that show particular elements outlined in DCM 8.8.2. Examiners must note and attempt to resolve any responses that appear vague, generic, not specific, or otherwise suspicious or inconsistent when adjudicating claims. The presence of any one element may not necessarily be an indication of fraud, but should serve as a flag to the disability examiner that greater care is needed in adjudicating the disability claim.

Section 9, *Remarks*, is used for the continuation of answers to other items. Disability examiners should review for additional information that may be relevant to the disability determination.

Section 10, *Relinquishment Of Rights*, contains information advising that disability applicants are not required to relinquish rights to return to the his/her railroad employer prior to full retirement age.

Section 11, *Certification*, asks the applicant if an attorney or non-family member assisted him/her in completing the application and whether the applicant paid a fee for that assistance. The disability examiner should verify that a USTAR work item for *Facilitator Physician Tracking* (PPT-FPT**)** has been created. If a USTAR work item has not been completed notify the supervisor or lead. The disability examiner should consider if additional interview of the applicant is needed. See DCM 8.7.2 for more information.

If the applicant indicates that he/she has or will have a guardian sign the application, check to see there is a Form AA-5, *Application for Substitution of Payee* in file. If no form is in file, have the FS develop for the form. See FOM1 1710 AA-5 for more information.

NOTE: In cases where the examiner cannot reach or is not getting a response from the applicant, please note if the applicant has a guardian/representative signing the form for the applicant, before denying a claim for failure to comply.

Section 12, *How To Return Your Application*, explains how to return the application to the RRB field office.

Disposition

The disability examiner will use information collected on the AA-1D, along with other relevant information in file, to determine how the applicant functions on a day-to-day basis and make a disability determination. If the outcome of the decision is impacted by material discrepancies found on the AA-1D, an explanation as to how the conflicting information was resolved should be indicated in D-Brief. See DCM 12.5 for information on D-Brief. The form should be imaged.

Receipt For Your Claim

The ***Receipt For Your Claim*** page of the Form AA-1D is detached and given to the applicant when the claim is officially filed. The text of the detached portion is appropriate only if a completed application has been received. FS will only date and release this receipt for an initial disability retirement claim after the employee's Form AA-1 is received.

11.2 "G" Forms

G-3EMP, Report of Medical Condition By Employer

See FOM1 1720, G-EMP.

G-26F, Disability Coordination Material

Use

Disability examiners use the Form G-26F when transmitting documents to SSA. The form should be attached on top of all medical and non-medical documents being forwarded to SSA.

Access

The form can be found on RRAILS.

Completion

Complete as follows:

Item	Entry
RR Claim Number	Enter the railroad claim number of the applicant
RR Employee's SS No.	Enter the RR employee's social security number

Wage Earner's SS No.	Enter the social security number of the person whose wage record the applicant is filing under at SSA
RR Employee's Name	Enter the name of the railroad employee
Wage Earner's Name	Enter the name of the person whose wage record the applicant is filing under at SSA.
Disabled Person's Name and Date of Birth	Enter the name of the disabled applicant and that person's date of birth
Remarks	Enter any information that is pertinent to this transmittal

Disposition

1. Email the G-26F document to SSA. For instructions on scanning and sending the form by email to SSA, click here How To Scan and Email Documents .

2. Send the G-26F document to IMAGING.

G-26t (02-15) - DPS Route Slip

Use

Form G-26t is a white color form and is used by disability examiners to route folders in the Disability Post Section (DPS) of DBD. This form is attached to a claim folder or folder packet. This is a stocked form and is not in RRAILS. For a copy of this form, contact DBD.

Completion

The following will describe when and how the items should be completed:

ITEM	ENTRY AND WHEN USED
"Medical Consultant"	Enter an "X" in this box if the folder is being forwarded to the medical consultant's office. Check the "Physical" and/or "Mental" box as appropriate. Also, fill in the filing date of the disability application.

"Single Freeze"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a single freeze disability determination.
"Dual Freeze"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a dual freeze disability determination.
"Widow(er)"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a widow(er) disability determination.
"Child"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a child disability determination.
"Continuance/Cessation"	Enter and "X" in this box when the folder is being referred to the medical consultant for a continuing disability review determination.
"Previously reviewed by Dr."	Enter an "X" in this box when the folder is being referred to the medical consultant for a reconsideration disability determination and the case was previously reviewed by a medical consultant. Also, enter the name of the doctor who previously reviewed the case.
"Additional M/E requested by Dr.“	Enter an "X" in this box when the folder is being referred to the medical consultant and additional medical evidence was obtained per a medical consultant. Enter the name of the medical consultant who requested the additional medical evidence.
"Reconsideration"	Enter and "X" in this box when the folder is being referred to the medical consultant and the case involves a reconsideration disability determination.
“OCC/T&P”	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves an Occupational or Total and Permanent (T&P) disability determination.
“Urgent”	Enter an "X" in this box when the folder is being referred to the medical consultant and the case

	involves a terminal illness (TERI), compassionate allowance (CAL), or other special handling.
“Reject Dr.”	Enter an "X" in this box when the folder is being referred back to the medical consultant because the examiner disagrees with the medical consultant. Enter the name of the medical consultant who previously reviewed the case.
"Routing Order"	Enter an "X" in this box when the folder is being routed to at least one of the destinations shown in the column under this heading.
"Review"	Enter a number in this box when the folder needs to be reviewed for a disability rating determination. The number should indicate the sequence of the routing order.
"Senior Examiner"	Enter a number in this box when you are routing the folder to a senior examiner. The number should indicate the sequence of the routing order. Also, enter in the Automated Folder Control System (AFCS) location of the senior examiner on the line.
"Claims Examiner"	Enter a number in this box when you are routing the folder to a disability rating examiner. The number should indicate the sequence of the routing order. Also, enter in the AFCS location of the rating examiner on the line.
"Supervisor, DBD"	Enter a number in this box when the folder is being routed to the disability post and CDR unit supervisor. The number should indicate the sequence of the routing order. Enter in the AFCS location of the supervisor on the line.
"Copying"	Enter a number in this box when routing the folder for copying. The number should indicate the sequence of the routing order. Use a paperclip or rubber band for the material to be copied.
“Medicare Section”	Enter a number in this box when the folder is being routed to the Medicare section. The number should indicate the sequence of the routing order.
"Recon Section"	Enter a number in this box when the folder is being routed to the Reconsideration (RECON) section.

	The number should indicate the sequence of the routing order.
"Claim Files"	Enter a number in this box when you are routing the folder to claim files. The number should indicate the sequence of the routing order.
"Other"	Enter a number in this box when you are routing the folder to a location not listed on this form. Enter the desired destination and the AFCS code of that location on the line. The number should indicate the sequence of the routing order.
"Dormant"	Enter an "X" in this box when the folder is being sent to the dormant cabinets. The call-up date and charge to entries must be completed.
"Call-up Date"	Enter the date that the folder should be called up from dormant. If the folder is returning to dormant, cross out the date on the top line and enter the new call-up date.
"Charge To"	Enter the Automated Folder Control System (AFCS) code you want the folder charged to after the dormant call-up date expires.
"Remarks"	Enter any remarks, instructions, comments, etc. you may have regarding this folder.
"Examiner Name Date"	Enter you name and the current date.

G-26t.1 (02-15) - DIS Route Slip

Use

Form G-26t.1 is a green color form and is used by disability examiners to route folders in the Disability Initial Section (DIS) of DBD. This form is attached to a claim folder or folder packet. This is a stocked form and is not in RRAILS. For a copy of this form, contact DBD.

Completion

The following will describe when and how the items should be completed:

ITEM	ENTRY AND WHEN USED

"Medical Consultant"	Enter an "X" in this box if the folder is being forwarded to the medical consultant's office. Check the "Physical" and/or "Mental" box as appropriate. Also, fill in the filing date of the disability application.
"OCC"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves an Occupational disability determination.
"T&P"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a Total and Permanent (T&P) disability determination.
"Widow(er)"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a widow(er) disability determination.
"Child"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a Child disability determination.
"Divorced or Remarried Widow"	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a Divorced or Remarried Widow disability determination.
"Additional M/E requested by Dr."	Enter an "X" in this box when the folder is being referred to the medical consultant and additional medical evidence was obtained per a medical consultant. Enter the name of the medical consultant who requested the additional medical evidence.
“Urgent”	Enter an "X" in this box when the folder is being referred to the medical consultant and the case involves a terminal illness (TERI), compassionate allowance (CAL), or other special handling.
“Reject Dr.”	Enter an "X" in this box when the folder is being referred back to the medical consultant because the examiner disagrees with the medical consultant. Enter the name of the medical consultant who previously reviewed the case.

"Routing Order"	Enter an "X" in this box when the folder is being routed to at least one of the destinations shown in the column under this heading.
"Review"	Enter a number in this box when the folder needs to be reviewed for a disability rating determination. The number should indicate the sequence of the routing order.
“Senior Examiner”	Enter a number in this box when you are routing the folder to a senior examiner. The number should indicate the sequence of the routing order. Also, enter the Automated Folder Control System (AFCS) location of the senior examiner on the line.
"Claims Examiner"	Enter a number in this box when you are routing the folder to a disability rating examiner. The number should indicate the sequence of the routing order. Also, enter the AFCS location of the rating examiner on the line.
“Supervisor, DBD”	Enter a number in this box when the folder is being routed to the disability initial unit supervisor. The number should indicate the sequence of the routing order. Enter in the AFCS location of the supervisor on the line.
“Physicians Tracking”	Enter a number in this box when the folder is being routed for physicians tracking. The number should indicate the sequence of the routing order.
“Copying”	Enter a number in this box when routing the folder for copying. The number should indicate the sequence of the routing order. Use a paperclip or rubber band for the material to be copied.
“Medicare Section”	Enter a number in this box when the folder is being routed to the Medicare section. The number should indicate the sequence of the routing order.
“Recon Section”	Enter a number in this box when the folder is being routed to the Reconsideration (RECON) section. The number should indicate the sequence of the routing order.

“Claim Files”	Enter a number in this box when you are routing the folder to claim files. The number should indicate the sequence of the routing order.
“Other”	Enter a number in this box when you are routing the folder to a location not listed on this form. Enter the desired destination and the AFCS code of that location on the line. The number should indicate the sequence of the routing order.
"Dormant"	Enter an "X" in this box when the folder is being sent to the dormant cabinets. The call-up date and charge to entries must be completed.
"Call-up Date"	Enter the date that the folder should be called up from dormant. If the folder is returning to dormant, cross out the date on the top line and enter the new call-up date.
"Charge To"	Enter the AFCS code you want the folder charged to after the dormant call-up date expires.
"Remarks"	Enter any remarks, instructions, comments, etc. you may have regarding this folder.
"Examiner Name Date"	Enter your name and the current date.

G-137, Medical Consultant Opinion

Use

This form is currently used by Disability and RECON examiners (PEMS Staff) to refer disability cases to the medical consultant for an opinion.

Access

The form is on RRAILS.

NOTE: In a case where a combined physical and mental RFC is requested, the examiner may either open the Form G-137 on RRAILS to type in *Physical and Mental* (alerting the medical consultant that two types of RFC’s are requested), or simply write in the words *Physical and Mental*. This is done in the top right hand margin of the Form G-137. If the form is opened on RRAILS it must be closed after any typed entry is made to preserve the form identification.

Completion

RRAILS pre-fills the claimant's Name,Examiner name, and Claim Number.The examiner enters the current date and after the claim number enters the applicable two-digit code. The two-digit code uses a series of alpha characters from A to Z to represent the month in which the Opinion is ordered and another series of alpha characters from A to H to represent the annuitant type (i.e., DBD commonly refers to this as the "suffix codes"). Use the following chart as a guide:

First Digit

If the initial order is within the month of	Use Code
January	A
February	B
March	C
April	D
May	E
June	F
July	G
August	H
September	I
October	J
November	K
December	L
If a secondary order is within the month of	Use Code
January	M
February	N
March	O
April	P
May	Q

June	R
July	S
August	T
September	U
October	V
November	W
December	X
If a third order is within a given month	Y
If a fourth or more order is within a given month	Z

Second Digit

If the Annuitant Type is	Use Code
Employee	A
Widow	B
Surviving Child	C
Retirement Child	D

Additional Code

If a fifth order is within a given month, use the original code for the initial order for that particular month for the first digit.

Use the following for the second digit:

If the Annuitant Type is	Use Code
Employee	E
Widow	F
Surviving Child	G
Retirement Child	H

The DBD clerk enters the Form G-137, *Medical Consultant Opinion,* into the Financial Management Integrated System (FMIS) and will verify that the pre-filled entries of NAME, Examiner Name, Claim Number and codes (i.e., suffix codes), and Date are correct, making any necessary adjustments.

Sections A and C are self-explanatory.

Section B - In section B, if an onset date is requested, usually the examiner will check two boxes. The first box checked will be for Severity Assessment & RFC. The second box checked will be Onset Date with an entry of the alleged onset date. This date will be the earliest date for which a medical evaluation is needed. In most instances, this will be the date in item 11 on the AA-1d, *Application for Determination of Employee's Disability*, or the date in item 12 of the AA-17b, *Application for Determination of Widow(er)s Disability*, or the date in item 12 of AA-19a, *Application for Determination of Child's Disability*. However, there may be situations where a different date would be appropriate, as decided by the examiner.

EXAMPLE 1: It may be possible to establish an unsuccessful work attempt prior to an actual date last worked. In this instance, a date earlier than claimed in items, 11 and item(s) 12 may be appropriate.

EXAMPLE 2: A child may allege disability from age 10, but the earliest medical evidence in file is from age 14. In this instance, a date later than that claimed may be appropriate since the later onset date would have no effect on the rate or beginning date of the annuity.

Section B of the G-137 is also used when the examiner must evaluate whether there has been significant medical improvement since the date of the last medical assessment. The examiner checks the box labeled Re-evaluation for Significant Medical Improvement. The medical consultant reviews all the medical submitted with the case and makes a determination on the G-137 SUP (citing the supporting medical records in Part II of the SUP). The medical consultant must state whether there has been 'significant medical improvement' (using the specific wording) or no medical improvement. The medical consultant may provide a Severity Assessment & RFC on the G-137 SUP and cite the supporting medical in Part II of the G-137 SUP. In cases where the Listing of Impairments is either met or equaled, no RFC will be provided in Part I. The Listing of Impairments will be identified in Part II, and the medical consultant provides the onset date of 'significant medical improvement' in Part II of the SUP.

Section D - In many cases the examiner may opt to leave this section blank, unless there is a need to highlight a specific piece of medical for review. The submission of the G-137 carries with it the implied request that all medical in the file is to be reviewed by the medical consultant. If the examiner opts to fill in this section, then the treating doctor's name and the date signed in Section 13 – Certification of any Form G-250, *Medical Assessment*, in the disability file may be entered.

Additionally, the examiner may enter any other treating doctor's RFC's in file by name and date signed. All references to the G-250 or other treating doctors must be signed by an acceptable medical source, such as the following:

- licensed physician,
- osteopath,
- psychiatrist,
- licensed optometrist,
- licensed or certified clinical psychologist,
- and persons authorized to send copies or summaries of medical records from a hospital, clinic, sanitarium, mental institution or health care facility.

Examples of unacceptable medical sources may be those individuals not licensed to practice medicine or surgery (i.e., nurse practitioners, physician assistants, naturopaths, chiropractors, audiologists, and certain therapists). Their reports will be made part of the file and used to support the acceptable medical records.

Section E – In this section, list the doctor's name and the date of each consultative examination or Specialist Consultative Examination (SCE) for which a separate RFC has been provided by the doctor. If there is no separate RFC and the doctor has included the RFC in the written narrative, the examiner may direct the medical consultant to 'see the narrative for the RFC'.

Adjudication

As stated in IB 17-20, *Reminder Concerning Adjudicating Medical Opinions*, once the G-137SUP, Medical Consultant Determination Worksheet, has been received back from the doctor providing the medical opinion, review it in its entirety to determine if it is acceptable. It is acceptable if the following conditions are met:

- all statements have been completed and descriptions are provided;
- all cited medical evidence is current (most current twelve months), supports the onset date and claimed impairment, and does not conflict with non-medical evidence;

  Example – EE alleges lumbar degenerative disc disease. A lumbar spine magnetic resonance imaging study (MRI) shows a lumbar fusion. Form AA-1D, *Application for Determination of Employee's Disability*, states difficulty walking with ongoing pain. A treating source exam from December 2015 shows decreased range of motion, straight leg raise positive, difficulty getting on/off exam table, and slow antalgic gait. A

specialized orthopedic consultative exam shows the same findings as the treating source exam of December 2015.

If the consultative medical opinion states that the EE is restricted to at least 2 hours of standing/walking, based on the MRI and treating source evidence, be sure the specialized consultative exam findings are also discussed and the objective findings from that report are listed.

- the referenced explanation is supported by the evidence, and is clear, legible and refers to the findings; and
- the medical opinion has been signed and dated on the appropriate form(s) by the consulting doctor.

When review has been completed, the DBD examiner must:

- indicate if the medical opinion is accepted or rejected in the “RRB Use Only” box; and
- sign and date the form.

Disposition

Step	Action
1	The examiner files Form G-137 on the right side of the folder on top of all other documents in file.
2	The examiner attaches a completed Route Slip to the front of the folder (G-26t white route slip for Post disability and RECON cases and G-26t.1 green route slip for Initial disability cases). If the medical opinion is being requested on an urgent basis, the examiner writes the word “URGENT” in the top margin of the G-137 and in the top margin of the route slip. The AFCS folder location charge is not changed at this time.
3	The disability and RECON examiners place the file in the designated pick up area in DBD for the DBD clerk. RECON examiners change the AFCS charge to DBD.
4	The DBD clerk picks up the case and charges the case to AFCS charge T0CE – Title DBD – Med Opin Contrtr (CEL) Offsite Vendor.

5	The DBD clerk will enter the form G-137 information into the Federal Management Integrated System (FMIS), verifying that the month and type suffix codes are correct. The DBD clerk will also enter the case information into an in-unit tracking system to verify release and return of the folder.
6	All files for the Med Opin Offsite Vendor are boxed and picked up by a courier. The same courier returns the completed disability cases usually within 3-4 business days with the G-137 and G-137 SUP (for physical evaluation cases only) filed inside each case. **NOTE**: In cases where the disability examiner has requested a combined psychological (mental) and physical evaluation or a singular psychological evaluation, additional forms may be included with the G-137 and G-137 SUP. The additional enclosed forms are the SSA-2506-BK, *Psychiatric Review Technique*, and the SSA-4734-F4-SUP, *Mental Residual Functional Capacity Assessment.* The psychological SSA forms are completed only by the consultative doctors. (See DCM 11.5 SSA Forms)
7	The DBD clerk verifies the return of the folder using the DBD in-unit tracking system and then passes the case on to the DBD examiner. RECON cases are either directly delivered to the RECON examiner or placed in the RECON bin in DBD for pick up by a RECON clerk.
8	The examiner reviews the form G-137 SUP received with the case and if acceptable pays for the medical opinion on the FMIS system. On page 4 of the G-137 SUP, box labeled *FOR RRB USE ONLY*, the examiner selects either box for *M/O Accepted or M/O Rejected*, and signs and dates in this box. The signature of the examiner and the date signed verify that the opinion was paid on FMIS. The FMIS screen showing set up of payment of the medical opinion is not filed in the folder. **NOTE:** There may be occasions when the examiner finds exception with the G-137 SUP and may need to return the case as a REJECT for additional review by the medical consultant.

G-137a, Medical Consultant Opinion – Continuation Sheet.

Use

This form is used by the medical consultant when completing the Form G-137 SUP. G-137a accompanies the G-137 SUP and functions as an extra page to the G-137 SUP if the medical consultant's comments extend beyond Part II on the SUP. On page 4 of the G-137 SUP the consultant will check the box labeled

“Check if additional pages are included” and attach the G-137a with all additional comments. (As such, this is an optional use form and only used when needed).

Access

The form will be available on RRAILS. The medical consultant does not have access to RRAILS to obtain the G-137 SUP and G-137a. However, the consultant is provided with the current WORD versions of the G-137 SUP and G-137a for their use.

Completion

Completion of the form is self-explanatory for the medical consultant. The consultant must sign and date the G-137a.

Disposition

The form is filed on the right side of the disability folder below the G-137 SUP.

G-137 SUP - Medical Consultant Determination Worksheet -

Use

In response to the G-137, Medical Consultant Opinion, the medical consultant places a completed Form G-137 SUP (for evaluation of physical impairments only) in the file and returns it to DBD. The G-137 SUP must be signed and dated by the consultant, and the examiner must confirm that the signature is provided and the date signed is correct. **NOTE:** Additionally, examiners must verify that the evaluation provided by the medical consultant covers the entire time period from the alleged onset date of disability entered on G-137 to the present date.

Access

The form is on RRAILS. The medical consultant does not have access to RRAILS to obtain the G-137 SUP and G-137a. However, the consultant is provided with the current WORD versions of the G-137 SUP and G-137a for their use.

Completion

The medical consultant completes the form in accordance with standard medical procedure for providing residual functional capacity assessments and medical narratives. The examiner should also confirm that any question asked on the initiating G-137 was answered on the corresponding G-137 SUP or answered on other enclosed Form SSA-2506-BK, *Psychiatric Review Technique*, and the Form SSA-4734-F4-SUP, *Mental Residual Functional Capacity Assessment.*

Disposition

The form is filed on the right side of the folder above the G-137.

NOTE: Note to File - During the onsite meeting between the disability or RECON examiner and the medical consultant, the medical consultant may write their opinion on a Note to File. The Note to File is filed on the right side of the disability folder.

G-197, Authorization To Disclose Information to the Railroad Retirement Board

See FOM1 1720, G-197.

G-219, Simultaneous Processing Disability Decision and Disability Freeze

Use

Effective April 23, 2015 and later, Form G-219, *Simultaneous Processing Disability Decision and Disability Freeze*, is a mandatory form that must be completed by the disability examiners in the Disability Benefits Division (DBD) when processing Occupational or Total & Permanent disability cases. The purpose of this form is to confirm that concurrent adjudication (i.e., simultaneous rating of both the disability decision AND period of disability [disability freeze or DF]) has been considered within **90 days** of the application filing date. The form is part of the disability determination process. The G-219 is on RRAILS.

Completion

ITEM	ENTRY AND WHEN USED
RRB Claim Number	RRAILS will pre-fill.
Applicant Name	RRAILS will pre-fill.
Application Filing Date	RRAILS will pre-fill the applicant's application filing date. This date can be found on the paper application (found either in the claim folder or in Imaging) or in APPLE. **NOTE:** This date is the date from which the 90 day time frame begins.

SECTION 1	This section is divided into three parts: Occupational Decision; Total & Permanent Decision; and Other.
Check the appropriate box:	The disability examiner must select (check) only one of the following eight reasons to describe the status of the disability case as shown below and then print the G-219 for signature. Examiners need to decide if the case is either Occupational, Total & Permanent or Other before selecting a reason.
Occupational decision – Evidence is **not** sufficient to complete the concurrent decision	Self-explanatory.
Occupational decision – Evidence **is** sufficient for concurrent decision, **Single Freeze completed**	Self-explanatory.
Occupational decision – Evidence **is** sufficient for concurrent decision, **Joint Freeze completed**	Self-explanatory.
Occupational decision – Evidence **is** sufficient for concurrent decision, **Joint Freeze deferred**	Self-explanatory.
Total & Permanent decision – Concurrent decision, **Single Freeze completed**	Self-explanatory.
Total & Permanent decision – Concurrent decision, **Joint Freeze completed**	Self-explanatory.

Total & Permanent decision – **Joint Freeze deferred**	Self-explanatory.
Other –	Select this box item for those disability cases that will be deferred for any other reason(s) not stated above such as a disability freeze earnings denial; and/or 1974 Act Medicare; and/or Financial Interchange (FI). Be very specific as to the reason why you are checking this box item. Type or write the reason in the space provided.
SECTION 2	This section only contains the Comments box item.
Comments	The examiner and/or authorizer must enter any comments or information that they may have to document specific notes or actions concerning the case for future case adjudicative action(s) and/or reference (documentation). Examiner and/or authorizer must enter claim file (case) status and any next steps to take in order to complete case adjudication. Type or write the information in the space provided.
Examiner Name and Date	Self-explanatory.
Authorizer Name and Date	Self-explanatory.

Disposition

The disability examiner prints out a copy of the G-219, then signs and dates, and sends an electronic copy of the form to the review folder. Upon receipt of the G-219, the disability authorizer confirms that the examiner checked the appropriate box during the authorization process. After the review is completed, the authorizer signs and dates, and sends the electronic copy of the G-219 to

Imaging for electronic documentation. The paper G-219 is filed down on the right side of the folder.

G-226, Disability Customer Service Time Lapse Exclusion Case

Use

Form G-226, *Disability Customer Service Time Lapse Exclusion Case*, is used by the Disability Benefits Division examiner when extenuating circumstances exist that cause a delay in the disability decision. It is essential to exclude these types of cases from the timeliness statistics in order to accurately reflect the agency's performance in rating disability cases. Form G-226 must be completed by the initial examiner prior to sending the case to authorization. The form should only be approved by the Disability Director, supervisors, lead examiners, or an individual(s) designated by a management official. See DCM 4.3.9 for guidance on when the exclusion applies.

Completion

Field	**ENTRY AND/OR WHEN USED**
RRB Claim Number	RRAILS will pre-fill.
Applicant Name	RRAILS will pre-fill.
Official Filing Date	Enter the actual or protected filing date. This date can be found on the application or on APPLE PF24 screen.
Reason for Exclusion	This section is divided into six parts with check boxes to designate a selection.
Claimant Delay	Check this box if a **timely** ordered consultative examination was excluded from the Consultative Medical Examination timeliness requirements due to one of the following reasons:

	• Claimant was a “no-show” for a scheduled examination appointment. • Claimant requested that the location or date of a scheduled appointment be changed. • The RRB requested that the location or date of a scheduled appointment be changed. • The contractor was unable, through no fault of its own, to contact the claimant in a timely manner. See DCM 4.3.9.1A for examples of when to use this reason code.
Recovery Delay	Check this box if a medical assessment was delayed due to the recovery period status post (s/p) treatment or surgery. Be sure to enter the type of treatment/surgery and the date of the s/p treatment/surgery that caused the delay. See DCM 4.3.9.1B for examples of when to use this reason code.
Evidence Delay	Check this box if required evidence was not submitted timely and list the required evidence in the Remarks section of this form. **Note:** This can be medical or non-medical evidence that caused the delay. See DCM 4.3.9.1C for examples of when to use this reason code.
Filing Delay	Check this box if the case has a protected or deterred filing date. Fill in the actual physical date the form was completed in the first date field and the date the form was

	either received or scanned into imaging in the second date field. See DCM 4.3.9.1D for examples of when to use this reason code.
Confinement Delay	Check this box if the applicant was confined to a correctional institution during the case development which caused a delay.
Other Delay	Check this box, if the examiner feels that the case should be excluded for a reason not covered by the guidelines listed above. Be sure to give a detailed explanation on why you feel the case should be excluded in the Remarks section of this form. See DCM 4.3.9.1F for examples of when to use this reason code.
Remarks	Use the remarks section for additional comments or as a continuation of explanations for the reasons for exclusions listed above. **Note:** Selecting "Evidence Delay" or "Other Delay" as a reason code requires entries to be made in the Remarks section.
Examiner Name	This field is prefilled from RRAILS with the name of the examiner initially opening the form.
Date	This field is prefilled from RRAILS with the date the examiner initially opens the form.
Approved	The Disability Director, supervisors, lead examiners, and individual(s) designated by a management official are authorized to

	check this box if they agree with the time lapse exclusion reason.
Denied	The Disability Director, supervisors, lead examiners, or individual(s) directed by a management official are authorized to check this box if they disagree with the time lapse exclusion reason.
Authorized Official Name	The Disability Director, supervisor, lead examiner, or individual directed by a management official who is approving or denying the exclusion will type or print their name after checking either the “Approved” or “Denied” box.
Authorized Official User ID	This field is prefilled from RRAILS with the user ID of the individual who is signed on to RRAILS at the time either the Approved or Denied box is checked. **Note:** Make sure to review this under your own sign in name as it is not possible to change this field once either the “Approved” or “Denied” box is checked. This field should also match with the name that is typed or printed in the above mentioned Authorized Official Name field. If this form is completed manually, then this field should contain the signature of the Disability Director, supervisor, lead examiner, or individual directed by a management official who reviews the form.
Date	This field is prefilled from RRAILS when the either the “Approved” or “Denied” box is checked. **Note:** If this form is completed manually, then the Disability Director, supervisor, lead

	examiner, or an individual designated by a management official should enter in the date after signing his/her signature in the “User ID” box.

Disposition

Examiner:

After completing Form G-226, the examiner must send the form to the *Disability Initial Authorization* folder. Then the examiner must also send an email to the Disability Initial supervisor with a cc to the Disability Post supervisor, Disability Director, Initial and Post lead examiners, and individuals designated by a management official to review the form. In this email, indicate that there is a G-226 in the *Disability Initial Authorization* folder for claim number xxx-xx-xxxx (enter the RRB claim number in place of the x’s) which needs to be reviewed and approved.

Approved:

If the exclusion is approved, the examiner will receive email notification from the authorized individual stating that the form was approved and is on Imaging.

Denied:

If the exclusion is denied, the examiner will receive email notification from the authorized individual that the exclusion was denied. The examiner is then to update DBrief and/or OLDDS to reflect that the case was not excluded from timeliness.

See DCM 4.3.9.2A for further details.

Supervisor:

Only the Disability Director and Supervisors are authorized to approve Form G-226. After receiving an email from an examiner that a G-226 is in the *Disability Initial Authorization* folder, the director or supervisor will review the form and either approve or deny the exclusion.

Approved:

If the exclusion is approved, the director or supervisor will release the form to imaging and send an email back to the examiner advising that the exclusion was approved and imaged.

Denied:

If the exclusion is denied, the director or supervisor will send an email to the examiner with the reason for the denial.

See DCM 4.3.9.2B for further details.

G-250, Medical Assessment

See FOM1 1720, G-250.

G-250A, Medical Assessment Of Residual Functional Capacity

See FOM1 1720, G-250A.

G-250(sup), Request For Medical Information From Treating Source In Cardiovascular Cases

Use

Form G-250(sup) should be included with all G-250's sent to treating physicians whenever a cardiovascular impairment is claimed by the applicant. This includes cases where the cardiovascular problem is not the primary impairment.

Completion

Prepare an original only. Send each form with each G-250 being sent to each treating physician.

Disposition

Mail the forms directly to the treating physician. As in all cases where development action is being initiated by headquarters, coordination between headquarters and the field office is necessary.

G-251, Vocational Report

G-251_Vocational_Report

Use

Form G-251, Vocational Report, is given to railroad employees who are applying for a disability annuity, a period of disability (disability freeze) and/or early Medicare. It is also given to a legal widow(er), a surviving divorced spouse, or a remarried widow(er) who is applying for a disability annuity and/or early Medicare, provided they have had some railroad or nonrailroad employment. It should not be routinely furnished to disabled children. However, there may be an occasional request from the Disability Benefits Division (DBD) to obtain a G-251 for a specific disabled child case.

It is not necessary to furnish Form G-251 for employees filing for a period of disability and/or early Medicare if they have previously filed a G-251 and have not worked since they last filed for disability.

Completion

See FOM1 1720 “G” Forms for more information on how Form G-251 should be completed.

Adjudication

Form G-251, Vocational Report, should be completed so that the last 15 years of work (from the date the form is completed) is reflected on the form. The DBD examiner will use several evidence sources to compare information, such as employment dates, job duties, hours worked, etc., that are provided by the applicant on Form G-251. The DBD examiner will also compare the information provided on Form G-251 to other source documents in file, including, but not limited to; Form AA-1D, *Application For Determination of Employee’s Disability*; Form G-626A, *Field Office Personal Observation Record*; wage records; Activities of Daily Living Report (ADL); and references to work in the medical evidence of record.

For employee Occupational cases, the DBD examiner will compare the information provided by the employee on Form G-251 with the employer’s description of the physical requirements and environmental factors as indicated on Form G-251A, Railroad Job Information (for more information on Form G-251A, see DCM 11.2, G-251A, Railroad Job Information). If there are material inconsistencies that may impact the outcome of the decision, the DBD examiner must resolve the inconsistencies. Actions to resolve include, but are not limited to:

- contacting the employee and reviewing the information provided on Form G-251; and/or
- contacting the employer and reviewing the information provided on Form G-251A. The employer should only be contacted for clarification, if after discussion with the employee material inconsistencies still exist.

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After discussing the details of the job description in question, if the discrepancy between the employee and employer’s job descriptions cannot be resolved, use OccuBrowse or other sources of job information for the job duties in question.

NOTE: All conversations with the employee and the railroad employer must be documented and imaged.

The G-251 asks for information regarding essential job duties. An essential job duty is a key function of employment that is unique to that job position. Without the function, the position would not exist. For example, the essential job duty for a locomotive engineer would be to confer with the conductor or traffic control

center personnel via radiophone to issue or receive information or instructions concerning stops, delays, or oncoming trains. Essential job duties for a locomotive engineer would not include compiling payroll data, such as hours worked, taxes and employee identification number, from time sheets and other records.

The DBD examiner must consider the employee's essential job duties when assessing his/her functional capacity for work activities.

The G-251 also asks for information regarding permanent accommodations for the employee's regular railroad job. A permanent accommodation from railroad work is defined as changes in work at the request of the employer that impact the essential functions of the occupation for at least a 5 year period. The permanent accommodations listed are: Job Duties, Work Schedule, Overtime Schedule, Attendance Schedule, and Other. Dates are also requested regarding when the restriction began and ended.

- Review Items 15, 19, and 23 of the G-251 carefully to ensure the permanent accommodation for railroad work was in place for at least 5 years.
- If a G-251A response was received, compare the information provided on the employee's G-251 to be sure that the information pertaining to permanent restrictions is consistent. (See above concerning how to resolve inconsistencies).

Examples of Permanent Accommodations are as Follows:

- **Job Duties –** A 55-year old brake repairer files for an occupational disability annuity in December 2016 on the basis of degenerative disc disease of the lumbar spine. A 50-pound lifting restriction has been placed on him by his treating physician. His railroad employer has provided him with a permanent accommodation of no lifting of objects weighing over 50 pounds. His team of co-workers handles heavy lifting duties during his shift. The accommodation was place in June 2010 through the present.
- **Work Schedule –** A 48-year old ticket agent files for a total and permanent disability annuity in October 2016. She is status post cancer resection surgery. She experiences fatigue related to her ongoing cancer treatment since September 2011. Her employer has provided a permanent accommodation in work schedule, allowing her to go for treatments and doctor appointments since September 2011.

- **Mandatory Overtime –** A 50-year old railroad locomotive engineer files for an occupational disability annuity in April 2016. His job requires mandatory overtime as the need arises. The requirement has been in place since he started in January 1996.

- **Non-Mandatory Overtime –** A 47-year old locomotive engineer is an "extra board" hire since March 2009. Depending on the assignment and the shift he receives, he may be required to work overtime hours.

- **Attendance Schedule –** A 57-year old conductor with chronic kidney disease, who does not require treatment with dialysis, files for an occupational disability annuity in December 2015. His railroad employer has given him a permanent accommodation in his attendance schedule due to his symptoms. He is allowed to work a part-time schedule of 4 days a week. This accommodation has been in place since September 2010.

For Occupational disability cases, the employee may work over 40 hours per week, which may include mandatory overtime. Consider this in the evaluation. For Total and Permanent disability cases, work must be evaluated using a 40-hour workweek, as it is commonly done in the national economy.

The DBD examiner must consider the employee's permanent job accommodations when assessing his/her functional capacity for work activities.

Disposition

The DBD examiner will explain how the applicant's job duties impacted the disability decision in D-Brief. The form should be imaged.

G-251A, Railroad Job Information Form

G-251A_Railroad_Job_Information_Form

Use

Form G-251A is completed at the time of filing by the field office and released to the employee's railroad employer when an employee is eligible for an occupational disability annuity. By completing the form, the railroad employer is given the opportunity to provide job information about the employee to the Railroad Retirement Board. Effective April 3, 2017, the Railroad Retirement Board (RRB) introduced a revised Form G-251A in accordance with the Disability Program Improvement Plan that will ask railroad employers to provide job information about applicants who apply for an occupational disability benefit under Section 2 (a)(1)(iv) of the Railroad Retirement Act (45 U.S.C. §

231a(a)(1)(iv)). Collection of job information from the employers will assist the disability examiner with making an accurate disability determination. Prior to this date, the RRB used Form G-251a and G-251b Job Information reports to collect this information. Form G-251a was released to employers for employees with a generic job description attached. Generic job descriptions were used for a select number of railroad occupations and were some of the more common types of railroad jobs. The generic job description described how select occupations were generally performed in the railroad industry for employees. Form G-251b was released to employers for employees who did not have a generic job description.

Completion

See FOM 1720 “G” Forms for more information on how Form G-251A should be completed.

Adjudication

The disability examiner must wait 30 days from the original date the G-251A was released before adjudicating the claim.

In instances where the disability examiner determines that the employee’s regular railroad occupation differs from the one entered on Form G-251A, the disability examiner should request that the field office release a new G-251A with the correct regular railroad job entered. If the request is made to the field office at least 30 days after the original G-251A was released, it is not necessary to wait an additional 30 days for receipt of the corrected form. For information on determining the employee’s regular railroad occupation, see DCM 3.2.2.

For employee Occupational cases, the DBD examiner will compare the information provided by the employer on Form G-251A with the employee’s description of the physical requirements and environmental factors as indicated on Form G-251, Vocational Report (for more information on Form G-251, see DCM 11.2, G-251, Vocational Report). If there are material inconsistencies that may impact the outcome of the decision, the DBD examiner must resolve the inconsistencies. Actions to resolve include, but are not limited to:

- contacting the employer and reviewing the information provided on Form G-251A; and/or
- contacting the employee and reviewing the information provided on Form G-251. The employee should only be contacted for clarification, if after discussion with the employer material inconsistencies still exist.

.

After discussing the details of the job description in question, if the discrepancy between the employer and employee’s job descriptions cannot be resolved, use OccuBrowse or other sources of job information for the job duties in question.

Section 1, *Completion Instructions -* The disability examiner should verify that the information on the upper right side on page 1 of the form, including if the regular railroad job determination is correct. It is acceptable for Form G-251A to be handwritten or typed by the field office.

Section 2, *Disqualification Information -* The disability examiner should check to see that a G-3EMP was released by the field office if the employer indicates the employee was disqualified. If the G-3EMP was not released to the railroad, contact the field office to have them release the form.

Section 3, *Summary of Duties -* This information should be compared to the job duties listed on Form G-251 by the disability examiner to verify that there is consistency between the employee and employer's descriptions.

Section 4, *Machinery, Tools, Equipment -* The disability examiner should verify that there is consistency between the employee provided the same information on Form G-251 regarding the use of machinery, tools, and equipment.

Section 5, *Environmental Conditions -* These conditions listed by the employer should be compared to the G-251 job description by the disability examiner to verify there is consistency between the railroad description and the employee's description.

Section 6, *Job Accommodations -* The disability examiner should compare the information provided by the employer and employee to verify there is consistency, and investigate if there is a discrepancy.

Section 7, *Sensory Requirements -* This should be compared to Form G-251 to verify consistency between the railroad description and the employee's description.

Section 8, *Physical Actions -* This must be compared to the G-251 job description provided by the employee to verify there is consistency between the railroad description and the employee's description. .

Section 9, *Remarks -* Provides space for continuation of answers that pertain to the various job actions.

Section 10, *Employer Certification -* Requests an employer certification. The disability examiner should check to verify that all items in this section are completed.

Disposition

The disability examiner will explain how employee's job duties for his/her regular railroad job as described on Form G-251 compares with the employer's description of the employee's G-251A in D-Brief. If the outcome of the decision is impacted by material discrepancies between the employee and employer job

description, an explanation as to how the conflicting information was resolved should be indicated in D-Brief. (See DCM 12.5.5.2 for additional information on D-Brief.) The form should be imaged.

G-252, Self-Employment/Corporate Officer Work and Earnings Monitoring

Use

Form G-252 should be used in disability cases in which the disability claims examiner has questions concerning the annuitant's claim of self-employment and/or work as a corporate officer. It will be used when the information contained on the AA-4, Self-Employment and Substantial Service Questionnaire, and within the file, do not provide sufficient information regarding the annuitant's claims. It will be released by the Disability examiner. Refer to DCM 8.5.14, Using Form G-252, Self-Employment/Corporate Officer Work and Earnings Monitoring.

Access

The form is on RRAILS only.

Completion

Prepare an original only. The examiner is to complete Items 1-6, and 11-12.

Items 11-12 – The disability claims examiner will need to enter the year(s) being requested. Box items are shown for two years worth of information. If there are three or more years needed, the annuitant can enter those years in Section 7 – Remarks and/or on a separate sheet of paper (see Note below).

In some situations, the annuitant may need to show their work and earnings information from their ABD based on conflicting, confusing and/or discrepant information from other sources (i.e., AA-4, G-254, letters, or questionnaires, etc.). This means that the annuitant may need to show more than 2 years worth of information based on what the disability examiner determines is necessary (i.e., specific year(s) or period in question, or all year(s) from annuitant's ABD).

NOTE: If the information being requested in items 11-12 are for the same year as the information included in an AA-4 that has already been submitted, check the box prior to item 11. This will prevent the annuitant from completing duplicate information.

Disposition

After completion of the necessary items, print the form from RRAILS. The form is to be released with Form RL-252, Cover Letter for Form G-252, and a return envelope. An e-mail should be released to the corresponding field office group mailbox informing them of the release of these forms and the years entered in items 11 and 12.

G-254, Continuing Disability Report

Use

Form G-254, Continuing Disability Report, is released to disability annuitants by the field office, at the request of the Disability Benefits Division (DBD). The Disability Benefits Division (DBD) will request the field office to secure Form G-254 when:

1. Determining if a disability annuitant continues to meet the requirements for a disability annuity prior to full retirement age; or
2. A report of work or a change in physical condition is received in headquarters, and the issue of continuing disability must be resolved. For Example: EDP policing, self-reporting, or third party reporting.

Completion

See FOM 1720, G-254.

Adjudication

DBD examiners must compare the information provided on the G-254 to all relevant sources in file, including recent medical evidence submitted with the G-254, and information from employers regarding dates worked/earnings breakdowns. If there are material inconsistencies on the G-254 that may have an impact on the decision, the disability examiner must resolve the discrepancies.

NOTE: If any suspicious patterns or inconsistencies are noted, such as the use of technical/descriptive terms or copied dialogue that cannot be resolved while examining the disability claim, the disability examiner should notify their lead examiner or supervisor as soon as possible. For more information on the elements of fraud, refer to DCM 8.8.

Section 1, General Instructions: The date entered in Section 1 is provided by the disability post examiner handling the continuing disability review (CDR) development. The examiner should consider the annuitant's onset date, ABD, and date of any prior G-254.

Section 2, Identifying Information: will prefill from RRAILS.

Section 3, Information about Your Work for an Employer: This section contains information about the annuitant's employment after the date provided in Section 1. The disability examiner should consider the relevant factors in assessing the nature, intensity, persistence, and the limiting effects of the individual's symptoms. In addition, the examiner should consider:

- Item 7: Consider all sources pertaining to work activity, such as the Detailed Earnings Query (DEQY), The Work Number (TWN), self-reported

work, and any work report(s) from a third party. Make sure the annuitant provides information regarding the details of this work.

- Item 11: When the entry is "Yes" in regard to returning to work with the same hours, duty and pay as the annuitant had before their disabling conditions began, possible medical improvement should be considered as part of the CDR decision. An example would be an occupational case in which the employee was able to return to his regular railroad job.
- Items 12 and 13: Consider whether the work was done under special conditions, such as a sheltered. For more information, refer to CFR 404.1573 or DCM 5.2.12.
- Item 14: If the annuitant does not list any impairment-related work expenses (IRWE), review Section 5 item 27 for possible M.D. co-pays and item 28 for possible prescription co-pays. When the employee earns over the annual Disability Work Deduction (DWD) amount, additional verification may be needed to determine if IRWE can be used to reduce the countable earnings for work deduction purposes. FOM I 1125.5.2 provides a chart with yearly DWD amounts. For development of IRWE, refer to DCM 10.8 and FOM I 310.55.1 for more information.

Section 4, Information about Self-Employment: If the annuitant reports working in self-employment, the disability examiner should:

- Determine whether an AA-4, Self-Employment and Substantial Service Questionnaire, and possible G-252, Self-Employment/Corporate Office Work and Earnings Monitoring, should be developed for review. Refer to DCM 10.4.5 for more information on self-employment determinations.

Section 5, Information about Your Condition before Full Retirement Age: Consider what the annuitant claims about their current medical condition(s) and review the following items listed below to determine if there is possible medical improvement:

- Types of treatment
- Medications
- Restrictions in Activities of Daily Living
- Whether a doctor has released the annuitant to return to work
- Report of recent higher education and how it might affect the disability annuity. Did the annuitant receive a degree since their disability annuity was awarded? Have they received any special training since their disability annuity was awarded? Refer to DCM 5.4 for educational consideration and DCM 3.6.1 under step 5 of the sequential evaluation process. In addition, please refer to Form AA-1d Section 5 instructions in DCM 11.2 for more information on the effects of recent education and/or vocational training received to determine if this affects the employee's ability to perform work.

Section 6, Continuation and Remarks: Review this section for any additional details regarding the information provided in the other sections of the G-254.

Section 7, Authorization and Certification: Identify who the report was completed by and verify the form is signed and dated.

Disposition

The Disability Post Section (DPS) examiners will review the G-254, along with all the other documentation needed for the CDR process, and prepare a decision for review, which will be authorized by another DPS examiner. The form should be imaged.

G-260, Report Of Seizure Disorder

See FOM1 1720, G-260.

G-321, Employee Initial Rating Checklist

Use

Form G-321 is used by initial disability examiners as a job aid to evaluate items for consideration or action when processing employee disability claims. This is an optional use form.

Access

The form is on RRAILS only.

Completion

Items 1-43 of Form G-321 are completed by the disability examiner if the employee disability claim is for an occupational disability. Items 1-32 and 44-56 are completed by the disability examiner if the employee disability claim is for a total and permanent disability.

Disposition

After completion of the necessary items, print the form from RRAILS. File the form on the left side of the folder. The form is not imaged. The form may be discarded after review.

G-321a, Widow/Child Information Checklist

Use

Form G-321a is used by initial disability examiners as a job aid to evaluate items for consideration or action when processing widow and children disability claims. This is an optional use form.

Access

The form is on RRAILS only.

Completion

Items 1-7, 9, 10 and 12-21 are completed by the disability examiner if the disability claim is for a widow(er). Items 1-17 and 21 of Form G-321a are completed by the disability examiner if the disability claim is for a child.

Disposition

After completion of the necessary items, print the form from RRAILS. File the form on the left side of the folder. The form is not imaged. The form may be discarded after review.

G-325.1, Disability Decision Rationale

Use

Form G-325.1 is used to give rationales and citation of used listings, standards, rules etc. for disability determinations in post entitlement cases.

Completion

Items 1-5 of this form are completed by the disability examiner. Items 6 and 7 are completed by the reviewing disability examiner.

Item	Entry
1	Claimant- Enter the first name of the person for whom the determination is made.
2	RRB Claim No. - Enter the six or nine digit RRB claim number.
3	Basis for Decision - Show the basis for the decision. Make a statement of causes and effects that documents the considerations and conclusions in reaching the decision. (See DCM 5.1.6 for more detailed information). If you are using a listing in your decision, state whether it is met or equaled. If you are applying a vocational rule as a framework, that should be stated.
4	Explanation of Actual Onset Date (If Different from Claimed Onset Date) - Complete this item only when the applicant is found disabled and the onset date determined is earlier or later than the onset date shown in the application being adjudicated.

5	Signature of Disability Examiner - The name of the disability examiner who completed items 1-4 and the date are entered by RRAILS.
6	Any Additional Rationale by Reviewing Examiner - This item is used by the reviewing disability examiner when there is additional rationale to be offered that leads to a similar decision. If there is no additional rationale, leave this item blank.
7	Signature of Reviewing Examiner - The reviewing examiner 's name and the date are entered by RRAILS. Citations of Listings Standards, Rules, etc. - Identify any established and published criteria used in reaching the decision. Any published criteria, including manual references, may be entered. Specifically, enter listings (whether met or equaled) and/or vocational rules used (whether applied strictly or as a framework).

Disposition

File the forms on the left side of the claim folder. In all cases the form must be imaged.

If:

- The case is a "self-auth" case, the examiner sends the form to imaging.
- The case is being reviewed, the examiner sends the form to the post auth folder and the reviewer sends the form to imaging.
- The case is a joint disability freeze case, the form is saved until after SSA signs off on the case and then sent to imaging.

G-383, Authorization Return Form

Use

Form G-383 is used by authorizers to identify adjudicative actions that may be incorrect, inconsistent, or incomplete with current procedure **or** if the authorizer disagrees with the proposed disability rating or continuing disability determination. This form is part of and initiates the reviewer return process (DCM 3.4.303) and is meant to:

- Track adjudicative issues and provide significant data to the Training Section regarding areas that may require additional training or clarification of current procedure, and
- Identify adjudicative issues which should be addressed by the rating claims examiner before a disability determination is authorized.

Form G-383 is a Microsoft Word document.

Access

Access Form G-383 from the Main Screen for RRAILS. Ensure that the RRAILS Shelf is open.

IMPORTANT: The G-383 is best viewed using a screen resolution of 1024 x 768 pixels. Monitors currently set to a screen resolution of 800 x 600 pixels result in images that appear larger than in other screen resolution settings. As a result, users may have difficulty viewing this form when the screen resolution is set to 800 x 600 pixels.

Adjustments to your monitor's screen resolution are done through the "Control Panel" in Microsoft Windows. In order to change the screen resolution of your monitor, click on the START button and look for "Control Panel."

1. "Control Panel" IS visible

   Click on Control Panel / Display (icon) / Settings (tab) / move the slider arrow in the Screen Resolution area to 1024 x 768 pixels using your mouse. Click the APPLY button. After the resolution is temporarily set, click OK to make the resolution change permanent.

   To return the screen resolution of your monitor back, follow the same instructions but move the slider arrow to the position that it was in originally.

2. "Control Panel" IS NOT visible

   Click on Settings / Control Panel / Display (icon) / Settings (tab) / move the slider arrow in the Screen Resolution area to 1024 x 768 pixels using your mouse. Click the APPLY button. After the resolution is temporarily set, click OK to make the resolution change permanent.

   To return the screen resolution of your monitor back, follow the same instructions but move the slider arrow to the position that it was in originally.

Completion

The claim number, prefix, and beneficiary symbol (bene sym) can either be prefilled into the G-383 by downloading it from RRAILS or it can be manually

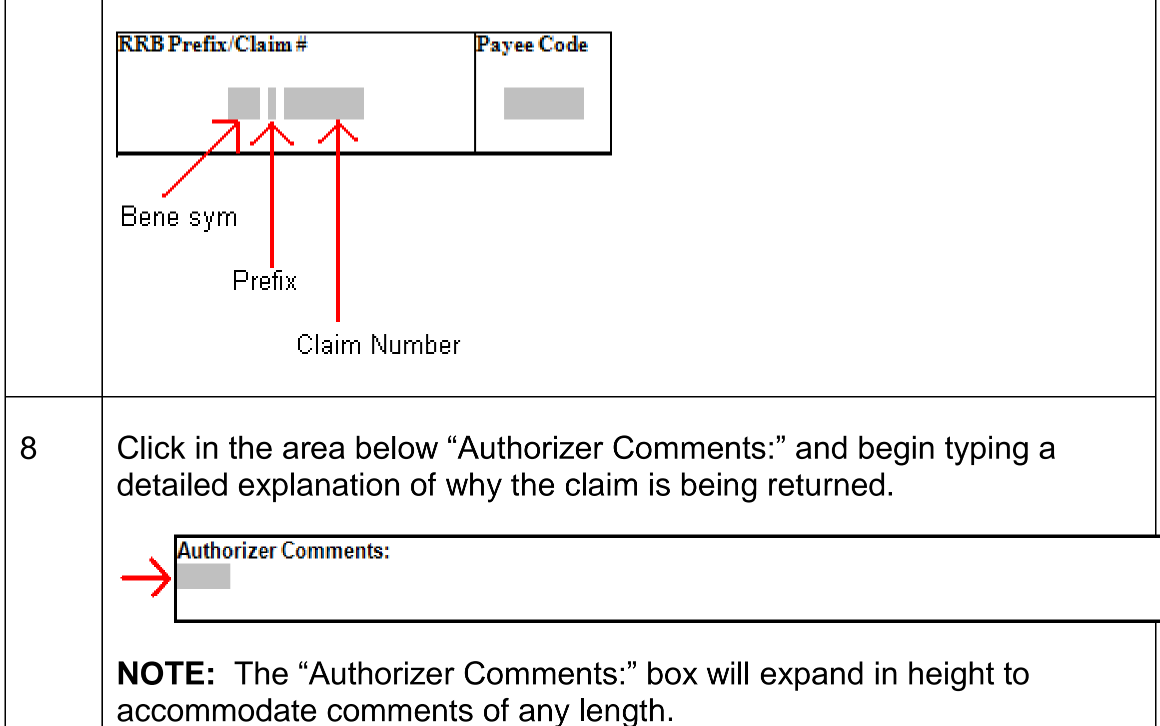
typed into the form. See FOM1 1596.20 for instructions how to download information into the G-383 from RRAILS.

Completion of Form G-383 is generally self-explanatory and shall be done using the following steps:

Step	Action
1	To open Form G-383, either: a) Double click on G-383 Authorization Return Form in the RRAILS shelf, Or b) Single click on G-383 Authorization Return Form in the RRAILS shelf AND then click the Open button.
2	Click on ***Select Type of Case*** or the down arrow. **Authorization Return Form** *** Select Type of Case *** Click "DISABILITY" from the drop down menu. The image will change to the image shown below. **Authorization Return Form** DISABILITY Press TAB on the keyboard. Then either press ENTER on the keyboard OR use the mouse and click on OK to verify that the Disability version of the G-383 should be opened. **You Selected DISABILITY.** If DISABILITY is correct select OK to proceed. Select Cancel to resume. OK Cancel **NOTE:** Clicking on Cancel will disable the rest of the Disability programming.

	If Disability was inadvertently selected and you wanted to enable the Medicare, Retirement, or Survivor programming instead, click on the word DISABILITY (as shown in the second image above). Then select of the correct version of the form. Otherwise just close the G-383 Word Document.
3	Type the examiner's name in the large box (REQUIRED) and the examiner's adjudicating unit in the smaller box (OPTIONAL). Examiner Name / Unit NOTE: The authorizer's name and RRB unit number are prefilled next to "Authorizer Name / Unit".
4	Select the **Type of Action** by clicking the appropriate radio buttons. a) If the "Occupational Only," "T and P Only," "Widow," or "Child" radio button was selected, then also select either the "Allowance" or "Denial" radio button. (REQUIRED) Type of Action: Occupational Only / Occupational and SF / T and P Only / T and P and SF SF and/or Medicare Only / CDR / Widow / Child Allowance / Denial b) If the "Occupational and SF" radio button was selected, then also select the "Allowance" (if both disability determinations are allowances), "Denial" (if both are denials), or "Occ. Allowance/SF Denial" radio button. (REQUIRED). Type of Action: Occupational Only / Occupational and SF / T and P Only / T and P and SF SF and/or Medicare Only / CDR / Widow / Child Allowance / Denial / Occ. Allowance/SF Denial c) If the "T and P and SF" radio button was selected, then also select the "Allowance" (if both disability determinations are allowances), "Denial" (if both are denials), or "TP Allowance/SF Denial" radio button. (REQUIRED) Type of Action: Occupational Only / Occupational and SF / T and P Only / T and P and SF SF and/or Medicare Only / CDR / Widow / Child Allowance / Denial / TP Allowance/SF Denial

	d) If the “SF and/or Medicare Only” radio button was selected, then also select the “Allowance” (if both disability determinations are allowances), “Denial” (if both are denials), or “SF Denial/Medicare” (if the single freeze is denied based on earnings but Medicare is allowed based on the 1974 Railroad Retirement Act amendments or government employment) radio button. (REQUIRED) Type of Action: Occupational Only / Occupational and SF / T and P Only / T and P and SF SF and/or Medicare Only / CDR / Widow / Child Allowance / Denial / SF Denial/Medicare e) If CDR was selected, no other radio button needs to be selected.
5	Select the appropriate reference manual(s) by clicking the appropriate box(es) on the left side. (OPTIONAL) Procedure References Cited/Dates Issued/Sources RCM: FOM: DCM: TOM: POMS: Procedure Agenda Other: If a reference manual is selected, then cite the section(s) of the manual by typing it in the space provided on the right side. (REQUIRED) If a reference is not listed, click the “Other” box and type the appropriate information in the space provided.
6	Click in the “Save Changes” box OR press ENTER. All selections and typed information will then fill into the G-383.
7	Type in the bene sym, prefix, claim number, and if necessary, the payee code if it was not prefilled into the G-383.



	RRB Prefix/Claim # / Payee Code (Bene sym, Prefix, Claim Number)
8	Click in the area below "Authorizer Comments:" and begin typing a detailed explanation of why the claim is being returned. **NOTE:** The "Authorizer Comments:" box will expand in height to accommodate comments of any length.

Disposition

The authorizer will prepare three copies of the G-383. Copies should be distributed to the:

- Rating examiner with the claims folder.

  NOTE: The authorizer shall log the claim file into the rating examiner's AFCS location and return the claim file to the rating examiner's work station.

- Rating examiner's supervisor, and

- Disability training specialist.

The authorizer shall prepare and distribute a fourth copy of the G-383 for his or her supervisor if the case being returned was completed by an examiner in the Initial Section of the Disability Benefits Division.

See DCM 3.4.303 for additional information about the reviewer return process.

G-405, Notice of Medicare Entitlement Action

See RCM 11_G405

G-460, Tracing on Request for SSA Medical or Other Evidence

Use

This form is to be used when tracing on a Form RR-5 and Form G-26f, or requesting medical evidence or other types of documentation with the Social Security Administration. The form is to be used for the first tracing of those forms.

Access

The form is on RRAILS only.

Completion

Complete the form as follows:

Item	Entry
SSA Claim Number	Enter the SS claim number of the applicant. This will usually be a social security number followed by a one or two letter suffix.
RRB Claim Number	Enter the RRB claim number of the applicant. This would usually be a social security number preceded by a one, two or three letter prefix
RR Employee's Name	Enter the name of the railroad employee
Disabled Person's Name	Enter the name of the disabled person who is applying for disability benefits
Disabled Person's Date of Birth	Enter the date of birth of the disabled person who is filing for disability benefits
Date of (RR-5/G-26f) Sent to SSA	Select either RR-5 or G-26f depending on which form you are tracing. After making the selection enter the date the original form was released
Remarks	Enter any remarks that are pertinent to the case (i.e. congressional or critical case) or that should be known by SSA

Sign and date the form next to the appropriate spaces and print. The bottom half of the form SSA Reply will be completed by SSA.

Disposition

1. Email the G-460 document to SSA. For instructions on scanning and sending the form by email to SSA, click here How To Scan and Email Documents
.

2. Send the G-460 document to IMAGING.

G-626A, Field Office Personal Observation Record

See FOM1 1720, G-626A.

Form G-626A is obtained by the field office for all initial disability applicants to record personal observations. Personal observations may be the result of an in-person or telephone interview. The G-626A must accompany the initial disability application package.

For more information on completion and disposition by the field office, see **FOM 1310**. For more detail on the high risk questions with examples, see **FOM1 Article 13, Appendix E**.

This procedure pertains to examiner handling of Item 1, which lists 5 criteria for possible high-risk scenarios. The five criteria are listed below with guidelines for examiner handling:

1. **Prior Earnings Fraud:** The applicant was previously reviewed for earnings fraud due to unreported work activity and such action was determined to be fraudulent. Disability examiners are required to review Contact Log and Imaging for any past history of fraud under the Railroad Retirement Act (RRA) and Railroad Unemployment Insurance Act (RUIA). **Note:** If there is a prior history of fraud under RUIA, there will be a contact alert message that reads "Prior RUIA Fraud G-626A required for Disability EE applicants - see FOM1 Article 13 Appendix E." In addition, check OLDDS to see if Form G-325A has been completed for a Continuing Disability Review (CDR) determination. In these cases, verify whether the CDR action was the result of fraud by the disability annuitant.
2. **LAG Earnings Needed:** The applicant needed lag earnings to attain 240 cumulative service months (except for settlement cases) and the employee is under age 51 **or** is entitled to a private pension from the railroad employer and is under age 56. Refer to **FOM1 209.10** for the definition of Lag. Disability examiners should review the DEQY to determine if a private pension is payable. In addition, the pension is indicated on the APPLE application, and sometimes also in the remarks section of APPLE.
3. **Possible Work/Earnings:** The field office staff identifies possible work/earnings from an incorporated business, limited liability corporation or self-employment with reported levels of income below the earnings

limitations established for disability annuitants. Disability examiners should refer to **FOM1 1125.5.2** for the amount of disability work deductions applicable for a particular year.

4. **No Earnings in Last 5 Years:** Examiners can verify this information by checking EDMA, obtaining a DEQY and checking The Work Number to see if the applicant has had earnings in the last 5 years.
5. **Uniform Responses/Patterns:** Entries on the disability application are uniform or other material information provided by the applicant appears inconsistent or is in need of further review. If this criteria appears to apply, examiners should review **DCM 8.8.2**, Elements of Fraud, for further information.

G-841C, Background Medical Evidence Transmittal Memorandum

See FOM1 1720, G-841C.

11.3 "RL" Forms

RL-11, Letter for G-3EMP Disqualification Request for Medical Evidence from Railroad Employers

See FOM1 1745, RL-11.

RL-11B, Letter Requesting A Transcript Of Hospital Records

See FOM1 1745, RL-11B.

RL-11D, Letter Requesting Medical Records from Worker's Compensation Or Other Agency Or Institution

See FOM1 1745, RL-11D.

RL-11D1, Request for Medical Evidence from Employers

See FOM1 1745,RL-11D1.RL-27, Notice to Employer of Disability Annuity Application Denial

Use

Use the RL-27 to notify railroad employers when an employee disability annuity application is denied. The RL-27 is only released to the railroad employers listed below:

RAILROAD	BA NUMBER

Amtrak	8301
Arkansas Midland	3889
Bessemer & Lake Erie	1303
Birmingham Southern	4507
Florida Central	2586
Florida Midland	5511
Florida Northern	5522
Indiana Harbor Belt	4217
Kankakee, Beaverville & Southern	2337
Lake Terminal	4221
McKeesport Connecting	4334
Metro North Commuter	3345
MG Rail, Inc.	3357
Mid-Michigan	4268
Pinsly RR Co.	7105
Pioneer Valley Co.	3113
Pittsburgh & Conneaut Dock	4249
Transtar	9237
Union RR Co. (Pitts PA)	4351

Completion

The RL-27 is available on RRAILS. The initial examiner should complete the RL-27. Enter the BA number in the block on the left side of the form. The BA number and RR employer name can be found on the EMPLOYEE/ SPOUSE WORK INFORMATION screen on APPLE. On that screen the BA number is listed under ER NO. Enter the RRB claim number, name, address, date last worked, occupation, and location on the right side of the form. Send it to the

imaging folder and notate in “Remarks” on the route slip that a RL-27 was completed.

Disposition

The authorizer should print out one copy of the RL-27 after authorizing the case, send the RL-27 to imaging, and put the printed copy in the outgoing mail tray.

RL-69, RRB Medical Consultants for DF/CDR

Purpose

This letter is used when scheduling examinations for the purpose of a disability freeze (DF) decision or a continuing disability review (CDR). This letter provides information to the annuitant as to whom the RRB contracts with for scheduling exams, and alerts them that the medical provider may be calling them by telephone to schedule an appointment.

Completion

Use RRAILS features as usual to open the letter with annuitant information included. Click on the greeting and then press the tab key. Dialogue boxes will open asking for information to complete the rest of the letter. Enter the requested information and click on “OK”.

Completion of the dialogue boxes will provide an explanatory sentence as to whether this is a DF decision or a CDR decision and an explanatory sentence as to why additional medical information is needed.

Disposition

Release original to the annuitant. Make a copy for the file. Send to imaging.

RL-121f, Disability Allowance Notice

Purpose

The RL-121f is a notice to claimants informing them that their claim for a disability has been approved or that additional information has been reviewed in order to determine whether an earlier onset date can be established. The letter is released when the disability rating is approved.

Access

This letter is available on RRAILS

Information regarding the navigation of the RRAILS screens, dialogue boxes, and the text and order of paragraphs on the letter is contained in DCM 12.4.

Completion

Required entries on the RL-121f are described below.

In all cases:

- Enter the name and address;
- Enter the claim number;
- Enter the disability onset date; and
- Sign the Director of Operations' name above the typed name.

An explanation of how the onset date was determined must always be given in the case of an employee, widow, or survivor child in which the onset date is different from that claimed. Examiners may compose a special paragraph or use a code paragraph. In the following situations, other information will also need to be given.

- The letter must state that the difference between the claimed onset date and the determined onset date has no effect on the ABD, if this is the case.
- The letter must state that additional information is being developed in an attempt to substantiate an earlier onset date, if this is the case.
- The letter must always include the reconsideration paragraph.

Other situations:

- The applicant must be told that the first payment should be received within 45 days of the estimated annuity beginning date if the annuity beginning date is in the future. This could occur in employee and widow cases in which the waiting period has not expired. The estimated annuity beginning date would be a date six months after the disability onset date. In advanced filing dates, the estimated annuity beginning date would be the day after the last day of compensated service. Also, state that the applicant should receive a letter explaining more about the monthly benefits at that time.
- There must be a statement that factors other than the onset date affect the ABD.

In the case of an employee, widow, or survivor child in which a disability annuity is already being paid and additional medical evidence has been requested in order to determine whether an earlier onset date is possible, the type of

information to be included in the letter is determined by the situation, as shown below.

- In cases in which additional information has been requested but has not been received, this must be stated in the letter. Include the statement that there will be no change in the current annuity.

- Give an explanation in cases in which additional information has been received, but there is no change in the onset date. Include the statement that there will be no change in the current annuity.

- The letter must give both the old and the new onset dates in cases in which a new onset date is set as a result of additional information. Explain that another letter will be sent concerning payment adjustments.

- Give an explanation in cases in which an onset date is established that is later than the date claimed.

- Always include the reconsideration paragraph.

Disposition

The original letter, with envelope, is for the annuitant. The initial disability examiner types the letter on RRAILS and sends it to an authorization folder. The authorizer approves the letter, prints out 2 copies, and sends to imaging before releasing one to the annuitant and placing the other in the file.

RL-213E, Continuing Disability

Use

Effective September 25, 2017, Form RL-213E is released by the Disability Benefits Division (DBD) to an employee disability annuitant acknowledging receipt and review of information submitted in response to any of the following forms that were released to them:

- G-254a, Continuing Disability Update Report;

- RL-4, Disability Reminder Notice - Retirement;

- RL-5, Disability Reminder Notice - Survivor; and

- RL-7, Disability Reminder Notice - Under Earnings.

After reviewing the response(s) submitted, DBD will release the RL-213E to the annuitant if it is determined that no other action is necessary. Prior to the above date, the RL-213E was only released in response to the Form G-254a.

Completion

The RL-213E is on RRAILS. RRAILS will prefill the name, address, and claim number. Verify that the entries are correct. The form has two dialog boxes and one drop down menu. In the first dialog box, select whether the form is going to a third party. If "No" is selected, the text prefills with "your condition," etc. If "Yes" is selected, a second dialog box appears that asks if the disabled person is the male or female employee or the male or female annuitant. Select the appropriate gender and status and the verb tense will prefill accordingly throughout the letter. From the drop down menu, select the form type the annuitant responded to.

Disposition

After completion of the necessary items, print the form from RRAILS and release to the applicant. Image a copy of the RL-213E to WorkDesk via the imaging button in RRAILS.

RL-250, Request for Medical Assessment

See FOM1 1745, RL-250.

RL-252, Cover Letter for Form G-252

Use

This form is to be released in conjunction with Form G-252, Self-Employment/Corporate Officer Work and Earnings Monitoring.

Access

The form is on RRAILS only.

Completion

The name, address and claim number are to be completed. Also select from the drop-down menu, the appropriate response for the second sentence in paragraph one. The dropdown concerns whether the person is self-employed, a corporate officer or both.

Disposition

Upon completion of the necessary items, print the form. The form should be sent to the addressee along with Form G-252, Self-Employment/Corporate Officer Work and Earnings Monitoring and a return envelope. This form is to be imaged and a paper copy is to be placed on the right side of the folder.

RL-259 Letter to US Embassy to Request Medical Exam for Applicant

Use

Form RL-259, Letter to US Embassy to Request Medical Exam for Applicant, is used by DBD staff to secure a specialized medical examination for an individual residing in a foreign country (other than Canada or, in some situations, Mexico). The form is released to the US Embassy or Consulate that P&S - RAC provided to DBD. (See DCM 4.3.6)

Access

The form can be found in RRAILS.

Completion

Move through the letter using the TAB button.

The name and address of the embassy or consulate are typed in the area below the RRB seal. Do not use abbreviations unless indicated by P&S - RAC.

The name and claim number of the individual are typed below “In reply refer to”.

Ensure that the claimant’s name and full address were prefilled in the appropriate area of the body of the letter.

List the names of all of the specialized medical examinations being requested in the *** Narrative Here *** area.

Type the total number of specialized medical examinations in the pop-up box that will appear:

Type the total cost of all requested specialized medical examinations in the space provided after “$”. The total cost of all specialized medical examinations can be found by accessing the EXMC table of FFS. See DCM 12.2.2 for instructions how to access FFS. After FFS is accessed, access the EXMC table by typing “N” in the ACTION field and then typing “EXMC” in the TABLEID field. (The first 4 characters of your USERID will be shown. Do not change the USERID.) The screen should look like this:

```
ACTION: N TABLEID: EXMC USERID: KLOT

1.  ENTER 'N' IN THE ACTION FIELD
2.  ENTER TABLE ID FOR REFERENCE TABLES
    ENTER 'SUSF' TO CREATE/MODIFY/APPROVE/SCHEDULE DOCUMENTS


COMMON TABLE ACTIONS:   N = NEXT TABLE
                        S = SCAN (AFTER KEY FIELDS ARE ENTERED)
                        E = END


COMMONLY USED REFERENCE TABLES:
          ALLT - STATUS OF ORGANIZATION BUDGET (FUND 8237) / OIG (FUND 8018)
          RQST - STATUS OF REQUISITIONS
          OBLH - OBLIGATION HEADER
          OBLL - OBLIGATION LINE
          DXRF - DOCUMENT CROSS REFERENCE
```

Press ENTER. The screen will look like this:

```
ACTION: S TABLEID: EXMC USERID: KLOT
EXAM COST REFERENCE TABLE
KEY IS TRANS CODE, EXAM NUMBER

        TRANS  EXAM             COST                      DESCRIPTION
        -----  ----      -----------------     ------------------------------
01-
02-
03-
04-
05-
06-
07-
08-
09-
10-
11-
12-
13-
14-
15-
```

Press ENTER again and the first page of examinations will be shown. Press ENTER again to page through the list of examinations.

Disposition

Upon completion of the necessary fields and items, print the form and send it to the addressee. This form is to be imaged and a paper copy is to be placed on the right side of the claims folder.

11.4 "RR" Forms

RR-5, Request for SSA Medical Evidence

Use

Form RR-5, Request for SSA Medical Evidence, is used by Field Service and Disability staff to secure medical evidence and the disability decision from SSA when a disability applicant has filed for or is receiving disability benefits under Title II (Disability Insurance Benefit; DIB) or Title XVI (Supplemental Security Income: SSI). It is not needed when, the SSA evidence is in the RRB claim folder. In most cases Field Service will release the form at the time of the applicant's filing. Disability may need to release the form in cases where it is determined the person has filed at SSA after having already filed at RRB.

Access

The form can be found on RRAILS.

Completion

Complete the RR-5 as follows:

Item	Entry
1. SS Claim Number(s)	Enter the social security claim number of the applicant
2. RRB Claim Number	Enter the RRB claim number of the applicant
3. RR Employee's Name	Enter the name of the railroad employee
4. Disabled Person's Name	Enter the name of the applicant filing for disability benefits
5. Filed at SS District Office	Enter the location of the SS field office where the applicant applied for SS benefits if known. Otherwise leave blank
6. Disabled Person's Date of Birth	Enter the applicant's date of birth

At the end of Part I the examiner should ensure the name of the requesting office and the date the form is being released is correct and their name is entered. SSA will complete Part II of the form.

Disposition

1. Email the RR-5 document to SSA. For instructions on scanning and sending the form by email to SSA, click here: How To Scan and Email Documents.

2. Send the RR-5 document to IMAGING.

The adjudicating headquarters office is responsible for tracing for Form RR-5. See DCM 4.3.8C2 for tracing instructions.

11.5 SSA Forms

SSA-831-U3, Disability Determination and Transmittal (Social Security Administration)

Use

SSA-831-U3 is used to record joint freeze (JF) and Financial Interchange (FI) disability decisions. It is available on RRAILS. (See DCM 6.7.3 to determine when a JF and FI decision is made.) Instructions for items to be completed by the RRB disability examiner or reconsideration specialist are shown below.

Completion

RRB entries are 1 - 7, 9, 12, 15 - 16, 19 - 20, 25A, 27 (partial), 28 - 31, and 34

Item	Entry
1	"DRS" is pre-filled
2	DDS code "992" is pre-filled
3	Self-explanatory
4	Enter the employee's SSA number in the block labeled "SSN". Leave the block labeled BIC empty.
5	Self-explanatory
6	Self-explanatory. Entry is only made for a widow or child with claim numbers ending in 30 (FI cases).
7	Check the FZ box for employees; check the DWD box for widows; check the CDB-D box for children.

9	Self-explanatory
12	"RRB" is pre-filled
15	Complete if the decision is a grant and enter onset date. Check and complete Box B if the decision is a closed period of disability and enter the date the disability ceased.
16A & 16B	Enter primary and secondary (if any) diagnoses. Leave Body Sys Box Blank. Enter 6-digit diagnostic code in CODE NO box. (See DCM 3, Appendix B for diagnostic codes.)
19	Complete in denial cases • Check box A if the railroad employee's DF insured status ends after the date of adjudication and in all widow and child cases. • Check box B where the date that insured status is last met before the date of the current determination and the railroad employee is found not disabled on or before the date last insured (DLI). Enter the DLI after checking this box.
20	For employee, enter railroad job title, years of railroad service, and years of education. For widows and children, enter the corresponding information with job title and years of service for last non-railroad job in PRW period, if applicable. In all cases, enter "(91-40)" after the job title.
25A	Self-explanatory
27	Enter RRB letter number to be released (e.g. RL-210 or RL-260 for employees, NLN for widow or child) in the far right of the box. SSA fills out the other portions of this item.
28A	Check box for employees and enter first full month of disability above the box.
28B	Check box only for widows and children with a closed period of disability.
28C	Check box in all allowances and enter onset date.
28D	Check box for all allowances that are not closed periods.

28E	Check box in all cases that are closed periods of disability and enter the last day of the second month after the disability ceased.
29	If the railroad employee is not insured for a SSA Disability Insurance Benefit (DIB; cash annuity), enter the SSA letter number to be released (e.g. "SSA-810" or "SSA 813.1"). Enter "NLN" for railroad employees who are insured for a DIB as well as widows and children.
30	RRAILS should pre-fill your name. All decisions must be signed or initialed.
31	Self-explanatory
34	For employees enter onset date and Medicare effective date. If applicable, enter "20/40 insured for DIB". For widows and children, type "FI#" (FI Number) and "dependent RR annuitant", and enter the claimant's SS# and whether the annuitant is a widow or child.

NOTE: The SSA disability examiners will complete items 8, 10-11, 13-14, part of 16, 17-18, 21-24, 26-27, 32-33, 35-38 as appropriate for the type of decision.

Disposition

The form is placed on the left side in the claims folder before sending to SSA for JF or FI decision. Items 32, 33, and 37 will be completed when SSA agrees with the decision proposed by RRB. SSA will make a copy of the SSA-831 for their records. The form remains in the file when returned to RRB.

SSA-2506-BK, Psychiatric Review Technique Form (Social Security Administration)**Use**

SSA-2506-BK is used by SSA (Disability Determination Services doctors and Administrative Law Judges) in assessing mental impairments. The form is also used by the medical consultants of the Railroad Retirement Board when assessing mental impairments in disability cases. The form is not completed by RRB disability examiners, but is completed and forwarded from the RRB medical consultant in response to the request for G-137 Medical Consultant Opinion.

Disposition

The form is placed on the right side of the folder, usually directly above the G-137 series documents.

SSA-4734-F4-SUP, Mental Residual Functional Capacity Assessment (Social Security Administration)

Use

SSA-4734-F4-SUP is used by SSA (Disability Determination Services doctors and Administrative Law Judges) in assessing mental residual functional capacity in mental impairment cases. The form is also used by the medical consultants of the Railroad Retirement Board when assessing mental residual functional capacity in mental impairment cases. The form is not completed by RRB disability examiners, but is completed and forwarded from the RRB medical consultant in response to the request for G-137 Medical Consultant Opinion.

Disposition

The form is placed on the right side of the folder, usually directly above the G-137 series documents.

13.1 Definitions of General Terms

13.1.1 Occupational Disability

The Railroad Retirement Act identifies occupational disability as a permanent physical or mental condition that renders one unable to work in his or her regular railroad occupation in the railroad industry.

13.1.2 Regular Railroad Occupation

Regular railroad occupation is defined as the occupation in the railroad industry in which an employee:

- Has engaged in service for hire in more calendar months than the calendar months in which he or she has been engaged in service for hire in any other occupation during the last preceding five calendar years, whether or not consecutive; or

- Has engaged in service for hire in not less than one-half of all of the months in which he or she has been engaged in service for hire during the last preceding 15 consecutive calendar years.

If an employee last worked as an officer or employee of a railway labor organization and if continuance in such employment is no longer available to him or her, the regular railroad occupation shall be the position to which the employee holds seniority rights or the position which he or she left to work for a railway labor organization.

13.1.3 Impairment

An alteration to an individual's health status that is assessed by medical or functional means.

13.1.4 Permanent Impairment

Permanent impairment refers to a physical or mental impairment or combination of impairments that can be expected to result in death or has lasted on a continuous basis or can be expected to last for a continuous period of not less than 12 months.

13.1.5 Disability

An alteration to an individual's capacity to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements.

13.1.6 Treating Physician

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

13.1.7 Consultative Exam (CE)

An examination by a physician (often a specialist) performing a medical evaluation on a limited basis at the expense of the Railroad Retirement Board.

13.1.8 Consulting Physician

A consulting physician is a doctor (often a specialist) to whom the claimant's medical record may be referred for a review to provide opinions concerning a claimant's residual functional capacity and/or the sufficiency of the medical evidence in the file.

13.2 Initial Step In Occupational Disability Adjudication

The initial step in the adjudication of occupational disability is the review of the Disability Application filed with the Railroad Retirement Board (RRB) field office and forwarded to the Chicago headquarters for review. After receipt of the file at headquarters, a new claim folder is established and forwarded to the Disability Benefits Division (DBD) for adjudication. The file should contain information about employment and medical records pertaining to the nature of the claimant's disability. The initial step is to review the file for completeness, assess eligibility, and determine if there is sufficient medical evidence to adjudicate a claim.

The forms that should be included in the file are listed below:

13.2.1 Form AA-1 - Application For Employee Annuity

This form contains information needed for determining entitlement for an employee annuity under the Railroad Retirement Act. Information on this form includes data concerning the claimant's past railroad work. The data in this section should be used to ascertain the claimant's regular railroad occupation.

13.2.2 Form AA-1d - Application For Determination Of Employee Disability

This form contains information about the claimant's disability and medical providers which have treated this condition.

13.2.3 Form G-3-EMP - Report Of Medical Condition By Employer/Form RL-11

Form G-3-EMP contains information concerning the claimant's ability to work including the ability to perform his or her regular railroad occupation, a description of the type of work that he or she can perform, work restrictions and disqualification information. The information on this form may be based upon the results of medical evaluations that have been conducted by medical examiners on behalf of the railroad. Form RL-11, *Letter for G-3EMP Disqualification Request for Medical Evidence from Railroad Employers* requests that the employer complete the G-3-EMP form. (These forms should only be released in cases where the applicant meets the requirements for an occupational

disability annuity (see DCM 3.2.1) and claims to have been disqualified by the carrier.) Form G-197, *Authorization to Disclose Information to the Railroad Retirement Board*, must be included with all G-3EMP requests. The G-197 form must be signed by the applicant or authorized individual, authorizing the release of medical information to the RRB.

NOTE: If the applicant does not claim disqualification by the carrier or doesn't qualify for an occupational disability annuity, then use Form RL-11D1 to request medical evidence by the employer. If the employer attaches 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.

13.2.4 Form G-250 - Request For Medical Records

The claimant's medical records from the treating physician(s) should accompany the submitted disability application. Copies of the claimant's medical records and a narrative summary should have been requested in the G-250 form from the claimant's treating physicians(s) by field office staff. The claims examiner should determine if information from all treating physicians is available for review. The claimant should have identified the physician(s) who has treated him for the condition on the AA-1d form and the claims examiner should ascertain if the reports from all physicians are present in the file.

The Railroad Retirement Board regulations identify acceptable sources of medical evidence (Section 220.46). These sources include:

- Licensed Physicians
- Licensed Osteopaths
- Licensed Psychologists
- Licensed Optometrists (for measurement of visual fields and visual acuity)

13.2.5 Form G-250A - Medical Assessment Of Residual Functional Capacity

This form is provided to the claimant's treating physician(s) and contains information concerning the claimant's ability to perform work-related activities. It is to be completed along with the G-250 form.

13.2.6 Form G-251 - Vocational Report

This form contains specific information regarding the claimant's work history for the last 15 years. Information concerning job demands and environmental factors are also included in this report. The claimant is requested to sign this form and acknowledge that civil and criminal penalties may be imposed if fraudulent statements are provided.

13.2.7 Forms G-251A – Railroad Job Information

This form request job information regarding the claimant's job demands. The Field Office will release a Form G-251A to the employer. The Field Office will enter the regular railroad job position or occupation, location and date last worked. The employer must return the completed form within 30 calendar days from the date the form is released.

13.3 Determination Of Whether The Individual Is In Compensated Railroad Service

(See Figure 1 for Sect. 3-9)

The claims examiner must verify whether the claimant is currently in compensated railroad service. Persons who are in compensated railroad service are not eligible for benefits.

13.4 Determination Of Whether Mental Or Physical Impairment Is Expected To Last 12 Months Or Result In Death

The claims examiner needs to evaluate whether the impairment(s) is expected to last 12 or more months or result in death. If the impairment is not expected to last 12 months or result in death, the claim is denied. The claims examiner should obtain additional medical evidence if the information in the file is insufficient to make this determination. If the impairment(s) is expected to last 12 or more months, a determination needs to be made as to whether the information contained in the medical record is sufficient to perform an initial disability rating as identified in Section 5 of this document.

Documents which need to be reviewed to determine if the impairment is expected to last 12 months or result in death include:

13.4.1 Form AA-1d - Application For Determination Of Employee Disability

The nature of the claimant's medical condition is described in Section 3 of the AA-1d form along with information concerning the date that the claimant last worked. For persons who have chronic conditions that are not expected to improve and who are not working, it is reasonable for the claims examiner to assume for the purpose of a claim evaluation that the condition could be expected to last 12 months.

13.4.2 Form G-250 - Request For Medical Records

The claimant's medical records from the treating physician(s) should accompany the submitted disability application. Copies of the claimant's medical records and a narrative summary should have been requested by the field office (Form G-250) from the claimant's treating physician(s). This information should be reviewed to determine if the claimant has a chronic medical condition that is not expected to improve.

13.4.3 Medical Evidence Of Record

Medical evidence of record includes hospital records, imaging studies, consultative examinations and ancillary tests. These types of documents provide objective evidence to confirm and evaluate an impairment and need to be reviewed to determine if an impairment will last 12 months or result in death.

13.5 Determination Of Whether The Information In The Medical Records Is Sufficient For Reaching An Initial Disability Decision

Information concerning the nature of the medical condition should be reviewed in conjunction with information concerning the date the claimant last worked as identified in Section 3 of the AA-1d form. Data concerning diagnosis, symptoms, objective findings, laboratory test results, X-ray and other imaging findings, treatment and prognosis should be in the medical record. Ideally, this information should be summarized in a narrative report. If a narrative report is not available, the claims examiner may have to review the individual medical records. Such information forms the medical basis for the preliminary adjudication of a disability claim. In addition, the Residual Functional Capacity Evaluation, as specified in Form G-250a, should have been completed by the physician and be available for review. If the claims examiner determines that the information is not sufficient to perform a disability adjudication, additional information should be requested from the claimant's physician(s) to continue the claims review process.

If the information in the medical records is considered to be sufficient to reach a disability determination, then an assessment needs to be made as to whether the claimant's condition meets or equals the RRB's Listing of Impairments (20 CFR Part 220).

13.6 Determination Of Whether The Condition Meets Or Equals The RRB Listing Of Impairments

13.6.1 Overview Of The Listing Of Impairments

The RRB's Listing of Impairments is a listing of conditions by the major body systems which are considered to generally prevent an individual from engaging in substantial gainful activity.

The information contained in the claimant's medical records must be reviewed concerning whether the employee's medical condition is considered to meet or equal the standards identified in the Listing of Impairments. The purpose of the Listing of Impairments is to identify those individuals who unquestionably have disabling impairments.

13.6.2 Determination Of Whether The Condition "Meets" The Listing Of Impairments

An impairment meets a listing only when it manifests the specific findings described in the medical criteria of that listed impairment. The determination that the condition meets the Listing of Impairments cannot be based on a diagnosis alone since other findings associated with the condition must also be present. These requirements can include confirmatory medical test findings to confirm the existence of the impairment and specific objective findings which indicate significant functional impairment.

EXAMPLE: The mere diagnosis of active rheumatoid arthritis is not considered sufficient to meet the Listing of Impairments. The following factors must also be present:

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints and with signs of joint inflammation (swelling and tenderness) and current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either:

- Positive serologic test for rheumatoid factor; or
- Antinuclear antibodies; or
- Elevated sedimentation rate; or
- Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

13.6.3 Determination Of Whether The Condition "Equals" The Listing Of Impairments

To determine if an impairment or combination of impairments equals the Listing of Impairments, a comparison must be made of the medical findings (the set of symptoms, signs and laboratory findings) in the claimant's medical record 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 and duration 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; or

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

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

If a claims examiner believes that a listing is equaled, the case may be sent to the consulting physician for review.

13.6.4 Medical Condition Does Not "Meet" Or "Equal" The Listing Of Impairments

If the condition does not meet or equal the criteria identified in the Listing of Impairments, then the condition should be assessed in accordance with the criteria identified in Section 7.0.

13.7 Determination Of Whether The Employee Has Been Medically Disqualified From Regular Railroad Occupation By Railroad Employer

Information from the employer concerning the claimant's ability to perform the duties of the regular railroad occupation should be reviewed. Information concerning this matter should be present in Form G-3-EMP, which is generally completed by the railroad medical officer or other railroad representative in cases where the applicant claims to have been disqualified by the carrier. Form G-3-EMP provides information concerning the claimant's ability to perform his or her regular railroad occupation for medically documented reasons and has evidence that supports the conclusion that the applicant is unable to perform his or her occupation. If the employee is not allowed by his railroad employer to continue working in his or her regular railroad occupation, the claims examiner will consider the claimant disabled unless, based on the evidence in the Form G-3-EMP and elsewhere in the file, the claims examiner determines that no reasonable person could conclude that the employee can no longer perform his or her regular railroad occupation for medical reasons.

In cases where a disqualification notice is received, it is not necessary to have medical evidence in file which details the severity of the disability. Rather, it is sufficient to make a rating with medical evidence in file that confirms the impairment. In these types of cases do not delay an occupational disability rating by developing medical evidence or scheduling medical examinations.

EXAMPLE 1: A clerk has been disqualified by the railroad due to a history of degenerative arthritis. Medical evidence submitted consists of treating physician notes and chiropractic records. The records submitted did not include X-ray reports. The claimant also states on AA-1d that he/she takes medication for arthritis. The medical evidence submitted supports the claimed impairment for which the claimant was disqualified. There was no medical evidence submitted that contradicts or disputes the disqualification, therefore, the claimant can be rated occupationally disabled without further development.

13.8 Determination To Ascertain If The Condition And Job Title Are Covered In The Occupational Disability Tables (A Tables)

Information in all of the medical records, the AA-1, and Form G-251, Vocational Report should be reviewed by the claims examiner to ascertain whether the claimant's condition and job title are included in the Tables. If the information indicates that the condition and the job title for the claimant's regular railroad occupation are included in the Tables, the claims examiner should evaluate the evidence in accordance with the procedures identified in Section 9.

If either the condition or the job title is not included in the Tables, then the claimant's condition should be evaluated in accordance with the criteria identified in Section 10, Independent Case Evaluations.

13.9 Claims Evaluation For Conditions And Job Titles Covered In The Tables

13.9.1 Establish The Medical Diagnosis

Confirmatory tests can include information from medical records that document the presence of a condition, a surgical procedure, or the result of a specific diagnostic test. In some instances, confirmatory tests may also provide information on the claimant's functional capacity and are also listed as disability tests. Confirmatory test information is present in the initial section regarding each body part covered in the Tables. Appendix A contains information further detailing specific test criteria for the confirmatory test results or findings in the Tables.

If the information is incomplete, then further information should be obtained concerning the claimant's medical condition from other sources including consultative exam and/or functional evaluation tests. If some of the information is not in accordance with the rest of the medical information, it should be evaluated in accordance with the criteria identified in Section 10.

There are two types of confirmatory tests: highly recommended and recommended. These tests are discussed below.

13.9.1.1 Highly Recommended Tests

The designation of a confirmatory test as being highly recommended means that the test is almost always performed to establish a diagnosis. For many conditions, only one highly recommended test finding is suggested to establish a diagnosis. There may be times when that test is not available or is negative, but other detailed testing confirms the diagnosis.

EXAMPLE A: For the condition of pulmonary hypertension, only one confirmatory test is considered to be highly recommended: the electrocardiogram. This condition is

identified in the Tables as highly recommending an electrocardiogram with definite right ventricular hypertrophy to confirm the diagnosis.

An electrocardiogram with evidence of right ventricular hypertrophy will confirm the diagnosis. However, it is reasonable to consider that a Swan-Ganz catheter may be inserted into the pulmonary artery to directly measure the pressure. This would also establish the diagnosis.

There may be some conditions for which several highly recommended tests are suggested to establish a diagnosis. In these circumstances, all highly recommended tests are suggested together to establish the diagnosis.

<u>EXAMPLE B</u>: Three highly recommended criteria are identified for the diagnosis of chronic back pain, not otherwise specified. These criteria include:

- A history of back pain under medical treatment for at least one year, and
- A history of back pain unresponsive to therapy for at least one year, and
- A history of back pain with functional limitations for at least one year.

Sometimes the claimant may have undergone detailed testing which may provide more comprehensive information than one of the A highly recommended tests listed in the Tables, making the simpler test unnecessary. To illustrate, in Example A above, if the medical records contained direct measurement of elevated pulmonary artery pressure, an electrocardiogram would not be necessary to confirm the diagnosis. <u>In cases where the highly recommended test is absent, there must be a logical, rational basis, based on the medical record, for accepting the diagnosis. The case summary rationale must support this decision.</u>

<u>13.9.1.2 Recommended Tests</u>

The designation of a confirmatory test as recommended means that the test may not be performed, or be positive, to establish the diagnosis. However, a positive test provides significant support for confirming the diagnosis. If there are no highly recommended test(s) for the condition, at least one of the recommended tests should be positive.

There are two categories of recommended tests which are described below.

A. <u>Imaging Studies</u>

These studies can include MRI, CAT scan, myelogram, or plain film X-rays. For conditions where several of these imaging studies are identified as recommended tests, at least one of the test results should be positive and meet the confirmatory test criteria. For some conditions, such as degenerative disc condition, there are several equivalent imaging methods that can be used to establish a diagnosis.

B. Other Tests

This category of tests refers to non-imaging studies. For some conditions, there is no single confirmatory test which can be used to establish a diagnosis since all available medical tests may have significant false negative or false positive rates. For example, electro-diagnostic tests, including electromyography and nerve conduction studies, are frequently abnormal in a person with a radiculopathy. However, some individuals with a radiculopathy can have normal electro-diagnostic test results.

If there is no highly recommended confirmatory test requirement and the confirmatory tests only include non-imaging procedures, at least one of these tests should be positive. The greater the number of tests that are positive, the greater the confidence that the correct diagnosis has been established.

EXAMPLE: The diagnostic confirmatory tests for ventricular ectopy, a cardiac arrhythmia, include the following recommended tests:

- Medical record review, i.e., a review of the claimant's medical records, or
- Holter monitoring, or
- Provocative testing producing a definite arrhythmia.

In this situation, only one of the recommended confirmatory tests should to be positive to reach a diagnosis. However, the more tests that are positive, the stronger the support for the diagnosis.

If a diagnosis cannot be confirmed and all medical information is obtained, the claim is denied.

In most circumstances, the claims examiner should not request that a confirmatory test be performed to establish the diagnosis at the expense of the RRB through a consultative examination (CE). In some situations where a CE is being planned and a simple test may be performed to establish a diagnosis, the claims examiner has the discretion to request a confirmatory test.

In no circumstance should the claims examiner recommend that invasive testing be performed to confirm the diagnosis. Several of the confirmatory tests which are described in the Tables are invasive and it is not the intention of the Tables to suggest that invasive tests be performed. The inclusion of invasive tests in the Tables confirmatory test section is intended to help the claims examiner evaluate the significance of findings which may be part of the submitted medical record.

13.9.1.3 Disability Determination

To reach a disability determination, disability test results need to be reviewed by the claims examiner. Disability tests measure the functional impact or impairment that a condition has on a person. The results of the test can classify a person as Disabled (D) or needing an Individual Case Evaluation (ICE). These terms are defined below:

A. "D" - If the claimant has a "D" result, this signifies that the claimant is disabled. Only one D disability test finding is required to reach a determination of disability.

B. "ICE" - If the claimant does not have any D results, the claim must be evaluated using the process described in Section 10.

13.10 Independent Case Evaluations (ICE)

Independent Case Evaluation (ICE) is used for claims in which job titles and/or medical conditions are not covered by the Tables. The second situation in which cases are subject to ICE are claims where the job and medical condition are met, but there is no matching disability test. The third situation in which cases are subjected to ICE are claims which have not received a "D" rating because medical variations make it necessary to look at specific job information and/or specific medical information to make a determination. The fourth situation in which claims are reviewed using ICE are situations in which the job titles and the medical conditions may be covered, but the information is not consistent or cannot be simply clarified. In this review, information in the Table regarding diagnosis and confirmation tests, as well as the tests judged to determine disability, may be a guide for the claims examiner in the decision process.

Independent Case Evaluation is a three step process:

The first step, medical information is reviewed to establish diagnosis and to establish an understanding of the condition by the claims examiner. Particular attention should be paid to the functional limitations of the condition. The impairments from the medical conditions relevant to claimant's regular occupation are determined.

The second step, the job information is evaluated to determine the job demands.

The third step, the medical information regarding relevant impairment is compared to the job demands.

13.10.1 Assessment Of Medical Information

13.10.1.1 Confirming The Diagnosis

The diagnosis will provide the claims examiner with the functional limitations that may be expected on a particular claim. The diagnosis is important for this reason to assess the other medical information. In some cases, the diagnosis is established through the initial review of the Tables.

13.10.1.2 Assess Concordance Of Medical Findings In Entire Medical Record

The information in the medical record should be reviewed to determine whether the opinions among physicians regarding medical condition findings are consistent, including the claimant's history, physical examination findings, laboratory or other test results, and other information in the claimant's file. The claims examiner should review the AA-1d to ascertain if all relevant treating physician(s) medical records are available. If physicians have had a role in providing treatment or assessing the claimant's condition and these records are not available for review, the disability examiner may use the most expeditious means available to obtain that medical evidence, if necessary. Once all relevant information has been secured, it should be reviewed and integrated into the disability determination process to decide if there is consistency of response among treating physicians. <u>However, if the information available from one or more physicians contains clear and convincing evidence, especially if there is objective supporting information, the claims examiner may proceed without obtaining all records from all treating physicians.</u>

13.10.1.3 Significant Difference In Medical Findings

If the medical records reveal that there are marked differences in the treating physicians' findings, then a CE and/or functional test should be obtained.

<u>EXAMPLE</u>: A brakeman's medical records reveal conflicting evidence concerning the character and functional impact of an underlying low back condition. The claimant reported to his orthopedist a history of prolonged back pain of five years duration with severe symptoms for three years. The claimant reported in his history that his low back problems had kept him from participating in sports which he had participated in prior to the onset of his severe back problems three years ago. An MRI revealed degenerative disc changes.

The claims examiner reviews the claimant's entire medical record which includes medical treatment that he received from an osteopathic physician for the past three years just before he sought consultation with the orthopedic consultant. These medical records reveal a contradictory history from that provided to the orthopedist. The medical records reveal that the claimant had received medical therapy for a neck and later a low back strain following water-skiing and basketball injuries in the past two years. The claimant's stated medical history as provided to the orthopedist is not consistent with the history in his medical records with respect to the impact that the pain has had on his lifestyle.

Since the RFC from the orthopedist could reasonably be expected to be based upon the claimant's medical history (rather than objective medical evidence), the quality of the RFC is jeopardized. In this type of situation, the claims examiner should request a consultative examination to resolve this matter and/or functional testing.

13.10.1.4 Significant Differences In Opinion Of RFC Among Treating Physicians And An Approach To RFC Quality Assessment

The RFC is a medical assessment and is based upon a review of the available medical evidence; it represents the judgment of the physician. The RFC should be based upon clear and convincing medical evidence demonstrating an impairment. In such circumstances where clear and convincing medical evidence is not present, a CE with authorization to perform functional capacity tests may be required.

EXAMPLE: A carman has a history of obstructive lung disease and has complaints of shortness of breath with exertion. The treating physician recommends no exertional activity. If the RFC is based primarily on symptoms of shortness of breath without consideration of the actual measurements of lung function or exercise performance, the finding is invalid. Shortness of breath can be caused by many factors including anxiety, psychological, and other factors. Lung function tests, such as Forced Expiratory Volume in one-second, are best predictors of exercise ability and should be used to establish performance limitations.

The following criteria should be assessed in determining the quality of an RFC:

A. Is the RFC largely based upon symptoms rather than objective evidence?

If the RFC is not supported by objective evidence of a condition that will result in impairment, then the treating physician's RFC should not be considered as being sufficient. The claims examiner should request additional information or records, a CE, or functional testing where appropriate.

EXAMPLE: The claimant, an engineer, reports a history of chronic low back pain. The physician's RFC opined that the claimant not lift over 35 pounds, bend, or stoop. No medical report is available, but a review of the medical records reveals that although the claimant sought medical attention on several occasions for low back pain, no specific abnormal physical findings have been documented. A plain film X-ray revealed that the claimant had some minor degenerative changes of the spine, but the radiologist reported these were normal for the claimant's age. No other definitive tests have been performed. The nature and extent of pain is not clearly documented in the medical records.

In this case, the RFC is largely based upon subjective symptoms. The claims examiner can request that a consultative examination and/or functional test be performed.

EXAMPLE: A general laborer works on maintenance of way for the past 10 years. His work includes repetitive lifting of tie plates and spikes not removed by the automated spike puller. This job requires the claimant to stand most of the day, walk on uneven surface, lift and carry objects weighing up to 20 pounds. He presents with a 5 year history of low back pain that is worsening. He reports prolonged standing and lifting of objects over 20 pounds is painful. Attempts at

therapy have been unsuccessful. A report from his treating physician identifies that he has radicular pain in the L5 - S1 nerve distribution. An EMG reveals evidence of polyphasic wave activity in muscle innervated by L5 nerve. An MRI reveals diffuse degenerative disc changes more pronounced at L5-S1, but without definitive nerve impingement. A straight leg raise test is positive (both supine and sitting positions).

A review of the medical records reveals that physical therapists, his primary physician, and orthopedist specialist all have reported similar complaints, consistent physical findings, and recommended that he avoid heavy work including frequent standing, repetitive lifting, bending and twisting. The recommended limitations include no lifting over 40 pounds, no repetitive lifting over 10 pounds, and no prolonged standing or walking.

In this case, there is clear and convincing evidence that the RFC provided by the treating physician(s) is based upon valid medical evidence. The claimant's symptoms are consistent with the clinical findings including physical examination findings, imaging studies, and diagnostic tests. This medical history and the examination findings have been consistently reported by all of his medical care providers.

B. Is the RFC based upon objective tests that have poor reliability or validity and are, therefore, poor predictors of functional capacity?

If the objective tests have limited reliability and/or validity, then the claimant should be referred for a CE and/or functional tests to ascertain his or her functional capacity.

<u>EXAMPLE</u>: A dispatcher with a degenerative lumbar disc disorder has a treating physician's RFC which opines that the claimant cannot lift any objects over 10 pounds and is restricted from any activity involving repetitive bending or stooping. A review of medical records reveals that the dispatcher describes experiencing chronic low back pain for over one year that is aggravated by movement including lifting and bending. Physical examination is reported to reveal the presence of paravertebral muscle spasm and a diminished range of lumbar motion to 50% of what would be expected (method of measurement and reproducibility are not identified). Lumbar sacral X-rays reveal the presence of degenerative disc changes throughout the lumbar spine, but more pronounced in the L4-5 and L5-S1 regions. An MRI reveals the presence of a significant disc bulge at these same levels but there is no report of any spinal stenosis or disc herniation.

In the Form G-250a the physician identifies several factors that support this RFC conclusion. These factors include the presence of degenerative disc changes in lumbar vertebrae seen with lumbar sacral spine X-ray, a disc bulge on an MRI, and the presence of back spasm and marked limited range of lumbar motion to <50% of the expected range.

This RFC is based upon medical evidence. However, as with many cases of chronic back pain, the evidence is of limited usefulness; see Table 1 for an example of significant findings related to the low back. Therefore, no one finding tells us that this man's back pain is significant and disabling. Together, they do support a physical basis for back pain, but are not diagnostic.

The examiner can look for indications in the medical records that this dispatcher has had maximal therapy, including work conditioning and strengthening in physical therapy. The examiner should look for consistency of findings across different providers, and evidence of attempts to return to work. If that evidence is not clear and convincing, functional testing can be ordered. (see Section 11)

13.10.1.5 Request For Consultations

Depending upon the amount of information in the file, the claims examiner may request that the claimant undergo functional tests in addition to, or in lieu of, other CEs. In such cases, if functional tests alone are recommended, the claims examiner should contact the claimant's treating physician(s) to ascertain whether there is any contraindication or physical limitations to obtaining a functional test. If a CE is going to be performed, the CE can provide authorization to conduct the testing.

The protocols for functional capacity tests are described in Appendix C. The results of the examination and/or test(s) can be used to ascertain whether the claimant has an impairment that precludes the performance of the claimant's job functions. Additional review by a consulting physician may be required to resolve significant discrepancies between the treating physician's RFC opinion and that of the functional tests.

13.10.1.6 RFC Limitations Are Not Consistent With Functional Capacity Tests

Some claimants may have already undergone functional capacity tests, such as isometric strength tests, an FCE, or other tests. These results should be reviewed. If the treating physician concluded that the claimant's functional capacity is substantially below those that have been measured in functional tests, then the claimant should be referred for a CE evaluation and/or functional tests to ascertain the basis for this discrepancy. Alternatively, the treating physician may be requested to provide a rationale for the basis of his or her conclusions after reviewing the results of the functional testing.

13.10.1.7 Weight Of Evidence Determination

If there is a concordance of medical information, the medical information should be assessed using a weight of evidence approach. The weight of the medical evidence is assessed to determine if there is clear and convincing objective evidence that the claimant has a significant medical condition and that this condition prevents him or her from performing his regular job. Under this approach, the claims examiner would find a claimant to be occupationally disabled if the medical evidence, once weighed, demonstrates that it is more reasonable to conclude that the claimant is unable to

perform his or her occupation than to reach a contrary conclusion. The types of findings which support a determination that a condition has a significant functional impact are identified in Figure 4. Alternatively, factors which support a lesser impact are also identified in Figure 4.

Information from the medical history should also be reviewed to ascertain whether the claimant's medical condition has been associated with any episodes of pain or other symptoms which have resulted in an inability to perform the critical tasks of his occupation. The significance of the pain episodes is strengthened in general if they are associated with objective findings. Medical records can provide an overall indication of the claimant's condition over time and may significantly reflect his or her ability to perform a task over a given time frame. Information pertaining to any continued job activity should be closely examined.

The medical records should be reviewed to ascertain whether the claimant has been provided appropriate medical treatment and therapy for the condition(s) and whether the response to therapy has been (un)successful; this provides additional support to the physician's opinion that the claimant' s medical condition is permanent. The records should be examined to ascertain whether there is evidence of poor compliance with medical treatment, including failure to keep appointments, use of appropriate medication, or other factors. If the claims examiner determines that the claimant may not have had the opportunity to receive an adequate course of therapy, and therefore concludes the condition may not be permanent or expect to last 12 months, it is highly recommended that the case may be referred for a CE.

For further discussion of this topic, refer to L82-165, "Weight to be given testimony of treating physician."

13.10.1.8 Presence Of Substantial Objective Evidence Of Condition And Impairment

EXAMPLE: A carman has a history of degenerative lumbar disc disease. His medical findings include a history of chronic pain of several years duration, participation in a back exercise and rehabilitation program, use of anti-inflammatory medications, and participation in a weight loss program for obesity which resulted in a normalization of his weight and 25 pound weight loss. However, he continues to experience low back pain. Over the past six months, he has experienced shooting radicular leg pains affecting his right leg in the distribution of the L5 nerve. His physical examination revealed limitation of lumbar mobility and a positive right straight leg raised test. An MRI revealed evidence of significant disc degeneration in L4-5 and L5-S1 disc spaces with narrowing of the intervertebral foramen and spinal stenosis. The L4-5 disc appears to be impinging on the nerve root, but this is not clearly evident on the MRI. An EMG revealed evidence of muscle denervation affecting the muscles innervated by L5 nerve. Flexion and extension views of the back revealed no spinal instability.

In this case, the presence of multiple medical findings supports the conclusion that there is substantial objective evidence of a significant condition and impairment. Although any

isolated finding might not be sufficient to conclude that the claimant is disabled, together the findings support a diagnosis of a radiculopathy and spinal stenosis. The findings support a determination that the claimant is occupationally disabled since there is a high degree of clinical correlation of symptoms and the reported abnormal findings all support a common effect.

EXAMPLE: A trainman had a condition affecting his back and knee. He indicates that his ability to lift, carry, squat, and climb ladders is affected by both the conditions. The back condition is characterized by chronic back pain and he has been diagnosed with degenerative disc disease. The physical findings reveal nonspecific findings and an X-ray reveals degenerative disc changes.

The claimant also has arthritis of the right knee. X-rays of the knee revealed degenerative changes and the joint space is 2 - 3 mm. There is mild atrophy of the quadriceps muscles. His physician has completed an RFC stating that he cannot climb ladders more than occasionally, cannot squat more than occasionally, and cannot lift more than 20 pounds.

This trainman has atrophy of the quadriceps muscle, indicating disease in right knee significant enough that he has loss of muscle strength from disuse. This is clear and convincing evidence that the limitations set by the knee will be disabling for this job, which requires extensive climbing. Although the data on the back may not be sufficient at this point, the knee can be considered independently.

13.10.1.9 Limited Objective Evidence Of Significant Impairment

In this situation, although the claimant has one or more medical findings, the claims examiner determines that there is insufficient evidence upon which to reach a disability determination. There are several findings which could lead the claims examiner to reach the conclusion that the evidence is not sufficient to reach a "D" finding and that a CE and/or functional test should be performed.

13.10.1.10 Factors Supporting Lessening Impact

If the medical record reveals the presence of several factors supporting lessening impact identified as having a role in minimizing the impact of other findings, especially any factor that would suggest an inconsistency between examination findings and symptoms or exaggerated responses, the claims examiner should request a CE and/or functional tests. Figure 4 identifies the factors supporting lessening impact. The claims examiner needs to evaluate the entire medical record and determine if there is evidence of a significant number of negative mitigating factors which would make a determination solely on the basis of a review of the medical file valid.

13.10.1.11 Additional Testing

If the claims examiner determines, based upon a review of the available medical evidence, that a final decision cannot be reached concerning disability for a claimant,

the claims examiner should request a CE and/or functional tests. Factors that should contribute to such a recommendation for additional testing include those identified in Figure 4. Factors which provide lessening support for a disability include differences between RFC assessments among physicians and limited objective evidence. In these circumstances, additional medical testing is recommended to resolve the matter of residual functional capacity.

In general, a CE may be conducted in conjunction with the functional capacity test. Such an examination should especially be considered where:

- There is minimal objective evidence, and/or
- there is conflicting medical evidence in file, and/or
- the reliability/validity of the evidence is questionable, and/or
- there are significant negative mitigating factors.

The claims examiner has the option to obtain a CE and/or functional capacity test. Section 11 contains an overview of the types of functional capacity tests that can be performed. The decision concerning the scope of additional testing that should be performed is based upon several factors. The claims examiner must exercise professional judgment in this matter depending on the needs of the case.

If the claims examiner finds that most of the evidence suggests that the person is not capable of performing the critical job demands but the evidence has some inconsistencies, limited functional tests may be requested to help confirm this assessment. In situations where the EPIC or PILE tests are not available, then isometric strength tests could be performed. However, it is important that limited testing not be used to assess disability for cases where there are potential multiple impairments or where there is minimal overall objective evidence. A more complete assessment of the claimant's overall effort and ability to perform tasks in a number of dimensions is recommended.

<u>EXAMPLE</u>: A shop laborer has a history of a radiculopathy and a herniated disc condition. He had an operation for this condition five years previously, underwent an L4-5 laminectomy, and had a subsequent back fusion. He returned to work and has been successfully performing his job for the past several years. However, over the past five years, he has experienced a recurrence of significant back pain.

Although there is evidence of back pathology and prior surgery, there is no evidence that new pathology or any other event has changed the claimant's clinical picture since his surgery and he was able to work after the surgery with no apparent problems. More comprehensive testing is indicated.

13.10.2 Job Information

Determining the correct regular railroad occupation and associated job duties is required for occupational disability adjudication. Accurate job information is important for evaluating whether an applicant's impairment precludes performing his/her regular railroad occupation.

The regular railroad occupation is defined as follows:

- The occupation in which he/she has engaged in service for hire in more calendar months than calendar months in which he/she has been engaged in service for hire in any other occupation during the last preceding 5 calendar years, whether or not consecutive; or

- The occupation in which he/she has engaged in service for hire in not less than one-half of all of the months in which he/she has been engaged in service for hire during the last preceding 15 consecutive calendar years; or

- If an employee last worked as an officer or employee of a railway labor organization and if continuance in such employment is no longer available to him/her, the "regular railroad occupation" shall be the position to which the employee holds seniority rights or the position which he/she left to work for a railway labor organization.

13.10.2.1 Sources For Job Duty Information

Job duty information is required in the occupational disability process to compare with impairment-related restrictions. Relevant job duties are determined from several sources:

A. Form G-251, Vocational Report - Form G-251 is completed by the applicant. The information on this form includes work history for determining the regular railroad occupation and a job description of tasks performed. The tasks include a narrative description, environmental hazards and physical activities involved in an 8-hour work day.

B. Form G-251A, Railroad Job Information – Effective April 3, 2017, the Railroad Retirement Board (RRB) introduced a revised Form G-251A in accordance with the Disability Program Improvement Plan that will ask railroad employers to provide job information about applicants who apply for an occupational disability benefit under Section 2 (a)(1)(iv) of the Railroad Retirement Act (45 U.S.C. § 231a(a)(1)(iv)). Collection of job information from the employers will assist the disability examiner with making an accurate disability determination. Prior to this date, the RRB used Form G-251a and G-251b Job Information reports to collect this information. Form G-251a was released to employers for employees with a generic job description attached. Generic job descriptions were used for a select number of railroad occupations and were some of the more common types of railroad jobs. The generic job description described how select occupations

were generally performed in the railroad industry for employees. Form G-251b was released to employers for employees who did not have a generic job description.

The field office will be required to determine the employee's last regular railroad occupation and send the form to the employer The employer will then be given 30 calendar days to respond. Do not trace this form with the field office or the railroad employer. If the employer does not respond within this time, use the job duty information on Form G-251 when evaluating the occupational disability determination.

If the G-251A is returned, ensure that the correct regular railroad occupation has been determined using the guidelines above.

13.10.2.2 Assessing The Employee's Regular Occupation Job Information

The file should be reviewed to determine whether the job information received by the employer and the applicant are consistent. When reviewing job information, all sources that submit information must be considered.

A. Assessing Job Information That is in Agreement

In this scenario, the job information on Form G-251 and the job information received from the railroad employer is in agreement, or no job information is returned from the railroad employer. Since all information is in agreement, no further action is necessary for assessing job information.

B. Assessing Job Information When Differences Exist

Differences in job information must be reconciled only when they are material.

A "material" difference is defined as job information that is received from different sources, a difference in job duties exists and the difference prevents the examiner from making a sound disability decision and therefore needs to be reconciled. For example:

A carman has a history of low back pain. The objective medical evidence in file shows degenerative disc disease and he/she is restricted to lifting 50 pounds occasionally. The employee claims to lift 75 pounds frequently in his job duties. The railroad employer indicates that the employee lifts only 40 pounds occasionally. Because the actual disability determination depends on the correct amount of lifting the employee did, this difference is considered "material" and must be resolved.

C. Assessing Non-material Differences

There may be situations where differences exist in job information but they will not be material. When there are "non-material" differences, the occupational

disability rating should not be delayed for reconciliation. One scenario involves receiving information from an employee and an employer with discrepancies and areas of agreement. The areas of agreement (i.e., those job tasks common to both employee and employer job descriptions) may be precluded because of the medical condition.

<u>EXAMPLE</u>: A switchman has a history of severe degenerative arthritis in both knees. Objective medical evidence shows he is precluded from walking along uneven terrain. The G-251 shows that the employee lifts 75 pounds daily, bends, crouches and kneels constantly and walks along the railroad tracks for 6 hours a day. The railroad employer submits job information that states the employee lifts 40 pounds occasionally and sometimes bends, crouches and kneels. The employer does agree that the employee walks along uneven terrain for 6 hours per day.

In this case there are differences in job information. However, since there is agreement between the railroad employer and employee on the amount of walking along uneven terrain, and such activity is precluded because of the medical condition, a favorable rating can be made without reconciling the differences.

There may also be instances where there is discrepant job information and there are areas of agreement that are not precluded by the medical condition.

<u>EXAMPLE</u>: A secretary suffers from chronic obstructive pulmonary disease. A spirometry shows the FEV1 to be 80 percent of normal and the only restriction placed on the employee is to avoid fumes, noxious gases and dust. The G-251 indicates that the employee lifts 40 pound boxes of paper daily, sits 8 hours per day and sometimes bends, kneels and reaches. There is no indication that the secretary was exposed to fumes, noxious gases or dust. The railroad employer indicates the secretary had to lift 25 pound boxes of paper and was not exposed to any environmental hazards.

Since there is no restriction on the amount of weight to be lifted, the discrepancy that involves the boxes of paper is non-material and does not have to be reconciled. The only restriction is based on environmental hazards, which are not found in the work place, and the claim should be denied.

Another type of non-material discrepancy involves discrepant job descriptions, but the claimant's impairment would restrict him/her from performing the duties provided in either job description.

<u>EXAMPLE</u>: A conductor has angina with exertion. A review of the medical evidence of record shows the claimant has chest pain which is suggestive of angina and is relieved with nitroglycerin. A review of the cardiologist's notes states that his patient is unstable and restricts him to lifting 20 pounds maximum. The employee's vocational reports states that he lifts 75 pound knuckles daily.

The railroad employer submits information that the employee lifts hoses that weigh 50 pounds maximum.

here is a discrepancy in what was lifted and how much it weighed. In this situation, the employee would be precluded from lifting either amount. Therefore, these discrepancies do not need to be reconciled and the claim can be granted.

13.10.2.3 Reconciling Material Differences

Material differences will usually result from an oversight by either the applicant or the employer. Request the field office to resolve the discrepancy by first calling the parties to clarify the job information in question. If material differences still exist, the examiner should utilize OccuBrowse and other sources of job information to resolve the differences.

13.10.3 Determination Of Disability Through The Use Of ICE

Once the medical information and the job information has been reviewed using the above process, the claims examiner shall make a disability decision based on his/her assessment and understanding of the information. If the medical and job information indicate that an individual is not capable of performing the duties of his/her regular occupation, then the claimant is disabled. If the medical and job information indicates that an individual is capable of performing the duties of his/her regular railroad occupation, then the claim is denied.

13.11 Functional Capacity Tests

Functional capacity tests provide objective measures of a claimant's maximal work ability. These tests range from simple measures of lifting capacity, such as an isometric strength test, to a functional capacity evaluation (FCE) which provides a systematic, comprehensive assessment of a claimant's overall strength, mobility, and endurance in addition to his or her functional capacity to perform physically demanding tasks, such as standing, walking, lifting, or kneeling. The tests should be performed to provide the claims examiner with evidence of how a claimant's condition affects his or her ability to perform a function.

13.11.1 Ordering a Functional Capacity Evaluation (FCE)

Disability examiners may not order a FCE without authorization from the RRB’s medical consultant, CEL. CEL will request a FCE when CEL’s doctors determine a FCE is necessary in order to make an occupational disability determination.

CEL will make their request for a FCE on Form G-137sup. In addition, they will contact the office of the Director of Disability Sickness and Unemployment Benefits Division (DSUBD) informing the Director of their request for an FCE The case will then be forwarded to the Director’s office.

The Disability Initial Section Supervisor or the Disability Operations Analyst will be responsible for developing and ordering the FCE. The FCE report will be returned to the Initial Supervisor or Operations Analyst who will forward the file to the medical consultant, CEL, for the final RFC. CEL will then return the case with an RFC assessment to the Supervisor or Analyst who will enter the payment for the FCE and the consultant opinion. The file will be forwarded to the disability examiner for rating.

If a case is returned to a disability examiner by CEL requesting a FCE, and it has not been seen by the Director of DSUBD, the Initial Supervisor or the Operation Analyst, refer the case to one of them.

13.11.2 Functional Capacity Test Selection

Two categories of functional capacity tests can be used to assess the claimant's functional ability depending upon the nature of the condition(s). If the principle problem is related to lifting, a limited testing approach utilizing progressive lift tests or an isometric lift test can be used to only assess this ability. For medical conditions involving multiple body systems that could affect task performance, an FCE should be performed. Similarly, if the results of lift testing provide indeterminate results, the claimant should receive an FCE.

13.11.3 Lifting Tests

Progressive lift tests measure a person's capacity to perform lifting by presenting increasing loads for the lifting. Two progressive lift tests are recommended, the EPIC lift capacity test and the PILE. In addition, an isometric strength test can be used to assess lifting ability, but this provides more limited and less specific information than the progressive lift tests. The EPIC and PILE tests are the preferred tests to assess lifting since they involve an assessment of the person's lifting capacity in several domains. The isometric strength test is useful as a screening evaluation to provide supplemental information and is primarily useful to provide confirmatory information for claimants who have other significant objective evidence of an underlying low back disorder.

13.11.4 Functional Capacity Evaluation

The FCE is an assessment tool that can be used to determine a person's maximal work ability. The components of an FCE include a questionnaire, interview, general musculoskeletal evaluation and physical demand tests such as lifting, squatting, walking, etc. An FCE is most useful for orthopedic conditions and not very useful for heart and lung conditions. This type of testing can also be performed for low back conditions if the results of lifting tests reveal intermediate test results where the loss is less than 50%, but greater than 25% or in cases involving multiple conditions.

13.11.5 Interpretation Of Functional Capacity Test Finding

The functional capacity tests should be integrated with other medical information from the claimant's disability evaluation. If the appropriate test criteria have been

established, the test results can be utilized in the occupational disability claims evaluation process. The claimant may have received an FCE or other functional test at the request of his or her treating physician which may be submitted as part of the medical documentation. It is important that the functional capacity test criteria meet the quality control provisions for the relevant tests. Progressive lift tests will identify the percentage of loss of lifting capacity that the claimant has compared with population norms. In addition, the testing will identify the claimant's ability to lift a specific load.

The claimant's absolute ability to lift should also be compared with the agreed upon job demands. If the claimant has received an EPIC test, the assessment includes a determination concerning the ability of the person to perform sedentary, light, medium, heavy, or very heavy work in accordance with the lifting demands identified in the Department of Labor's, Dictionary of Occupational Titles (DOT). If the claimant has received an FCE, the evaluation should include an assessment of the claimant's ability to perform work in accordance with the demand levels identified in the DOT as well as other specific demands unique to the claimant's occupation which may involve hand dexterity, stair climbing, or other physically demanding tasks not specifically addressed in the DOT classification. These other demands are not specifically assessed in progressive lift tests.

The claims examiner should assess whether the claimant's work abilities and any limitations identified by the treating physician are consistent with the findings from functional capacity tests. If the treating physician(s) RFC evaluation is not consistent with the ability objectively measured in a functional capacity test, the claims examiner may send the results of the functional capacity test to the treating physician and request an opinion from the treating physician concerning the basis for the RFC limitations. Alternatively, the claims examiner may request a CE and provide this information as part of the medical record for review. A functional capacity test may also be scheduled concurrently with a CE.

13.11.6 Quality Test Criteria

The performance of a claimant during functional capacity tests is dependent on several factors including instruction, effort, and the claimant's underlying clinical condition.

For a claims examiner to use information from a functional capacity test for an evaluation of a claimant, the test should meet the criteria identified. These criteria require that the test be performed by a qualified professional and that the claimant's effort is determined to be adequate by a trained examiner. For some tests, such as the EPIC test or an FCE, the heart rate of the claimant is required to be monitored to assure proper effort in performing the test.

Figures

Figures 1 through 5 and Table 1 can be referenced in the Occupational Disability Standards training packet.

Appendices

See 20 CFR Part, 220, Appendix 1

The following appendices contain Confirmatory Test descriptions, Disability Test descriptions, and Testing Protocols. These supplements help in evaluating medical evidence for occupational disability claims.

Many of the test results and protocols are referred to in the Tables of the Occupational Disability Standards. However, the appendices also contain information that is not included in the Tables. The information that does not relate to the Tables is useful for claims that require an Independent Case Evaluation (ICE). For example, thyroid disorder is not covered in the Tables, but if an employee claims this condition as an impairment the confirmatory test description in Appendix A, Confirmatory Test Descriptions, is available as a guide to confirm the diagnosis.

Appendix C, consists of the protocols for numerous examinations. There are some tests, however, that should **not** be requested. These tests are:

Thallium studies

CT scan and myelogram

Electromyography

Nerve conduction velocity studies

HLA-B27 assay

Tuberculosis cultures

Holter monitors

These tests are either invasive (thallium studies), have acceptable substitutes (X-ray rather than CT scan) or should be part of the medical evidence of record (tuberculosis cultures). These procotols are available as an aide to examiners when these tests are submitted as medical evidence of recor

Appendix A - Confirmatory Test Descriptions

1.0 Cancer

Confirmation: The confirmation of cancer requires that the diagnosis be confirmed by histological examination of tissue obtained from a biopsy. It is rare for a diagnosis to be confirmed without a biopsy. The examiner should evaluate the medical records and confirm the presence of a pathology report to confirm the presence of the condition. Typically the claimant will have consulted with an oncologist and an examination of the

medical records from the oncologist should provide confirmatory information. A very high degree of reliance should be given to any diagnosis of cancer by an oncologist.

Distant disease: This diagnosis refers to metastatic cancer or cancer that has spread to a site distant from the original tumor. In most circumstances the prognosis for distant or metastatic cancer is very poor.

Localized disease: This diagnosis refers to cancer that is confined to the organ involved. Sometimes cancer may be localized to a small portion of the involved organ or be limited to single tissue within the organ. Persons with in situ cancer often have life spans equivalent to the general population and have no functional impairment after the removal of the tumor.

Regional disease: This diagnosis refers to cancer that is confined to the organ and surrounding lymph nodes.

2.0 Endocrine

Medical record review - Confirmation of condition and need for insulin use. This term refers to insulin dependent diabetes mellitus (IDDM). There are two principle types of diabetes mellitus: insulin requiring or insulin-dependent (IDDM) and non-insulin dependent diabetes mellitus (NIDDM). Persons with IDDM must use insulin to control their blood sugar. In persons with IDDM their diabetes is due to a lack of insulin. These persons are prone to developing ketoacidosis and small changes in their insulin dose can produce dramatic changes in blood sugar control. To confirm the presence of IDDM the medical records must contain evidence of an episode of ketoacidosis or absent or low blood insulin levels.

Persons with NIDDM have diabetes due to the development of a resistance to insulin. Many of these persons are obese and their glucose metabolism can be improved with weight reduction. Some of these persons may be treated with insulin to control their blood sugar but do not require insulin for control and are not prone to developing ketoacidosis or ketoacidotic coma. These persons should not be considered to have insulin-dependent diabetes mellitus even though they may take insulin at some time to control their diabetes.

Medical record review - Confirmation of condition by blood test. This result pertains to thyroid disease (hyperthyroidism, hypothyroidism and thyroiditis) controlled or uncontrolled. The confirmation of the overall condition should be accomplished by verifying the presence of an abnormal blood test (thyroid hormone level or thyroid stimulating hormone level) and possible abnormal imaging studies (thyroid scan).

Most persons with thyroid disorders can readily control their condition with appropriate replacement hormone therapy or other medical treatment. The designation that a thyroid condition is uncontrolled should be made by an endocrinologist and a specific reason(s) for the lack of control should be designated. Complications of thyroid conditions can include muscle weakness, tremors, cardiac rhythm disorders and other

problems. If complications remain after a course of adequate therapy, are verified by objective findings, and an endocrinologist judges the condition to be not controllable, then the thyroid condition should be considered as being uncontrolled.

3.0 Cardiac

Angiography - Definite occlusion >60% of one vessel. The minimum requirement is considered to be greater than 60% occlusion of one major coronary artery.

Cardiac catheterization - Poor global function and not coronary artery disease. This term refers to a result which shows poor global functioning of the heart that cannot be attributable to underlying coronary artery disease. This type of finding is seen with cardiomyopathy conditions.

Infarction - Proven by history. This term refers to a documented myocardial infarction or heart attack. The medical records must be reviewed for evidence of hospitalization for a myocardial infarction or heart attack. The initial medical records should be reviewed and there should be a confirmatory test finding that documents the heart attack such as elevations of cardiac enzymes on blood testing.

4.0 Respiratory

Methacholine challenge - Positive FEV_1 decrease >20% at PC $\leq$8 mg/ml. This term refers to a drop of 20% in FEV_1 with the administration of a dose of methacholine of 8 mg/ml or other equivalent method such as a histamine challenge.

Spirometry - FEV_1/FVC ratio. This is a marker of obstruction that is seen in persons with underlying asthma when they are symptomatic. Asthmatics can have normal lung function when they are asymptomatic. If they are symptomatic at the time of testing, then this finding or a diminished FEV_1 should be observed. This test result finding is not required if the person has medical records documenting the occurrence of previous episodes of asthma. This would include a medical record demonstrating wheezing or airway obstruction that reverses with the administration of a bronchodilator.

5.0 Lumbar Sacral Spine

Electromyography - Definite denervation. Positive signs of denervation can include multiple positive sharp waves or fibrillation potentials. These findings are consistent with acute nerve root compression. Changes associated with chronic denervation include polyphasic waves. EMG changes should be correlated with distribution of symptoms and imaging study abnormalities. The presence of EMG findings in muscles unrelated to pain, symptoms in affected parts, or imaging studies abnormalities, can have minimal functional impact.

Medical record review - Documentation of failure of implant following surgical procedure. This term refers to the failure of a device implanted for correction of an underlying problem.

MRI, CAT or myelogram - Neural impingement of spinal nerves below L1. This term refers to the occurrence of central disc herniation or other pathology that causes direct pressure on the sacral cauda equina nerve roots. Cauda equina syndrome is the result. This condition can be demonstrated by either MRI, CAT or myelogram

MRI, CAT or myelogram - Significant degenerative disc changes. Degenerative changes are common in the general population and some studies report that up to 70% of asymptomatic persons over the age of 50 have degenerative back changes. Osteophytes and disc space narrowing and degeneration are common, especially in the lower lumbar spine. There are no absolute criteria representing a clear delineation between findings that are responsible for pain and those seen in asymptomatic persons. Since degenerative changes can be seen in asymptomatic persons, imaging findings should correlate with clinical findings if the findings are going to be used for evaluating impairment and disability status.

Findings that have been reported to have essentially no relevance include tropism or misorientation of the facet joints, increased lumbar lordosis, spina bifida occulta, transitional vertebra, Schmorl's nodes, and lumbosacral tilt.

MRI, CAT or myelogram - Evidence of neural compression. This term refers to evidence of degenerative disc or joint changes that result in nerve root compression. The disc or joint pathology should involve the nerve root and correlate with the person's radicular symptoms including pain, numbness, tingling, or weakness. In the lumbar spine, the exiting nerve root is named for the vertebrae about which it exists. Thus, a L5-S1 disc herniation causes impingement of an S1 nerve root. Symptoms should be checked to see if they match the nerve root distribution.

MRI, CAT or myelogram - Significant narrowing: spinal cord canal or intervertebral foramen. This term refers to significant narrowing of the spinal canal, nerve root canals, or intervertebral foramina. This condition is also known as spinal stenosis. There should be evidence that narrowing of the canal or other structures results in compression of neurological structures and correlates with symptoms. A narrow spinal canal can be congenital or relate to degenerative changes which can result in entrapment of the spinal canal or nerve roots. Stenosis can also be classified as the basis of which segments of the spinal canal are affected (central canal, the subreticular, lateral recess or the neural foramina). Symptoms must be correlated with imaging study findings since it is possible to have findings of spinal stenosis in an asymptomatic person.

There are differences of opinion regarding the precise dimensions or size that differentiate a normal spinal canal from a canal with significant narrowing. In general when using a CAT scan to evaluate the spinal column, an anterior posterior diameter of less than 11. 5 mm (distance from the posterior surface of the vertebral body to the superior portion of the corresponding spinous process); or an interpedicular distance of less than 16 mm (transverse diameter); or a canal cross section of less than 1.45 cm are considered small. These dimensions are often provided on imaging study results. With reference to the lateral recess area, a measurement of less than 3 mm is

considered small. There are no widely accepted criteria for normal dimensions of the nerve root foramina. A small spinal canal favors the occurrence of compression of intraspinal neurological structures from degenerative spinal changes.

Nerve conduction testing - Definite slowing. Confirmation of the condition requires evidence of definite slowing. This can be manifested by the absence of the H wave or by delay of 3mm/seconds. Nerve conduction slowing must be correlated with the distribution of symptoms and imaging study abnormalities. The presence of nerve conduction slowing unrelated to the pattern of pain distribution or other relevant symptoms or imaging study abnormalities can have minimal functional impact.

Physical examination - Atrophy of affected limb greater than 2 cm. The presence of muscle atrophy can be observed in the lower extremity secondary to chronic denervation or disuse because of neurologic compromise. The circumference of the involved leg should be compared to the non involved leg (above knee). Atrophy should not be able to be explained by the presence of nonspine-related problems such as contralateral hypertrophy that might occur with a dominant limb or with increased use of a limb. Atrophy should be correlated with electrodiagnostic findings (electromyography - or nerve conduction testing) where possible.

Physical examination - Straight leg raise. This is a physical examination finding that provides evidence of compression of the lumbosacral nerve roots and provides supportive evidence of a radiculopathy. The test involves raising the leg to determine if this produces symptoms of pain in distribution of the nerve root in the affected leg.

There can be false positive results with this physical examination test. There are certain physical examination findings that can be performed by an examiner to determine if the claimant's response in a straight leg test is valid. Not all examiners perform a validity check on this physical examination finding. If the medical report contains information on tests for validity of the claimant response, then a positive finding is to be judged as more significant.

The validity criteria can include:

- Crossed opposite straight leg raise - if lifting of the leg without pain produces sciatic pain in the contralateral leg, the result is to be judged as more valid (positive contralateral straight leg raising test).

- Consistent repose to equivalent sciatic tension (stretching) - claimant response to raising leg while in the sitting position is compared to the response while supine (lying down).

- Response of claimant while supine to dorsiflexion and plantar flexion of the ankle- normally ankle dorsiflexion will relieve the pain and plantar flexion will increase the pain.

- Response of claimant while supine to hip internal and external rotation when the leg is straight - normally external rotation will decrease the complaints.

  Sensory examination - Loss of sensation in affected dermatomes. This term refers to the loss of sensation in areas of the lower limb corresponding to the distribution of the affected nerve.

6.0 Cervical Spine

Electromyography - Definite denervation. A diagnosis is established by positive signs of denervation which can include multiple positive sharp waves or fibrillation potentials. These findings are consistent with acute nerve root compromise. Changes associated with chronic denervation include polyphasic waves. EMG changes should be correlated with distribution of symptoms and imaging study abnormalities. The presence of EMG findings in muscles unrelated to pain, other relevant symptoms, or imaging studies abnormalities, can have minimal functional significance.

MRI, CAT or myelogram - Neural compression of spinal nerves. A diagnosis is established when clinical findings demonstrate evidence of a spinal curve or compromise of spinal nerves through the intervertebral foramina.

MRI, CAT or myelogram - Significant neurogenic compression. This term refers to findings that produce significant spinal cord pressure including anterior compression of the spinal cord from posterior osteophytes, posterior compression from the ligamentum flavum, especially with extension of the cervical spine, or evidence of vascular compromise of the spine by effects on spinal arteries, or from a degenerated or torn disc that has encroached on the spinal cord. Significant encroachment of the spinal canal is more prominent when there is a narrow (10 mm or less sagittal diameter) spinal canal.

MRI, CAT or myelogram - Significant disc degeneration. There are no definite criteria to define what degree of significant disc degeneration is associated with pain or impairment. It is not uncommon for asymptomatic persons to exhibit degenerative changes of the disc.

MRI, CAT or myelogram - Significant joint degeneration. There are no definite criteria to define what degree of significant joint degeneration is associated with pain or impairment. It is not uncommon for asymptomatic persons to exhibit degenerative changes of the joints.

Medical records review cervical - rheumatoid arthritis. Confirmation requires evaluation by a rheumatologist.

Medical records - Continued pain post-surgery. The claimant should have continued pain after surgery that interferes with the ability to perform occupational activities. The claimant is not responsive to conservative therapy including medications or physical therapy for at least one year after surgery.

Medical records - Radicular pain. This term refers to pain in the distribution of the affected nerve root. Radicular pain should be correlated with imaging study findings.

Nerve conduction testing - Definite slowing. Confirmation of the diagnosis requires evidence of definite slowing. Slowing is manifested by the absence of the H wave or by delay of 3mm/seconds. Nerve conduction slowing should be correlated with the distribution of symptoms and imaging study abnormalities. The presence of nerve conduction slowing of nerves unrelated to the pattern of pain distribution, other relevant symptoms, or imaging study abnormalities, have minimal functional significance.

Physical examination - Atrophy of affected arm greater than 2 cm. A diagnosis is established by the presence of muscle atrophy that can be observed in the upper extremity secondary to chronic denervation or disuse because of neurologic compromise. The circumference of the involved arm should be compared to the non involved arm (above elbow). Atrophy should not be able to be explained by the presence of non spine-related problems such as contralateral hypertrophy that might occur with a dominant limb or with greatly increased use of a limb. Atrophy should be correlated with an electrodiagnostic finding (electromyography -or nerve conduction testing) when possible.

Physical examination - Evidence of myelopathy. Myelopathy is a condition caused by compression of the spinal cord which can involve both upper and lower motor neurons. Compression can be due to several factors including both disc herniation and/or compression from degenerative bony changes involving the cervical spinal joints and surrounding structures. The diagnosis requires confirmation by imaging studies including CAT, MRI or myelogram.

Upper motor neuron findings involve lower extremities and can produce symptoms of spasticity, increased deep tendon reflexes, and a positive Babinski test (not all may be present at same time). These are also called long tract signs. Some persons can also exhibit a stooped wide-based gait or jerky gait.

Lower motor neuron involvement affects the upper extremity and results in weakness of the upper extremity. The distribution of weakness is dependent upon which nerve root is affected. Lesions at the C4-5 disc level involve the C5 nerve root and can produce deltoid weakness, shoulder abduction problems, and a loss of the biceps reflex. Lesions at the C5-6 disc level affect the C6 nerve root can cause weakness of the biceps, elbow flexion and forearm supination, and wrist extension. A C6-7 disc lesion affecting the C7 nerve can produce weakness of elbow extension, as well as finger and wrist extension. A lesion at the C7-T1 disc can involve the C8 nerve and produce both weakness of elbow extension and finger flexion.

7.0 Shoulder

Medical record review - Condition with permanent functional limitations. This term refers to the presence of an underlying medical condition that has produced a permanent impairment of the elbow, e.g., a permanent angular deformity of the elbow

following a fracture, or limitation of range of motion following a traumatic injury involving the joint. This abnormality should be confirmed with an imaging study.

8.0 Hand And Arm

Medical record review - Documentation of medical condition for permanent limitation. This term refers to the presence of an underlying medical condition that has produced a permanent impairment of the wrist, hand or thumb. This condition should be confirmed with an imaging study.

Nerve conduction studies - Definite median nerve conduction slowing at wrist.

Physical examination - Definite reproducible evidence of limitation. This term refers to the presence of a physical finding that is measured consistently (or reliably) by different qualified medical examiners.

9.0 Hip

Alkaline phosphatase - Increased up to 50 times. This term refers to a blood test finding.

10.0 Knee

The terms are self-explanatory.

11.0 Ankle And Foot

The terms are self-explanatory. All reports should include the name and signature of the physician reading the test.

- The name of the technician administering the test should appear on the report.

Appendix B - Disability Test Descriptions

1.0 Cancer

Category 1. Conditions which are identified as Category 1 are classified as being disabling. These conditions either have a poor prognosis (in general < 50% 5-year survival rate) or the treatment required for the condition is associated with significant impairments which would make it impossible for the railroad employee to perform the job.

Category 2. Category 2 conditions represent an intermediate group for which an individual determination is required. In general, conditions that have extensive local spread or more aggressive histopathology are more likely to be considered as disabling while those with more differentiated tumors (in general, less aggressive growth potential) and minimal local extension are more likely to be classified as a nondisabling.

Category 3. Category 3 conditions are considered as being nondisabling. Persons with these conditions generally have a life span that is similar to that of the general population with minimal impact on daily activities or ability to perform occupational tasks.

2.0 Endocrine

The terms are self-explanatory.

3.0 Cardiac

The terms are self-explanatory.

4.0 Respiratory

PO_2 - arterial. No specific cut-off level is provided for PO_2 which would result in a "D" classification since other measures are thought to better represent an indication of disability status. Other factors can also affect the arterial PO_2 including altitude, breath holding, and obesity. Exercise capability is thought to correlate better with FEV_1 than PO_2. However, an arterial PO_2 of <60 mm Hg in an claimant breathing room air (at sea level) with a confirmed lung condition provides strong evidence of severe pulmonary impairment. Such a claimant would be unlikely to be able to perform physically demanding work.

5.0 Lumbar Sacral Spine

Lifting capacity diminished by 50%. This term refers to a decrease in lifting capacity by 50% using a valid measure of lifting capacity.

No specific test or "gold standard" is available for measuring lifting capacity. Several tests can be used for this type of assessment and each method has its own particular limitations. Several factors can affect the lifting capacity of the worker other than musculoskeletal capacity or strength. Limiting factors may include fear or anxiety about the test or unclear instructions. For a test to be a valid predictor of lifting capacity, these factors need to be assessed as part of the quality control procedure. These tests have been selected based upon the following criteria:

MRI, CAT, myelogram - Significant narrowing of the spinal canal. This term refers to spinal stenosis which has been defined as narrowing of the spinal canal, nerve root canals, or intervertebral foramina. For a diagnosis to be confirmed, there should be evidence that the narrowing of the canal results in compression of neurological structures and is correlated with symptoms of the affected dermatomes. A narrow spinal canal can be congenital or be related to degenerative changes resulting in entrapment of the spinal canal or nerve roots. Stenosis can also be classified on the basis of which segments of the spinal canal are affected (central canal, the subreticular, lateral recess or the neural foramina).

There are differences of opinion regarding the precise dimensions or size that differentiate a normal spinal canal and a canal with significant narrowing. When using a CAT scan to evaluate the spinal column, an anterior posterior diameter of less than 11.5 mm (distance from the posterior surface of the vertebral body to the superior portion of the corresponding spinous process) an interpedicular distance of less than 16 mm (transverse diameter), or a canal cross section of less than 1.45 cm are considered small. With reference to the lateral recess area, a measurement of less than 3 mm is considered small. There are no widely accepted criteria for normal dimensions of the nerve root foramina. A small spinal canal favors the occurrence of compression of intraspinal neurological structures from degenerative spinal changes.

Symptoms should be correlated with imaging study findings since it is possible to have findings of stenosis in asymptomatic persons.

MRI, CAT, myelogram - Significant compression of the dural sac. This term refers to the presence of a compression of the dural sac which results in spinal cord or nerve root compression. There must be correlating symptoms in the appropriate distribution of the nerve root. The presence of correlating electrodiagnostic findings (EMG or NCV) provides strong supportive evidence in establishing the diagnosis. This finding in the presence of a narrow spinal canal can also be considered as significant narrowing - spinal canal.

MRI, CAT, myelogram - Significant narrowing of the intervertebral foramen. This condition is the presence of a narrow intervertebral foramen that could produce impingement of a nerve root. There must be correlating symptoms in the appropriate distribution of the nerve root. The presence of correlating electrodiagnostic findings (EMG or NCV) provide strong supportive evidence of confirmation of the diagnosis. This finding in the presence of a narrow spinal canal can also be considered as significant narrowing - spinal canal.

MRI, CAT, myelogram - Disc extrusion with neural impingement. This condition is the presence of a disrupted disc that has resulted in direct impingement of a nerve root. To confirm the diagnosis and result in a "D" determination, there must be correlating symptoms in the appropriate distribution of the nerve root. The presence of correlating electrodiagnostic findings (EMG or NCV) provides strong supportive evidence of the diagnosis. This finding, in the presence of a narrow spinal canal, could also be considered to be classified as significant narrowing - spinal canal.

Medical record review - Frequent flare-ups with objective findings. This term refers to evidence of repeated infections over the past three years with corresponding blood findings demonstrating chronic infection, abnormal bone scan findings showing increased uptake consistent with active infection, and/or positive bacterial cultures requiring antibiotic therapy (usually intravenous and requiring hospitalization).

Physical examination - Lower extremity weakness. This term refers to the presence of lower extremity weakness due to neurogenic compression of spinal canal or nerves that significantly interferes with gait or ability to use lower limb. To establish a diagnosis,

there should be correlating imaging study findings demonstrating pathological correlation in the spinal canal to account for the weakness and the underlying electrodiagnostic findings. There should be demonstrated atrophy in the affected limb.

X-ray flexion/extension - Segmental instability. This term means the flexion and extension comparison roentgenograms showing significant injury-related anterior-to-posterior translation of two adjacent vertebral bodies of 5 mm or more.

6.0 Cervical Spine

MRI, CAT, or myelogram - Significant spinal cord pressure. Imaging findings that can account for significant spinal cord pressure include anterior compression of the spinal cord from posterior osteophytes, posterior compression from the ligamentum flavum, especially with extension of the cervical spine, evidence of vascular compromise of the spine by effects on spinal arteries, or from a degenerated or torn disc that has encroached on the spinal cord. Significant encroachment of the spinal canal is more prominent when there is a narrow spinal canal (10 mm or less sagittal diameter).

Multilevel - Neurologic compromise. This condition is muscle weakness involving more than one nerve segment. Muscle weakness should be confirmed with appropriate imaging study findings (the presence of radiological evidence of confirming lesion, i.e., disc spur, etc. involving appropriate nerve segment innervating the muscle group responsible for the weakness). Ideally,

electromyographic or nerve conduction study findings should provide confirmatory electrodiagnostic evidence. Isolated radiological findings have little significance.

Physical examination - Lower extremity weakness and/or significant spasticity. The examiner should demonstrate the presence of weakness or spasticity in a claimant with confirmed compression of the spinal cord. The presence of associated gait problems makes these findings more disabling. These findings should be correlated with imaging study findings of significant spinal cord pressure. Without confirmatory findings on imaging studies, the presence of these physical findings should not be considered disabling.

7.0 Shoulder

The terms are self-explanatory.

8.0 Hand And Arm

The terms are self-explanatory.

9.0 Hip

The terms are self-explanatory.

10.0 Knee

Physical examination - Valgus deformity, 16-20 degrees. Deformity measured by femoral-tibial angle; 3 degrees to 10 degrees valgus is considered normal.

Physical examination - Valgus deformity, 8-12 degrees. Deformity measured by femoral-tibial angle; 3 degrees to 10 degrees valgus is considered normal.

X-ray of knee. X-rays of the knee should be taken in the standing position.

11.0 Ankle And Foot

X-ray - Ankle 0 mm. This term refers to absence of joint space from degenerative changes. The normal cartilage interval is 4 mm.

X-ray - Talonavicular joint 0 mm or 1 mm. This term refers to the joint space of the talonavicular joint. This joint space is typically between 2 - 3 mm. The ankle should demonstrate some associated degenerative changes.

Appendix C - Test Protocols

Protocol For Progressive Lift Tests

Two progressive lift tests are recommended for the RRB disability assessment: EPIC and PILE. The following procedures should be followed with respect to the administration of these tests:

The person undergoing testing should have medical authorization prior to performing the test.

The health professional administering the test should have completed an approved course of training for the test and demonstrate an acceptable level of proficiency.

The facility must have the appropriate equipment to administer the test.

The written test protocol contained in the examiner or administration manual for the test must be followed.

The examiner must assess and report the examinee’s test results using the criteria specified by the test designed and the test-specific protocols.

Written reports must follow the procedures described in the test-specific protocols.

The final report should include a ranking of the subject against population norms and must include a statement concerning the evaluator’s assessment of the subject’s efforts in performing the test.

Isometric Strength Lift Test Protocol

The RRB recommends an isometric strength lift test as part of a protocol to assess the functional capacity of an individual. There are several recommended test protocols that have been published in the peer-reviewed literature for this type of test. The RRB recommends that the Zeh test protocol be used for assessing isometric strength lifting capacity (Zeh J, Hansson T, Bigos S, Spengler D, Battie M, Wortley M. (1986) Isometric strength testing: recommendations based on a statistical analysis of procedure. Spine. 11(1): 43-46).

The Zeh protocol limits the number of exertions or lifts that the subject must perform and minimizes the risk of injury associated with lifting. An isometric lift test is less comprehensive and specific than a complete Functional Capacity Evaluation (FCE). If there are minimal findings or there is an impairment of other body parts or systems, then the FCE should be considered as the initial test requirement.

The following parameters should be followed for all isometric strength tests performed by the RRB:

The University of Michigan strength test system or equivalent should be used. (Chaffin D, Herrin GD, Keyserling WM. (1978) Preemployment strength testing: An updated position. *J. Occu Med.* 20: 403-408).

Lift should be measured in arm, leg or squat, and torso. One lift maneuver should be performed for each position.

Instructions to the claimant should be objective, with no emotional appeal.

Subjects should be asked to increase exertion during the first 2 seconds, then hold steady for 3 more seconds.

Subjects should not be given specific test results to compare with norms or with other volunteers' performances.

Other influences on performance (e.g., noise, spectators) should be minimized.

The final report should include a ranking of the subject against population norms and must include a statement concerning the evaluator's assessment of the subject's effort in performing the test.

Subjects should be instructed to discontinue the test in case of any physical discomfort.

Authorization from a treating or board-appointed examining physician should be obtained prior to the testing procedure.

The value of the isometric lift test can be increased by increasing the numbers of lifts. The number of lifts can be increased to two lifts for each position upon recommendation of the board-appointed examining physician or with approval of the treating physician(s).

Instructions For Thallium Studies

Thallium study (nuclear myocardial perfusion) is a nuclear medicine technique used to measure the viability of heart muscle. It is usually done in conjunction with an exercise protocol to stress the heart muscle (medications can also be used to stress the heart muscle without physical exercise.)

The following guidelines should be adhered to when conducting and reporting on the thallium (myocardial perfusion) imaging study:

Provide the date of testing

An exercise protocol should be indicated on the report (e.g. Bruce protocol) and the percent of maximum heart rate should be reported.

The thallium should be injected at peak exercise (usually 1 minute prior to cessation of exercise).

The dose of the thallium injected should be reported.

Imaging studies should be done immediately to assess the “exercise” portion of the study. A “redistribution” imaging study should be obtained 3-4 hours later, anterior, left anterior oblique (45 degrees) and left lateral views should be obtained for each imaging study.

The results should be interpreted by a board certified nuclear medicine physician and include comments on lung activity, distribution and if any abnormalities are reversible or non-reversible.

The physician's name and signature should appear on the report.

Instructions For Holter Monitoring (Ambulatory Electrocardiograph)

The Holter monitor records the heart’s electrical activity through electrodes placed on the chest over a 24 to 48 hour period. The electrical impulses are then transmitted to an amplifier, which records them on a small magnetic tape recorder for later review by the physician.

The following guidelines must be adhered to when conducting and reporting on Holter monitoring:

Ambulatory electrocardiographs use a bipolar lead system. Generally, the leads of a two-channel system approximate lead V_1, and V_2. The lead configuration should be indicated on the report.

The patient should be required to complete a diary card for the duration of the test. On this card the patient should record his/her activities and symptoms during the monitoring period.

The technician will then correlate the electrical activity with the symptoms and activities reported on the card.

The date of recording must be provided.

The date of analysis must be provided.

The length of the recording must be reported and must be for at least a 24 hour period.

A comment on the quality of the scan should be included with the report.

Any abnormal findings (e.g., abnormal rhythm, ectopic beats, etc.) should be indicated as well as any associated symptoms experienced by the patient.

If any abnormalities are noted on the 24-hour Holter monitor, correlation to existing disease should be commented on.

The name of the technician scanning the initial readings should be indicated.

All reports should be signed and dated by the physician.

The physician interpreting the results should be a board certified cardiologist.

Instructions For CT And Myelograms

CT and myelograms are common imaging studies used to assess the anatomy of the lumbar spinal canal, the knee, shoulder and wrist.

The following guidelines must be adhered to when conducting and reporting on CT and myelograms:

Provide date of exam.

All CT scans and myelograms should be read by a board certified radiologist. The radiologist's name and signature should appear on the dictated report.

CT cuts should be made no wider than 0.5 cm. When evaluating low back pain, the cuts should be made parallel to the vertebral endplates.

Myelography and CT-myelography should use a water-based contrast media, not oil based.

The technical protocols for these imaging tests should be described on the radiologist reports.

Instructions For Spinal Instability X-Rays

Spinal instability X-rays are X-rays of the cervical, thoracic and lumbar spine done in full flexion and extension views. These are functional studies which are designed to demonstrate motion or lack of motion of the spinal vertebrae.

The following guidelines should be adhered to when conducting and reporting on spinal instability X-rays:

Provide date of examination.

A description of the vertebral bodies should be included with the report. Particularly, the report should comment on any disk space narrowing and alignment of the vertebral canal.

The physician's name and signature should appear on the report.

Instructions For Electromyography (EMG)

Electromyography is used to assess neurologic dysfunction. The overall diagnostic objectives of this test is to assess suspected myelopathy (dysfunction of the spinal cord), radiculopathy (dysfunction of a spinal nerve root), neuropathy (dysfunction of a peripheral nerve at a distance the nerve root), and myopathy (muscle abnormalities).

The following guidelines should be adhered to when reporting on EMG studies:

Provide the date of testing.

- The muscles being tested should be included in the report.
- Electrical activity of the muscle(s) being tested at rest, on needle insertion and during contraction should be reported.
- Recruitment patterns and drop-outs of motor unit potentials should be reported.
- The physician’s name and signature should appear on the report.

Instruction For Nerve Conduction Velocity Studies

Nerve conduction studies are tests of peripheral nerves performed by stimulating the nerve at one point and measuring the action potential either at another point along the nerve (sensory conduction) or of the muscle innervated by the nerve (motor conduction).

The following guidelines should be adhered to when conducting and reporting on nerve conduction velocity studies:

Provide the date of testing.

The nerve being tested should be indicated as well a any latency in the conduction times (in milliseconds). Normal values should be included for comparison.

An assessment by the reviewing neurologist should be included in the report.

The neurologist's name and signature should appear on the report.

Instructions For HLA-B27 Assay

HLA-B27 is a serologically defined allele of the human HLA-B locus. The presence of the HLA-B27 antigen strongly suggests ankylosing spondylitis and related disorders.

The following guidelines must be adhered to when conducting and reporting on HLA-B27 assays:

Samples must be received within 48 hours of collection.

Prior to analyzing any samples, instrument quality control should be performed using negative control samples. Positive controls should also be used. Any quality control results that indicate a failure should be recorded and action taken.

Results should be reported as negative or positive.

The name of the technical supervisor or medical director should appear on the report.

Instructions For Tuberculosis Cultures

Many laboratories have adopted the recommendations to use rapid acid-fast bacilli (AFB) smears, growth detection (i.e., primary culture), identification, and drug-susceptibility testing for M tuberculosis.

The following guidelines must be adhered to when conducting and reporting on AFB smears and primary tuberculosis cultures:

The regulations implementing the 1988 Clinical Laboratory Improvement Amendments (CLIA) require all laboratories that perform any mycobacteriology testing to enroll in federally approved proficient testing (PT) programs.

It is important to identify which category the laboratory reporting the results falls into:

AFB smears performed and all specimens for primary culture referred to another laboratory.

AFB smears and primary cultures for M tuberculosis performed, but all AFB positive culture isolates referred for organism identification and drug-suspectibility tests.

AFB smears and primary culture with identification of M tuberculosis isolates performed but referred to drug-susceptibility testing.

AFB smears, primary culture, identification and drug susceptibility testing for M tuberculosis performed.

Rapid laboratory testing to identify and determine the drug susceptibility of M tuberculosis isolates is vital to effective diagnosis, treatment and control of TB.

Liquid culture method should be used in order to decrease the time required to detect and solate mycobacterium, as well as increase the sensitivity of the culture to M tuberculosis.

Results should be reported as negative or positive. If result is positive, sensitivities of the culture to certain antibiotics should also be reported.

Name of supervising microbiologist should be on the report.

Instructions For Multiple Sleep Latency Testing (MSLT)

MSLT is the only scientifically validated objective test of excessive sleepiness. The MSLT is used to establish a diagnosis of specific sleep disorders or to determine the severity of sleepiness.

For correct interpretation, the MSLT must be performed under appropriate conditions and requires accurate technique. The following guidelines must be adhered to when conducting and reporting on multiple sleep latency tests. The following protocols are accepted by the American Sleep Disorders Association.

For correct interpretation, the MSLT must be performed following an all night polysomnogram to provide accurate documentation of the proceeding nights sleep.

MSLT are routinely performed at 2 hour intervals, beginning 1.5 to 3 hours after the end of the nocturnal recording.

The testing bedrooms should be quiet and dark and intermitted noises (e.g. elevator, toilet, sirens) that are likely to abort sleep onset should be avoided. If such noises are unavoidable, the noise should be documented on the polysomnographic chart recording.

The light level in the bedroom should be very low and should not vary with the time of day.

Room temperature should be kept constant.

- The patient/subject should be prohibited from ingesting alcohol or caffeine on the day of the test.
- Since the study may be influenced by sleep for up to 7 nights beforehand, the patient should have completed sleep diary forms for 1-2 weeks prior to the sleep study.

- The MSLT should consist of five nap opportunities in order to determine both severity of sleepiness and presence of two or more sleep onset rapid eye movement (REM) period for the diagnosis of narcolepsy.
- A 4-hour nap test may be performed for determination of excessive sleepiness, but this test is not reliable for the diagnosis of narcolepsy unless at least two sleep onset REM periods have occurred.
- Sleep onset should be determined by the first epoch of any stage of sleep, including stage 1 sleep.
- The absence of sleep on any nap opportunity should be recorded as a sleep latency of 20 minutes.
- The MSLT report should include the onset and offset time of each nap, latency from lights out to the first epoch of sleep, amount of each sleep stage, total sleep time, mean lateness to sleep of all naps and number of sleep onset REM periods.
- All reports should include the name and signature of the physician reading the test.
- The name of the technician administering the test should appear on the report.