

**Fibromyalgia Disability and Social Security: A Physician's Perspective on The New Requirements of SSR 12-2p** by Richard N. Podell, M.D., MPH

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In 2012 Social Security published detailed guidelines for patients/claimants with Fibromyalgia (FM) who wish to apply for Social Security benefits. (1) This essay explains these new guidelines and helps to organize the information that Social Security Requires.

*First, What Is Fibromyalgia(FM)? Is It an Important Cause of Disability?*

Populations studies tell us that fibromyalgia affects between 2% and 5% of adults in the U.S.—several million plus people. For most, FM's symptoms are annoying but manageable. However, for a significant minority, severe pain, fatigue, non-restorative sleep, cognitive difficulties and other symptoms dominate their lives—often to the degree that they can no longer work.

Until fairly recently many physicians and much of the public were skeptical about fibromyalgia. However, as scientific research has advanced, formal certifying agencies including the Social Security Administration and almost all medical specialists now agree that Fibromyalgia is a real and mainly physical illness. (2-4)

A key mechanism causing FM pain is a neurological phenomenon called “Neural Sensitization”. In essence, the central nervous system's pain signaling pathways become hyper-sensitive. Small stimuli that would normally cause little pain amplify as their signals travel through the spinal cord, and into the brain. Because of this neurological amplification, persons with FM experience pain at much lower levels of pressure, heat, or cold stimulation than do others.

Neural sensitization has been proved by sophisticated brain imaging techniques such as functional Magnetic Resonance Imaging (fMRI). Functional MRI differs from standard MRI by its ability to measure the level of blood flow within specific areas of the brain. Increased blood flow reflects increased activity of those areas.

A typical experiment applies a standard amount of mild pressure, heat or cold to the skin or muscle while monitoring the brain's fMRI reaction. *Healthy persons do not complain of pain and have little or no increase in blood flow activity observed within the brain's pain centers. In contrast, persons with Fibromyalgia, when exposed to the same low level of stimulus, do report increased pain. And their fMRI scans show simultaneously increased blood flow within the brain's pain centers.*(5)

Alan Light, PhD, from the University of Utah Medical School, provides evidence of increased activity of certain specific genes when FM patients complain of prolonged worsening pain after doing mild exercise. (6)

These studies prove that persons with Fibromyalgia genuinely feel the pain they report. If we think of the central nervous system's pain signaling pathways as a radio set, neural sensitization indicates that the radio's volume control knob is turned up to very high.

Neural sensitization may also play a role in a broad range of difficult to treat health conditions. These may include: chronic fatigue syndrome, irritable bowel syndrome, osteoarthritis of the knee, chronic low back pain, irritable bladder syndrome, temporal mandibular joint dysfunction, migraine headache, tension headache and perhaps also anxiety disorders. If so, Fibromyalgia might be just the tip of an important iceberg. (7)

Social Security's key document, *Social Security's Policy Interpretation Ruling, Evaluation of Fibromyalgia, SSR 12-2p*, was published in the Federal Register on July 25, 2012. (1) This document presents Social Security's views on Fibromyalgia disability.

These new guidelines tell the applicant, claimant's representative and physician the specific information social security requires in order to make a decision on disability. Despite its intimidating title SSR12-2p is very "patient friendly".

For example, SSR 12-2p recognizes that persons with severe Fibromyalgia can have relatively "good days" when they can do a fair amount, but also "bad days" when they can do very little. Persons with frequent bad days often cannot work regularly despite their ability to function better on "good days". Thus, SSR 12-2p states:

**"For persons with FM, we will consider a longitudinal record whenever possible because the symptoms of FM can wax and wane so that a person may have "bad days" and "good days".** Presenting information about "bad days" is a useful way to demonstrate a client's disease severity.

Perhaps most importantly, SSR 12-2p asks about the patient's total health burden—physical, psychological, medicine side effects—not just their fibromyalgia pain. **"We consider all relevant impairments, including impairments that are 'not severe'"**

But SSR 12-2p also creates problems. It requires the patient, physician and claimant's representative to provide specific information and to do this within a very specific set of formats. These formats will be totally unfamiliar to most physicians. One purpose of this essay is to help patients and claimant's representatives help the physician navigate through this territory.

***Since few patients (and even fewer physicians) will want to master the details of SSR 12-2p on their own, the benefit of involving a claimant's representative early in the process becomes much more important than it had been before.***

*Most challenging, the patient and his or her representative will have to tutor the physician so that the all-important physician's letter to social security satisfies SSR 12-2p's requirements.*

*This essay has two sections. In the first I will explain the key points of SSR 12-2p. In the second I offer worksheets that help organize the information that social security requests. A copy of these worksheets completed by the patient and representative should be provided to the physician before he or she writes the social security report.*

*I have also included a "model letter" to help the physician structure the social security letter. This will help the physician by identifying the key points that Social Security requires. Word to the Wise: Explaining this to the physician will require a high level of tact and diplomacy.*

## **Section I: Explanation of SSR 12-2p**

SSR 12-2p asks the claimant and the physician two basic questions:

- 1) Is there sufficient evidence to prove that the claimant suffers from the medically determinable impairment (MDI) of Fibromyalgia (FM)?*
- 2) Are the symptoms and limitations caused by the claimant's Fibromyalgia pain, fatigue, poor sleep, cognitive difficulties and other symptoms severe enough to prevent the person from working?*

**How to Prove the Diagnosis of Fibromyalgia.** SSR 12-2p permits the use of either of two methods to establish the diagnosis of FM. However, the physician should state which of the two methods he or she has used. (For example see my "model letter" in Appendix II.)

SSR 12-2p allows the physician to use the Criteria for diagnosis contained in the American College of Rheumatology (ACR) report of 1990. (8). Or the physician can use the more complex but more practical Criteria in the ACR's more recent report of 2010 (9). Both methods are considered valid by SSR 12-2p and by the ACR. For practical reasons the ACR Criteria will be the most often used.

*According to the **1990 ACR Criteria** the diagnosis of Fibromyalgia should meet these three criteria:*

1. A history of chronic widespread pain affecting all four quadrants of the body and also the spinal area for a period of at least 3 months
2. Pain produced when a standard level of pressure is applied to at least 11 of 18 anatomically defined sites on the body known as “tender points”.  
(The practical problem is that most physicians have not been trained to do a proper tender point exam.)
3. **“The presence of as second clinical disorder (that causes pain) does not exclude the diagnosis of fibromyalgia.”** (Emphasis added.) For example, about 25% of patients with Rheumatoid Arthritis also qualify for the diagnosis of Fibromyalgia.

If your client’s physician is comfortable doing a standard “tender point” exam, and if that exam then demonstrates pain at 11 or more of the 18 standard tender points, it’s okay to use the 1990 ACR Criteria to justify the diagnosis.

If the physician’s diagnosis depends on the 1990 ACR criteria, he or she might physician might consider a paragraph in the report along these lines:

*“Mr./Ms. X satisfies the American College of Rheumatology’s 1990 Criteria for the diagnosis of Fibromyalgia. This method has been endorsed by Social Security’s Policy Interpretation Ruling, SSR 12-2p.*

*Specifically, he/she has a long history of chronic widespread pain affecting all 4 quadrants of the body and also the spine. On physical examination he/she demonstrates pain at (state the exact number of painful tender points) of the 18 standard Fibromyalgia tender points. (There should be at least 11 of 18. )*

*His/her chronic widespread pain has been present for xx years or xxx months. Mr./Ms. X has been evaluated for the presence of other health conditions and diagnoses. No other condition has been found that better explains the patient’s severe pain and related symptoms.”*

#### **The 2010 ACR Criteria:**

As a practical matter most physicians will chose to use the 2010 ACR diagnostic criteria as modified in SSR 12-2p. These criteria do not require examination of the tender points.

**But, the 2010 method creates its own set of problems. That’s where the organizational worksheets in appendix II become important.**

The 2010 method requires a modestly complex set of calculation to define two crucial indices. The first, the **WPI (Widespread Pain Index)** asks how many body areas were painful during the previous week. The second index the **SS (Symptom Severity Score)** focuses on the severity and number of symptoms the patient recently experienced in addition to pain.

When faced with these calculations the physician might be tempted to throw up his or her hands . *But, because the patient and the claimant's representative will help the physician with this task, all obstacles can be removed.*

Nor can the physician avoid these calculations by using the 1990 tender point criteria to diagnose Fibromyalgia. We will still need the WPI and the SS calculations to demonstrate the severity of illness and the patient's functional limitations.

Here's how SSR 12-2p has adapted the 2010 ACR Criteria to establish a diagnosis of Fibromyalgia. "We may find that a person has a Medically Disabling Illness (MDI) of Fibromyalgia (FM) if he or she has all three of the following Criteria:"

1. A history of widespread pain
2. Repeated manifestations of six or more FM symptoms, signs or co-occurring conditions, especially...fatigue, cognitive or memory problems ("fibro fog") waking un-refreshed plus a long list of other symptoms or co-morbidities. To quote SSR 12-2p: "We consider all relevant impairments, including impairments that are 'not severe'"

Please see Worksheet IB and IC in Appendix I for the symptoms relevant to making the diagnosis of FM using the SSR 12-2p's adaptation of the 2010 ACR method.

**( I strongly recommend that the patient and claimant's representative complete all these crucial worksheets early in their application process, provide a copy to the physician and then help the physician understand the worksheets and how to use them to write an effective report.)**

3. "Evidence that other disorders that could cause these repeated manifestations of symptoms and signs or co-occurring conditions were excluded."

(Criterion #3 from SSR 12-2p is tricky since it appears to contradict ACR's 1990 Criterion that specifically allows Fibromyalgia to be diagnosed in the presence of other painful health problems. **Thus, ACR 1990 states "The presence of a second clinical disorder does not exclude the diagnosis of Fibromyalgia?"** Did SSR 12-2p intend to contradict the ACR? I think that's not likely, but we can't yet be sure.

When appropriate the physician might include in his or her report a sentence along these lines: *Mr/Ms. X has been evaluated for the presence of other health conditions*

*and diagnoses. No other condition has been found that better explains the patient's severe pain and related symptoms.)*

**Once You Confirm the Diagnosis, how to establish the severity of illness.**

Once the diagnosis of Fibromyalgia has been documented Social Security's referees are required to "evaluate the intensity and persistence of the person's pain **or any other symptoms** and determine the extent to which the symptoms limit the person's capacity for work" (Note: I have added emphasis on the term "or any other symptoms" because SSR 2p requires a survey of symptoms in addition to pain. Hence the SS or Symptom Severity Score. The broad view greatly favors the case of a severely ill patient because most have many additional symptoms that are often severe.)

**Establishing Severity, Method #1: Compute the WPI (Widespread Pain Index) and the SS (Symptom Severity Score). (See Tables A and B in the text below. Also See Worksheets 2A and 2B in Appendix I. )**

**The 2010 ACR report and also SSR 12-2p asks us to calculate the WPI and the SS scores. This is required. Our challenge: How to make this simple and understandable enough for a physician to use within the time constraints of medical practice?**

**The WPI or Widespread Pain Index asks how widespread the patient's pain was during the previous week. The WPI does not ask whether the pain is due to Fibromyalgia, arthritis, disc disease, etc. It simply asks how many of 19 designated body areas were painful during the prior 7 days. SSR 12-2p does not ask how severe was the pain, but I have added that on the worksheet, to help the physician better understand the patient's degree of pain. Please note, any degree of chronic pain at a specific site during the prior week counts as a positive toward the WPI score.**

The WPI calculation is simple and straightforward. The patient should complete this calculation for several weeks, share it with the representative and then present and explain it to the physician.

Table A: The Widespread Pain Index (WPI)

Name \_\_\_\_\_ Date Completed \_\_\_\_\_

**These are the number of areas of my body where I had pain during the last week. (Potential Scores range from 0 to 19.)**

**Instructions:** Leave a line blank if there was NO significant pain in that area last week.  
 A single X (or check mark) means that pain occurred but was mild or infrequent Two xx's (or two checks) means that pain was moderately severe or moderately frequent. Three xxx's (or three checks) means that pain in that area was severe or very frequent. (Please mark all sites that apply. Whether, you mark one, two or three x's all lines with x's count toward the total score.)

Shoulder girdle left	_____	Shoulder girdle right	_____
Upper Arm left	_____	Upper arm right	_____
Lower arm left	_____	Lower arm right	_____
Hip (buttock, trochanter)left	_____	Hip (buttock, trochanter)right	_____
Upper leg left	_____	Upper leg right	_____
Lower leg left	_____	Lower leg right	_____
Jaw left	_____	Jaw right	_____
Chest	_____	Upper back	_____
Abdomen	_____	Lower back	_____
Neck	_____		

# of areas that were mildly painful \_\_\_\_\_ # of areas that were moderately painful \_\_\_\_\_ # of areas that were severely painful \_\_\_\_\_

**Add these up to obtain the Widespread Pain Index (WPI):**  
 \_\_\_\_\_ **(0-19)**

Interpretation: The higher the WPI (and the higher the number of sites with moderate or severe pain the) the more severe the probable functional limitations.  
 Format modified from 2010 ACR's table 4 by Richard Podell, M.D. DrPodell.org

**The SS or Symptom Severity Scale** is a more complex. The SS scale is made of two different parts. Seventy five percent of the score is based on the severity of three specific symptoms that almost always affect persons who have severe Fibromyalgia. There are 1) Fatigue 2)Waking Unrefreshed and 3) Cognitive Problems (difficulty with memory or concentration).

The last quarter of the SS scale asks about “the extent of Somatic Symptoms in general”. This refers to symptoms or health problems other than pain, fatigue, waking unrefreshed or cognitive symptoms. Does the patient have “few”, “moderate” or a “great deal of additional symptoms” ? **Please see Table B and also Worksheet 2B in Appendix I.**



Table B The Symptom Severity Score worksheet:

<p><b>Symptom Severity (SS) Score as per the 2010 American College of Rheumatology Criteria</b> Name _____ Date _____</p> <p><b>Part I focuses on how you felt <u>during the last week</u> , please rank the severity score for each of these three symptoms:</b></p> <p>1. <b>Fatigue</b> _____ 2. <b>Waking Unrefreshed</b> _____ 3. <b>Cognitive Difficulties (memory or concentration problems or “fibro fog”)</b></p> <p>Add the above 3 scores to get the Total Score for Part I: _____ (0-9)</p> <p><b>Instructions: Mark 0</b> if there was no problem. <b>Mark 1</b> if the symptom caused slight or mild problems, generally mild or intermittent. <b>Mark 2</b> if the symptom was a moderate or considerable problem, often present and/or at a moderate level. <b>Mark 3</b> if the symptom was severe: pervasive, continuous, or life-disturbing. (not life threatening but disturbing)</p>
<p><b>Part II focuses on what Social Security calls “Somatic Symptoms in general”</b></p> <p>Please review the list below. Social Security considers all these to be pertinent. Instead of asking about symptom severity, here they want to a measure of about how many other symptoms you had . After you have reviewed this list please indicate below on a 0-3 scale roughly how many of these symptoms you experienced <u>during the last week</u>.</p> <p><i>“Somatic Symptoms that might be considered: irritable bowel syndrome, muscle weakness, headache, pain or cramps in the abdomen, numbness or tingling, dizziness, insomnia, depression, constipation, pain in the upper abdomen nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud’s phenomenon, hives or welts, ringing in the ears, vomiting, heartburn, oral ulcers, loss of taste, change in taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss frequent urination or bladder spasms...and/or co-occurring conditions such as anxiety disorder, chronic fatigue syndrome, irritable bladder syndrome, interstitial cystitis, temporal-mandibular joint dysfunction, Gastroesophageal reflux disorder, migraine, sleep disorders or restless leg syndrome.”</i></p> <p>Other significant symptoms can be considered e.g. side effects of medicines, anxiety, heart or lung disease or other health problems that adversely affect your ability to work.</p> <p><i>Instructions: Please score Zero if you had none of these quoted symptoms. Score 1 if you had “few symptoms”. Score 2 if you had a “moderate number of symptoms”. Score 3 if you had “a great deal of symptoms”.</i></p> <p><i>My score for part II, the “somatic symptoms in general” scores is _____ (on a scale of 0-3)</i></p> <p>Now add up all four of your SS scores (Part I has 3 scores. Part II has one score) :</p> <p>Part I total _____ (0-9) + Part II total _____ (0-3)= <b>My total Symptom Severity Score (SS)= _____ (on a scale of 0 to 12).</b></p> <p><b>Finally, please go back now and circle any of the symptoms that you especially want your physician to be aware of.</b></p>

Basically, the higher the WPI score and the higher the SS score the more severe is the patient's illness and the more credible is the claim that one is not able to work.

Please note: Using the WPI and SS scores to establish severity of illness is different than using it to prove the diagnosis of FM. For the purpose of diagnosing Fibromyalgia a WPI score of only >/7 is required if there are also a moderate number of symptoms in addition to pain. (The SS score needs to be >/5.)**My personal experience is that most persons whose Fibromyalgia is severe enough to consider disability have WPI scores of >10 (on a scale of 0-19) and SS scores of at least 9( on a scale of 0-12). It is not rare for both scores to be higher.**

To repeat: **According to SSR 12-2p, Social Security wants to know about and intends to respect the impairing effect of all the symptoms and conditions that affect the individual patient—not just pain, and not only symptoms and limitations that are clearly caused by Fibromyalgia.** Social Security will consider other condition, even those not related to Fibromyalgia as potentially supporting a decision that the claimant can't work. **To quote: SSR 12-2p: "We consider all relevant impairments, including impairments that are "not severe".**

***Approach #2: Good Days/Bad Days and What Happens When the Patient Does Too Much.***

Please note: SSR 12-2p specifically invites a discussion of how the patient's ability to function varies from day to day. *"For persons with FM, we will consider a longitudinal record whenever possible because the symptoms of FM can wax and wane so that a person may have "bad days and good days".*

Patients with severe Fibromyalgia typically have "bad days" when they can barely leave the house, "medium days" when they can do somewhat more, and "Good days", when they can do considerably more.

"Bad days" often occur when a person with Fibromyalgia has tried to push through their limits the day before. However, bad days also occur unpredictably, without any clear trigger. This unpredictability is an added factor that makes work commitments difficult.

I suggest that your claimant provide both his/her physician and Social Security with a Good Day/Bad Day Work sheet similar to these:

Table C1: Good Day/ Bad Day Analysis

Name \_\_\_\_\_

Date completed \_\_\_\_\_

*On "bad days" I can do very little without causing my symptoms to increase. Typically such flare ups last for many hours or into the next days. On "moderate days" I can do somewhat more. On "good days" I can do considerably more. However, on any kind of day, if I push too hard or for too long, a prolonged flare up of symptoms is likely. Such flare ups often last for 24 hours or more.*

In recent months for each 30 day period I typical have about the following number of bad days \_\_\_\_\_ moderate days \_\_\_\_\_ good days \_\_\_\_\_ (total=30)  
(Or) For most 7 day weeks I typically have the following number of bad days \_\_\_\_\_ moderate days \_\_\_\_\_ good days \_\_\_\_\_ (total =7)

**On "bad days", I usually can do the following activities** without causing a substantial or long-lasting increase of pain, fatigue or related symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**On "bad days" I usually CAN NOT perform the following activities** without causing a flare-up of symptoms for many hours or more

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A specific example of what happened when I did too much during a "bad day" (Include, about when this happened, what you did, how long you did it, what was the flare up like, about how long did it take you to recover back to your baseline)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do your "bad days" tend to occur most often when you have done too much the day before? Yes \_\_\_\_\_ No \_\_\_\_\_

Do "bad days" also occur unpredictably for no obvious reason? Yes \_\_\_\_\_ No \_\_\_\_\_

Format prepared by Richard Podell, M.D., DrPodell.org

Table C2: Good Day/Bad Day Analysis

Name \_\_\_\_\_ Date completed \_\_\_\_\_ Time Period Referred to \_\_\_\_\_

**On “moderate days”, I usually can perform the following activities** without causing a substantial or long-lasting increase of pain, fatigue or related symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**On “moderate days” I usually CAN NOT perform the following activities** without causing a flare=up of symptoms for many hours or more

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A specific example of what happened when I did too much during a “moderate day”:

\_\_\_\_\_  
\_\_\_\_\_

**On “good days”, I usually can perform the following activities** without causing a substantial or long-lasting increase of pain, fatigue or related symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**On “good days” I usually CAN NOT perform the following activities** without causing a flare=up of symptoms for many hours or more

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A specific example of what happened when I did too much during a “moderate day”:

\_\_\_\_\_  
\_\_\_\_\_

Format prepared by Richard Podell, M.D., DrPodell.org

### ***Approach # 3: The FIQR (Fibromyalgia Impact Questionnaire Revised).***

Developed by Robert Bennett, M.D., then chairman of the Division of Arthritis and Rheumatic Diseases of the Oregon Health & Science University, the FIQR has been widely validated as a measure of the severity of illness and the limitations imposed by Fibromyalgia. The version of the FIQR in this paper has been modified to make it easier to use. Available at my web site: [http://www.drpodell.org/fibromyalgia\\_treatments.shtml](http://www.drpodell.org/fibromyalgia_treatments.shtml)) . Once there click on Helpful Info (at top of page). Then click on FIQR.

I strongly advise that every person who has significant Fibromyalgia should consider submitting a copy of the FIQR (reflecting the prior week's experience) to their doctors at the time of each and every visit—whether or not disability is being considered.

The FIQR asks people to rate the degree of difficulty that their illness causes with respect to common activities of daily living. FIQR is in the public domain and needs no permission to use.

The FIQR is a simple way for patients to keep track of how well they are doing. By entering copies of the FIQR into their medical records they are automatically documenting their symptoms and functional limitations. This should also help educate the physician about the patient's illness.

My main complaint about the FIQR is that patients sometimes under-report the severity of their illness. Some Fibromyalgia patients lean over backwards to underestimate the limitations imposed by the illness. Another problem can be in the phrasing of specific questions.

For example, one section of the FIQR asks patients to score on a zero to ten scale how difficult it was to comb or brush their hair during the last week. I've had several patients with very severe fibromyalgia who reported their score for this question as only a level 3, i.e. only mildly difficult. The reason: when their hair was long, it was so painful and difficult to comb and brush that they had to cut their hair short. Now it's much easier. Before the cut their hair their severity score would have been a 7 or 8.

Still, the fact that the FIQR has been accepted as valid in many academic journals is a big plus. I suggest that patient's applying for disability document their FIQR questionnaires for at least one week every month.

### ***Approach #4: Horizontal/Vertical Hours. (Mainly for people who are very ill.)***

Lucinda Bateman, M.D., a top physician in Salt Lake City developed this scale. I've modified it some. Basically people record how many hours a day they spend lying down versus

sitting or standing. For many of my patients the numbers are shocking, especially for those who have frequent “bad days”.

Horizontal vs Vertical Hours – In the chart below, estimate the number of hours you spend on each listed activity.

<b>Horizontal and Vertical Activity</b>	<b>Average day</b>	<b>Bad day</b>	<b>Good day</b>
Lying down sleeping or trying to sleep/nap			
Lying down but NOT sleeping or trying to sleep or nap			
Sitting with feet elevated			
Sitting with feet down or near the floor			
Driving or being driven in a vehicle			
Standing, moving around, or walking			
Other (specify):			
<b>Total hours</b> (should add to 24 for each day)			

*More advanced methods of providing evidence that the claimant is disabled.*

What more can an attorney or client do?

Quite a lot. But it takes time, money and specialized expertise. Attorney Barbara Comerford and I have done this successfully for a fair number of persons when the patient/client viewed the value of their private disability policy as justifying the expenses.

Consider these options:

1. (Most importantly), make a detailed review of all the patient’s medical records and all the internal records maintained by the disability insurance company. It’s not at all rare to find instances where the insurance company or its consultants overlooked or misinterpreted important medical information. This kind of intense review and medical expert report can easily take 12 hours plus of a physician expert’s time.
2. Obtain a detailed Trigger Point Evaluation.

The standard office examination by an internist or neurologist has little ability to measure the severity of a patient’s fibromyalgia. Nor do standard lab tests. A person with mild Fibromyalgia and a person with severe Fibromyalgia might look the same on standard examination and labs.

In contrast, a “trigger point” exam can provide objective information not available from the standard exam.

“Trigger points” are distinct from “tender points”. They can occur in any muscle. When pressed a trigger point causes pain to radiate from the point of pressure out to distant sites in a predictable pattern.

Janet Travell, MD, President Kennedy’s personal physician, and Professor at Cornell Medical School developed this field during the 1950s and 1960s. Most physicians with a special interest in Fibromyalgia know how to evaluate for trigger points.

3. A functional demonstration of increased symptoms caused by over-activity.

For example, I might ask disability candidates to type at a keyboard for 30 or 60 minutes or until they can do no more. They record their degree of pain from each of several muscle groups on a zero to ten severity scale. They score before starting the exertion and continue at intervals over the next 48 hours. This technique provides objective proof that their physical stamina is limited. But, be sure the patient/client understands that as a result of this exercise they might experience severe pain that might remain severe for 24 hours or longer.

As an aside, from a medical perspective I advise most attorneys and their clients to resist attending a standard IME (Independent Medical Exam). There is no medical literature to support a belief that some level of performance on an a standard IME protocol reliably predicts that a person with Fibromyalgia (or Chronic Fatigue Syndrome) will be able to sustain work activity for 40 hours a week. Performance over a few hours or even an entire day cannot predict whether a person can sustain that level of performance day after day and week after week.

And the IME testing itself might flare up the patient’s symptoms. Ironically, standard protocols don’t allow for the tester to ask follow up questions e.g. how the patient fared during the days after IME testing. Of course, hours or a day after an increased exertion is when Fibromyalgia symptoms are most likely to flare.

4. Neurocognitive Testing. Standard neurological examinations as done by quick questions and answers in a neurologist’s or internist’s office are not valid measures of the kind of cognitive deficits often found among persons with severe Fibromyalgia.

In contrast, formal (and expensive) neurocognitive testing often shows deficits in concentration, multi-tasking, handling complex problems and making rapid responses. (Basic intelligence scales typically remain intact.) With respect to holding a high level job, as is often a concern for private disability, cognitive limitations can be as or more important a problem than pain or fatigue.

Please note: Neurocognitive testers may be predisposed to believe in or not believe in the honesty or reliability of patients with complex, not too well understood conditions such as Fibromyalgia and Chronic Fatigue Syndrome.

5. Two Day Metabolic Exercise Stress Testing. This is especially useful for patients who qualify for the diagnoses of both Chronic Fatigue Syndrome and Fibromyalgia .

For Chronic Fatigue Syndrome it has been documented that when the exercise induced anaerobic oxygen threshold is measured during metabolic stress testing on two consecutive days, a chronic fatigue syndrome patient's ability to utilize oxygen often decreases abnormally on day #2. Documenting this decline in oxygen utilization supports a patient's self report that over-doing on one day leads to decreased performance ability on the next day.

The metabolic stress test is more sophisticated than the standard stress test usually done by cardiologists. I know of two sites that offer the two day metabolic test for persons with a diagnosis of chronic fatigue syndrome with or without accompanying Fibromyalgia.

6. At some point there will be commercially available lab or brain imaging tests that measure the severity level of Fibromyalgia related pain or fatigue. However, at this time such tests can be found only in a research setting.

**Footnotes:**

(1) **Social Security Administration, Disability Insurance Policy Interpretation Ruling SSR 12-2p Titles II and XVI: Evaluation of Fibromyalgia, Federal Register 2012; 77:43640** <https://www.federalregister.gov/articles/2012/07/25/2012-17936/social-security-ruling-ssr-12-2p-titles-ii-and-xvi-evaluation-of-fibromyalgia>

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*Appendix I: Worksheets To Help the Claimant and Physician Organize Key Information*

**WORKSHEET 1A: Diagnosing Fibromyalgia Using the 1990 American College of Rheumatology Criteria (ACR). This method is acceptable for SSR 12-2p**

According to the 1990 ACR Criteria to diagnose Fibromyalgia the patient should have:

1. a history of chronic widespread pain affecting all four quadrants of the body and also the spinal area for a period of at least 3 months
2. Pain produced when a standard level of pressure is applied to at least 11 of 18 anatomically defined sites on the body known as “tender points”.
3. “The presence of as second clinical disorder (that causes pain) does not exclude the diagnosis of fibromyalgia.”

Source: The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia. Adapted by Dr. Podell from table 8 in Wolfe F, et. al., *The American College of Rheumatology 1990 criteria for the classification of fibromyalgia: report of the multicenter criteria committee. Arthritis Rheum 1990;33:160-72.*

**WORKSHEET 1B: Diagnosing Fibromyalgia Using SSR 12-2p, as adapted from the 2010 American College of Rheumatology Criteria (ACR). This method is acceptable for SSR 12-2p**

SSR 12-2p states: “We may find that a person has a Medically Disabling Illness (MDI) of Fibromyalgia (FM) if he or she has all three of the following criteria:

1. A history of widespread pain.
2. Repeated manifestations of six or more FM symptoms, signs or co-occurring conditions, especially manifestations of fatigue, cognitive or memory problems (“fibro fog”) waking un-refreshed, depression, anxiety disorder, or irritable bowel syndrome.
3. Evidence that other disorders that could cause these repeated manifestations of symptoms and signs or co-occurring conditions were excluded.”

Comments:

1. For a discussion of the six or more FM symptoms please see Worksheet 1C.
2. With regard to point #3, SSR 12-2p seems to contradict the ACR Criteria. 1990 ACR states that you can diagnose FM despite co-occurring painful conditions. (“**The presence of a second clinical disorder does not exclude the diagnosis of Fibromyalgia.**”) Clinically, it is normal to diagnose Fibromyalgia in the presence of rheumatoid arthritis, disc Disease, osteoarthritis, etc. For the physician’s report I suggest considering using a statement such as “**Medical Evaluation has not disclosed any alternative diagnoses that better account for the patient’s symptoms and limitations.**”

<b>WORKSHEET 1C (For client and for doctor) : Symptoms, Signs, or Co-occurring conditions that can satisfy SR12-2p's requirement for at least six conditions that affect symptoms or ability to function for people with Fibromyalgia. This is based on SSR 12-2p</b>		
Symptom, sign or Co-occurring Condition. (Say yes only to those symptoms that affect total symptom severity or function to more than a mild or minimal degree.	Do these conditions Significantly Increase Your Symptoms and/or Reduce Your Ability to Function? If yes, mark <b>3</b> if their effect is severe, <b>2</b> if moderate, <b>1</b> if slight or mild	
	<b>Yes</b>	<b>No</b>
<b>Pain</b>		
<b>Fatigue</b>		
<b>Feeling Unrefreshed</b>		
<b>Cognitive Difficulties (concentration, memory)</b>		
Irritable bowel syndrome		
Tension Headache		
Migraine		
Irritable bladder		
Interstitial Cystitis		
Temporal-mandibular joint dysfunction (TMD)		
Chronic Fatigue Syndrome		
Anxiety		
Depression		
For the rest, <b>Circle only those that apply:</b> <i>irritable bowel syndrome, muscle weakness, headache, pain or cramps in the abdomen, numbness or tingling, dizziness, insomnia, depression, constipation, pain in the upper abdomen nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud's phenomenon, hives or welts, ringing in the ears, vomiting, heartburn, oral ulcers, loss of taste, change in taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss frequent urination or bladder spasms."</i> <i>Others that might reasonably apply include: medicine side effects, heart disease, lung disease, cancer, neurological disorders, etc. .</i>		

**WORKSHEET 1D: SAMPLE LETTER DOCUMENTING THE DIAGNOSIS OF FM, Based on SSR 12-2P AND THE 2010 ACR CRITERIA**

Dear Sirs:

Mr./Ms xx is a long time patient of mine who suffers from severe Fibromyalgia and related symptoms for approximately xxxx years. Because of this illness he/she has not been able to work since \_\_\_\_\_. Mr. Ms. Xx is a reliable historian

Mr./Ms xx satisfies the diagnostic criteria for Fibromyalgia as set out in Social Security's document SSR 12-2p: Titles II and XVI: Evaluation of Fibromyalgia.

Specifically Mr./Ms xx has a long history of chronic widespread pain—that is pain in all quadrants of the body and axial skeletal pain that has persisted for xxx years (must be at least 3 months).

Mr./Ms xx also demonstrates repeated manifestations of six or more Fibromyalgia symptoms, signs, or co-occurring conditions. These include:

1. Chronic fatigue
2. Cognitive or memory problems (“fibro fog”)
3. Waking from sleep unrefreshed

*In addition, Mr./Ms xx also suffers from multiple additional symptoms, signs and/or co-occurring conditions .*

*These include:*

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

7. \_\_\_\_\_ 8. \_\_\_\_\_ 9. \_\_\_\_\_

*Social Security in their SSR 12-2p and The American College of Rheumatology's 2010 report on Fibromyalgia* provide a list of additional symptoms or co-occurring conditions that can also be considered for the above list of 9 symptoms or conditions. (Comment: Only six symptoms or conditions are required; but , if relevant, it might be useful to list several )

“Somatic symptoms that might be considered: **muscle pain, irritable bowel syndrome, fatigue/tiredness, thinking or remembering problems, muscle weakness, headache**, pain/cramps in the abdomen, **numbness/tingling**, dizziness, **insomnia**, depression, constipation, pain in the upper abdomen, nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud’s phenomenon, hives/welts, ringing in ears, vomiting, heartburn, oral ulcers, loss of/change of taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss, frequent urination, painful urination and bladder spasms.”

Other conditions that might be considered relevant include **The Side Effects of Medicines, Chronic Low Back Pain, Osteoarthritis, Interstitial Cystitis, Irritable bladder syndrome, Migraine Headache, Tension Headache, Temporal Mandibular Joint Dysfunction (TMD) and Chronic Fatigue Syndrome**. Please note: I have put the most common occurring symptoms and co-occurring conditions into bold type.

On-going medical evaluations have excluded conditions that better explain these repeated manifestations of symptoms, signs, or co-occurring conditions. The diagnosis of Fibromyalgia is confirmed.

Dr. YYYYYYY

**WORKSHEET 2A: The Widespread Pain Index (WPI), based on the 2010 ACR Criteria.**

This is a format for calculating the 2010 ACR's Widespread Pain Index (WPI). This is also required by SSR 12-2p in order to document disease severity. Patient should complete this and provide a copy to the physician.

Name \_\_\_\_\_ Date Completed \_\_\_\_\_

**These are the areas of my body (out of a possible 19 areas) where I had pain during the last week**

**Instructions:** Leaving a line blank means there was no pain in that area. A single X (or check mark) means that pain occurred but was mild or infrequent. Two xx's (or two checks) means that pain was moderately severe or moderately frequent. Three xxx's (or three checks) means that pain in that area was severe or very frequent. (Please mark all sites that apply)

Shoulder girdle left	_____	Shoulder girdle right	_____
Upper Arm left	_____	Upper arm right	_____
Lower arm left	_____	Lower arm right	_____
Hip (buttock, trochanter)left	_____	Hip (buttock, trochanter)right	_____
Upper leg left	_____	Upper leg right	_____
Lower leg left	_____	Lower leg right	_____
Jaw left	_____	Jaw right	_____
Chest	_____	Upper back	_____
Abdomen	_____	Lower back	_____
Neck	_____		

# of areas that were mildly painful \_\_\_\_\_ # of areas that were moderately painful \_\_\_\_\_

# of areas that were severely painful \_\_\_\_\_ **Add these up to obtain the WPI:** \_\_\_\_\_

**This is the Widespread Pain Index (0-19)** The higher the WPI (and the higher the number of sites with moderate or severe pain) the more severe the probable functional limitations.

Format modified from 2010 ACR's table 4 by Richard Podell, M.D. DrPodell.org

**WORKSHEET 2B: The Symptom Severity (SS) Score based on the 2010 ACR Criteria. Patient should complete this and give a copy to the physician.**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*Based on how you felt during the last week please rank the severity of the following three symptoms on a scale of 0 to 3. **Mark 0** if there was no problems. **Mark 1** if the symptom caused slight or mild problems. **Mark 2** if the symptom was a “moderate or considerable problem, often present and/or at a moderate level”. **Mark 3** if the symptom was “severe: pervasive, continuous, or life-disturbing.”*

**FATIGUE (0-3)** \_\_\_\_\_ **WAKING UNREFRESHED (0-3)** \_\_\_\_\_  
**COGNITIVE SYMPTOMS (concentration, memory)** \_\_\_\_\_ = **TOTAL SS score=** \_\_\_\_\_

Next, please refer to the long list of symptoms and conditions listed below. Social Security wants to know if you have **few**, a **moderate number** of or a **great many** of these so-called “**somatic symptoms**”. Social Security considers these to be important in deciding whether you are able to work. **After you have reviewed the list please indicate below on the 0-3 scale below roughly how many of these symptoms you experienced in the last week.**

*“Somatic Symptoms that might be considered: irritable bowel syndrome, muscle weakness, headache, pain or cramps in the abdomen, numbness or tingling, dizziness, insomnia, depression, constipation, pain in the upper abdomen nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud’s phenomenon, hives or welts, ringing in the ears, vomiting, heartburn, oral ulcers, loss of taste, change in taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss frequent urination or bladder spasms...and/or co-occurring conditions such as anxiety disorder, chronic fatigue syndrome, irritable bladder syndrome, interstitial cystitis, temporal-mandibular joint dysfunction, Gastroesophageal reflux disorder, migraine, sleep disorders or restless leg syndrome.”*

Other significant symptoms that can be considered include: side effects of medicines, anxiety, heart or lung disease or other health problems that adversely affect your ability to work.

**Please score Zero if, during the last week, you had none of these symptoms. Score 1 if you had “few symptoms”. Score 2 if you had a “moderate number of symptoms”. Score 3 if you had “a great deal of symptoms”.**

*My score on this “somatic symptoms in general” list is \_\_\_\_\_ (on a scale of 0-3)*

**Now add up all four of your SS scores:**

**Fatigue + Waking Unrefreshed + Cognitive Symptoms+ “somatic symptoms in general”.**

**My total Symptom Score (SS) is \_\_\_\_\_ (on a scale of 0 to 12).**

**Finally, please go back now and circle any symptoms that are especially important and that want to be sure your doctor mentions in the doctor’s report to Social Security.**

Worksheet 2C: Summary of Scores and Interpretation of the WPI and SS scales of the 2010 ACR Criteria for Fibromyalgia. (WPI=Widespread Pain Index, please see Worksheet 21; SS =Symptom Score, please see Worksheet 2B).

My Widespread Pain (WPI score (number of painful sites during the prior week) was \_\_\_\_\_

My Symptom Severity (SS) score (for non-pain symptoms) during the prior week was \_\_\_\_\_

A diagnosis of Fibromyalgia is Confirmed if

a) WPI is  $\geq 7$  and SS is  $\geq 5$ . Do I meet these Criteria? No \_\_\_\_\_ Yes \_\_\_\_\_

b) WPI 3 to 6 and SS is  $\geq 9$ . Do I meet these Criteria? No \_\_\_\_\_ Yes \_\_\_\_\_

Pain Symptoms are more severe the higher they are on a scale of 0-19.

Non-pain symptoms are more severe the higher the SS score on a scale of 0-12.

Format developed by Richard Podell, M.D., DrPodell.org

**WORKSHEET 3A: Importance of Good Days and Bad Days To Social Security's Decision Making Process.  
Patient should complete and give a copy to physician.**

SSR 12-2p specifically invites a discussion of how the patient's ability to function varies from day to day. "For persons with FM, we will consider a longitudinal record whenever possible because the symptoms of FM can wax and wane so that a person may have 'bad days' and 'good days'".

Patients with severe Fibromyalgia typically have "bad days" when they can barely leave the house, "medium days" when they can do somewhat more, and "Good days", when they can do considerably more. (This pattern is also seen with Chronic Fatigue Syndrome.)

"Bad days" often occur when a person with Fibromyalgia has attempted to push through his or her limits the day before. However, bad days also occur unpredictably, without any clear trigger. This unpredictability makes work commitments difficult.

In recent months for each 30 day period I typically have had about the following number of bad days \_\_\_\_\_ moderate days \_\_\_\_\_ good days \_\_\_\_\_ (total=30)

(Or) For most 7 day weeks I typically have the following number of bad days \_\_\_\_\_ moderate days \_\_\_\_\_ good days \_\_\_\_\_ (total =7)



**WORKSHEET 3B: What Claimant Can And Can Not Do on Good Days and Bad Days Very Important. Patient should complete and give copy to physician.**

**On "bad days", I usually can do the following activities** without causing a substantial or long-lasting increase of pain, fatigue or related symptoms:

---

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**On "bad days" I usually CAN NOT perform the following activities** without causing a flare-up of symptoms for many hours or more

---

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**On "moderate days", I usually can do the following activities** without causing a substantial or long-lasting increase of pain, fatigue or related symptoms:

---

---

---

**On "moderate days" I usually CAN NOT perform the following activities** without causing a flare-up of symptoms for many hours or more

---

---

---

---

**On "good days", I usually can do the following activities** without causing a substantial or long-lasting increase of pain, fatigue or related symptoms:

---

---

---

**On "good days" I usually CAN NOT perform the following activities** without causing a flare-up of symptoms for many hours or more

---

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**WORKSHEET 3C: What Happens When Patient Tries to do Too Much. Patient should complete and give copy to physician.**

Give a specific example of what happened when I did too much during a “bad day” (Include, information about how long ago the incident occurred, what sort of exertion you did that caused a problem, what was the flare up like, about how long did it take you to recover back to your baseline)

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---

Give a specific example of what happened when I did too much during a “moderate day”.

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---

Give a specific example of what happened when I did too much during a “good day”.

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Do your “bad days” tend to occur most often when you have done too much the day before? Yes \_\_\_\_\_ No \_\_\_\_\_ Example: \_\_\_\_\_

Do “bad days” also occur unpredictably for no obvious reason? Yes \_\_\_\_\_ No \_\_\_\_\_ Example: \_\_\_\_\_

Format prepared by Richard Podell, M.D., DrPodell.org

**WORKSHEET 3D: Other Information Potentially Relevant to Demonstrating Claimant's Functional Limitations. Please see text of my essay for information about these methods of documenting the severity of illness and its effects on the ability to work.**

1. Fibromyalgia Impact Questionnaire Revised (FIQR). (May download from Dr. Podell.org, See Forms, then See FIQR)
2. Horizontal/Vertical Activity Score (See Table in Text of This Paper)
3. Trigger Point Evaluation
4. Functional Evaluations such as Dr. Podell's Typing Test to record how pain increases for many hours or days after moderate activity
5. Formal Neurocognitive Testing
6. Testimonials from Friends, Family, Co-Workers
7. Two Day Metabolic Exercise Stress Test

**WORKSHEET 3E: Fibromyalgia's Equivalence to Other Potentially Disabling Illnesses**

As described in SSR 12-2p, Social Security maintains a list of diseases that are considered impairments. Fibromyalgia is not on this list. However, SSR 12-2p states that the case reviewer will consider "whether FM medically equals a listing (for example listing 14.09D in the listing for inflammatory arthritis or whether it medically equals a listing in combination with at least one other medically determinable impairment."

My best guess is that under some circumstances Social Security will rank Fibromyalgia as impairment if the physician states that his patient's disease severity is comparable to that of a patient with a listed disorder such as multiple sclerosis or rheumatoid arthritis. For example, see where I've done this in my model letter.

**WORKSHEET 4A: How Claimant's Functional Limitations Make Working Difficult**

It might be useful if the physician is able to include in his or her letter to Social Security a statement along these lines:

Because of the severity of Mr./Ms. X's severe pain, fatigue, cognitive symptoms, poor stamina etc. he/she is not able to sustain activity for the length of time required by any job. This limitation is further compounded by Mr./Ms. X's pattern of having "bad days" when his/her symptoms are much worse, so that function is even more limited than usual. Such "bad days" typically occur about \_\_\_\_ times a month (or \_\_\_\_ days a week). "Bad days" occur when Mr./Ms. X does more than his/her usual activity the day before, or when he/she over-exerts for several days in a row. Such "bad days" also occur unpredictably. The frequency of bad days further hinders his/her potential ability to work.

**WORKSHEET 4B: SSR 12-2p asks “During an 8-hour workday...How Long Can Claimant Tolerate The Following activities?”**

For a Fibromyalgia patient Social Security might ask “Throughout an 8-hour workday, to the extent that positional changes are necessary, with rest breaks and meal breaks at appropriate intervals, your patient can tolerate the following activities for the specified durations.” The activities listed include, sitting, standing, walking, reaching, fine manipulation, etc. The most relevant time interval for severely ill patients will be “Occasionally: 0-2.5 HRs/Day, 0-1/3d of the Day”. If, the patient’s tolerance is <2.5 hours, I suggest that the physician consider writing in the duration e.g. <2 hrs. Most important: It can be very helpful, when relevant, for the physician to write in on Social Security’s Questionnaire comments such as “When Patients pushes to exceed these limits, symptoms of pain and fatigue increase substantially. Such post-exertional flare ups often last for 24 hours or longer.”

**WORKSHEET 5: Medical Opinion About Ability t to Work**

Near the end of the letter to Social Security , if I judge that the patient is disabled, I usually state something along these lines:  
To a reasonable degree of medical certainty, Mr. X is not able to work because of his/her illness. This disability is likely to be permanent.  
However, several attorneys have suggested that Social Security does not want the physician to provide an opinion on disability. Rather, Social Security wants the physician to opine on the patient’s symptoms and functions and leave the judgment on disability to them.  
I defer to the attorneys on this point.

**Appendix II “Model” Medical Letter To Social Security:**

The following is a letter adapted from one that I recently wrote to Social Security on behalf of a patient. But, first, let’s consider a very practical problem.

No physician is likely to tolerate being told what his opinion should be about his or her patient. And that’s certainly not the purpose of this letter. The purpose of the model letter is to help the physician address the very specific issues that SSR 12-2p expects the physician to cover. If the physician, with all good intentions, doesn’t do it Social Security’s way this might count their patient’s chances of obtaining a fair judgment.

Bottom Line: The claimant’s representative and the patient have to convince the physician to see them as constructive partners in the process.

Please note, that in the section on the diagnosis of Fibromyalgia I provide one paragraph using the 1990 ACR Criteria and an alternative paragraph using the 2010 ACR Criteria as modified by SSR 12-2p. Both methods are acceptable to Social Security. Normally, the physician will choose one paragraph model or the other.

#### Letterhead

#### **Re: Social Security Report for Samuel Jones, DOB 3/11/1969, SS: xxx xx xxxx**

Mr. Jones has been my patient for more than 5 years. He is a very reliable historian.

I have been his primary treating physician for severe Fibromyalgia pain and Chronic Fatigue Syndrome. He also suffers from migraine headache, asthma, recurring sinusitis, and irritable bowel. These conditions are treated by his family physician. He is also under the care of a psychiatrist for depression. This well controlled with medication.

**History:** Mr. Jones developed severe, unremitting fatigue in late 2000, shortly after undergoing sinus surgery and then a “flu-like” illness. In early 2001 he developed chronic wide spread pain. This has continued and worsened through to the present.

**Diagnosis:** Mr. Jones satisfies the diagnosis of Fibromyalgia using both the 1990 American College of Rheumatology Criteria and also using the 2010 American College of Rheumatology Criteria.

From the 1990 Criteria: He has a 10+ year long history of chronic widespread pain affecting all four quadrants of the body and also the spinal area. Using the 2010 American College of Rheumatology Criteria: he has a Widespread Pain Index (WPI) of 13 out of a possible 19. He has a Symptom (SS) Score of 11 out of a possible 12.

The 2010 Criteria state that the diagnosis of Fibromyalgia is documented if the WPI score is  $\geq 7$  and the SS score is  $\geq 5$ . Mr Jones’ WPI of 13 and SS score of 11 confirms the presence of Fibromyalgia and also confirms that his symptoms are severe and functionally limiting.

Mr. Jones He has had extensive medical evaluations. There are no other medical or psychological conditions that better explain his symptoms and functional limitations.

#### **Intensity and Persistence of Mr. Jones’ Pain and other symptoms and how they limit his ability to work:**

His typical pain level on most days is at severity 7 or 8 out of 10. This is true despite his need to take prescribed narcotic pain medicines. When he increases his activity pain severity can reach 10 out of 10. Unfortunately, the pain medicines, which he needs, tend to further hamper cognition.

#### ***Good days/Bad days analysis, as recommended by Social Security’s July 25, 2012 Policy Interpretation Ruling SSR 12-20: Titles II and XVI: Evaluation of Fibromyalgia.***

During a 7 day week Mr Jones typically experiences 3 bad days when he can do very little, 3 medium days when he can do somewhat more, and 1 good day a week when he can do more but is still limited.

Thus, on a bad day he CAN feed himself and his pets. But he is not able to drive a car due to severe pain and fatigue. He cannot do even the mild household chores.

On medium days he can leave home and drive a car locally for doctor’s appointments. However, he cannot concentrate enough to read more than a few pages of a book. He can be active outside the home for 1 or 2 hours on these days.

On his occasional good day he can be out of the house for 3 or 4 hours, for example, shopping for groceries. However, even on good days he has to lie down to rest for about two hours during the middle of the day.

**The adverse effects of attempting to increase his activities:** When he pushes too hard, Mr Jones typically suffers a flare up of pain, fatigue and other symptoms that last for 24 hours or more. He told me of a recent example: Starting on a “good day” he had to force himself to do several hours of errands for 3 days in a row. Usually, he would limit such increased efforts to one single day. When he pushed through for 3 days his pain and fatigue increased dramatically, forcing him to do almost nothing for several days afterward.

As recommended by SSR 2012-2p, I calculated Mr. Jones' SS (Symptom Score). For the symptom of Fatigue his score is 3 (severe). For the symptom Waking Unrefreshed, his score is 3 (severe). For Cognitive Symptoms (concentration, memory) his score is 2 (moderate severity). In addition he has many additional symptoms including frequent headaches, irritable bowel syndrome, dizziness, and medication side effects. Thus, his "somatic symptoms in general score" is 3.

Mr. Jones total Symptom Severity (SS)Score is 11 out of a possible 12. In summary, Mr. Jones' Widespread Pain Index (WPI) is 13. His Symptom Score (SS) is 11. Persons with such severe illness are typically not able to work. These high scores on the WPI and SS scales are consistent with the severe symptoms and functional limitations that Mr. Jones reports on his Good Day/Bad Day report.

**Physical Exam:**

(Paragraph That Might Be Used if a tender point exam is done ☺)

Mr Jones' physical exam also supports the severity of his illness. All 18 of 18 fibromyalgia tender points were painful on examination. He also demonstrated widespread allodynia (diffuse pain on modest pressure at multiple additional sites.)

(Alternative paragraph if tender point examination is not done:)

As is well established in the Fibromyalgia literature, except for tender points and diffusely increased sensitivity to pain, even persons with very severe and/or disabling Fibromyalgia usually have relatively normal physical examination findings. Their functional limitations reflect poor stamina, intense pain, decreased concentration and fatigue rather than weakness, swollen joints or markedly decreased range of motion.

In Mr. Jones' case, there is some limitation of neck and shoulder movement due to pain. Muscle strength is fair. Except where it is limited by pain, range of motion of joints is normal. Heart, Lung and Abdominal exams are normal. Mr. Jones' physical exam is fully consistent with the severity and limitations that are documented by the WPI, SS and Good Days/Bad Days reports.

**Does Mr. Jones Fibromyalgia related impairment equal the requirements of a listed impairment?** Fibromyalgia does not appear on Social Security's formal listing of impairments. However, in Mr. Jones case it would be fair to assess his Fibromyalgia related impairments as being equivalent to that affecting a person with inflammatory arthritis, multiple sclerosis or other listed impairments.

**Summary:** Mr. Jones has a Medically Determinable Impairment (MDI) that could reasonably be expected to produce the pain and other symptoms that Mr. Jones consistently reports. His pain and related symptoms have a substantial adverse effect on his ability to perform basic work activities. His impairments are severe.

Please see the attached forms for my response to specific questions Social Security has asked.

With regard to section VIII.

- A. Lift and Carry: <2.0 hours. He should not lift even very light weights repeatedly, as doing so makes his pain worse.
- B. Standing/Walking: < 2 hours. On many or most days he cannot stand and/or walk for even 2 hours a day without getting worse.
- C. Sitting: <2 hrs. Prolonged sitting worsens his pain.
- D. Push and/or Pull: He should not do this at all. Any repetitive activity of this type will make him much worse.
- E. Other: He should not do any motion repetitively. Repetitive Handling of objects (e.g. filing) would worsen symptoms.

Section IX. Are there any other conditions that limit his activity? Answer yes: His sleep is of poor quality. The Topamax he takes to prevent Migraine headache further clouds his thinking. He has very poor stamina, irritable bowel, frequent infections, and a modest degree of anxiety and depression.

Because of limitations of current treatments for Fibromyalgia and related symptoms such as chronic fatigue, it is not likely that Mr Jones condition will improve substantially. Given his severe symptoms, frequent exacerbations and the fact that modest increases in activity make him worse, it is difficult to imagine that there are any jobs in the economy that he could perform on a reliable basis.

Sincerely,

**Signed**