

Social Security Disability: A Practical Introduction to the Practice

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DEFINITION OF DISABILITY

The Social Security Act defines disability as follows:

The inability to engage in any substantial gainful activity by reason of a medically determinable impairment, physical or mental (or combination of impairments), which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 continuous months.

42 U.S.C. § 423(d)(1) & 20 C.F.R. § 404.1505

- The definition of disability is the same for both Title II (SSDI) and Title XVI (SSI) benefits.
- Disability is established based upon limitations caused by medically determinable impairments, not by diagnosis alone.

DISABILITY INSURANCE BENEFITS

- Title II, SSDI, DIB
- To be entitled to Disability Insurance Benefits, a claimant must have worked, and paid into the system, long enough to be fully insured to receive same.
- Depending on the claimant's age, usually a claimant must have worked at least 5 out of the last 10 years to be fully insured to receive benefits. (For SSI benefits there is no minimum work requirement.)
- Entitlement to Disability Insurance Benefits starts with the 6th month after the month in which a claimant is found to be disabled, or 12 months prior to the month of application, whichever of the two yields the less amount of benefits.
- After a claimant has been collecting DIB for two years, including any retroactive period of entitlement, the claimant is eligible to receive Medicare.

SEQUENTIAL EVALUATION PROCESS

In order to determine disability, in both Title II and Title XVI benefits, the Social Security Administration must go through a five step evaluation.

20 C.F.R. §§ 404.1520 & 416.920

- If the claimant is found disabled at any step, the evaluation stops.
- If not, the analysis continues to the next step.

Step 1: Is the claimant working and performing substantial gainful activity (SGA)?

- If the Social Security Administration determines that a claimant is performing SGA then the claimant is usually found not disabled.
- Substantial gainful activity is defined as work, performed either part time or full time, which is done for pay, or profit (even if profit is not made).
- Work is considered substantial, even if it is done on a part-time basis, if it involves doing significant physical or mental activities.
- The work may be substantial even if it is done on a part time basis, or if you do less, get paid less, or have less responsibility than when you worked before. 20 C.F.R. § 404.1572(a).
- Activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs are not ordinarily considered substantial gainful activity. *Id* at (c).
- As of 2014, SSA defined substantial gainful activity as that work, wherein the claimant earns, gross, more than \$1070.00 per month (non-blind claimant). SGA is defined by the year when it was earned.
- There are special rules for self employed individuals. See 20 C.F.R. § 404.1575.
- The regulations regarding substantial gainful activity can be found in 20 C.F.R. §§ 404.1571 through 404.1576.

STEP 2: Does the claimant have a severe impairment?

- An impairment, or combination of impairments, is considered severe if it significantly limits your physical or mental abilities to do basic work activities. 20 C.F.R. § 404.1521.
- Social Security Ruling 96-3P provides that an impairment that is not severe must be a slight abnormality that has no more than a minimal effect on the ability to do basic work activities. Thus, anything that causes more than a mild limitation in a claimant's ability to perform work related activities is considered a severe impairment.
- A severe impairment must be one that has lasted for a period of at least twelve continuous months, or one that is expected to result in death.
- If SSA finds that a claimant does not have a severe impairment, then a finding of not disabled is made and the claim is denied at step 2.

STEP 3: Does the claimant have an impairment that meets or equals an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1 (affectionately known as “The Listings”)?

- The listings are contained in Appendix 1, and are divided into two parts:
 - Part A contains criteria that applies to claimants over 18 years of age.
 - Part B contains criteria that applies to claimants under the age of 18.
- Each part describes major body systems impairments, considered severe enough to prevent an individual from doing any gainful activity, regardless of age, education, or work experience. 20 C.F.R. § 404.1525.
- Thus, if a claimant meets the medical requirements of a listed impairment, he/she is automatically found disabled.
- If a claimant’s impairment, does not specifically meet the requirements of a listed impairment, he/she can be found disabled if it medically equals the criteria of a listing. An impairment(s) is medically equivalent to a listed impairment in Appendix 1 if it is at least equal in severity and duration of the criteria of any listed impairment. 20 C.F.R. § 404.1526.
- Although the final decision as to whether a claimant equals a listing is made by the administration, the ALJ should call on the services of a medical advisor to evaluate the medical evidence. An ALJ cannot find that a claimant equals a listing without a medical opinion supporting the ALJ’s finding. Medical equivalence must be based on medical findings.
- When determining whether a listing is met, or equaled, the durational requirement still applies. That is, the medical impairment must have existed, at a listing level of severity, for at least one continuous year, or is expected to result in death.

Step 4: Does the severity of the claimant’s impairment preclude him/her from performing his/her past relevant work?

- At the fourth step, if a claimant has the residual functional capacity (mental or physical) to perform his/her past relevant work, then a finding of not disabled is made, and the analysis stops here.
- Past relevant work is that work that was performed, at the substantial gainful activity level for the year in which the work was performed, for the 15 years prior to the date of adjudication, or when the disability insured status was last met (not from the onset date of disability). 20 C.F.R. § 404.1565.
- At this step, the claimant’s residual functional capacity must be determined.
- Residual functional capacity (RFC) is defined as the most a claimant can physically, or mentally, do despite his/her limitations. 20 C.F.R. § 404.1545.
- RFC is assessed based on all of the relevant medical and other evidence and it must take into consideration a claimant’s ability to meet the physical, mental, sensory and other requirements of work.

- RFC is classified as sedentary, light, medium, heavy, or very heavy. 20 C.F.R. 404.1567 and SSR 83-10.
- In order to determine whether a claimant can perform his/her past relevant work, SSA must first evaluate the physical and/or mental demands of the claimant's past relevant work, as required by Social Security Ruling 82-62.
- SSA must then determine whether the claimant's RFC is sufficient to meet such demands. If not, then a finding is made that the claimant cannot perform his/her past relevant work, as performed by the claimant (or as generally performed in the economy) and the claim proceeds to the fifth step.
- In assessing RFC the limiting effects of all impairments, even those that are found not to be severe, will be considered.
- Generally, the claimant carries the burden of proof that he/she does not have the RFC to perform past relevant work. Once this burden is met, then it shifts to the SSA to show, at step 5 of the sequential evaluation process, that there is other work that the claimant can perform.

Step 5: Based on his/her RFC, can the claimant perform other work, existing in significant numbers, in the regional or national economy?

- At this step, the burden shifts to the SSA to assess whether the claimant has the residual functional capacity to perform other work.
- At this stage, the claimant's age, education and past relevant work experience will be taken into account.
- Generally, two tools will be used in determining whether a claimant is disabled at this step:
 - The Medical-Vocational guidelines (GRIDS),
 - Vocational expert testimony
- The GRIDS are found at 20 C.F.R. Part 404, Subpart P, Appendix 2.
- They apply solely to claimants who have an impairment, or combination of impairments, which result solely in exertional limitations. These are limitations which affect only the strength requirements of jobs.
- If the claimant has solely non-exertional limitations then the GRID rules can only be used as a framework in aiding the adjudicator in making a final decision. That is, if the strength limitations closely approach the factors of a particular rule, then the adjudicator has a frame of reference for considering the jobs or types of jobs precluded by other non-exertional limitations.
- If a claimant has an impairment, or combination of impairments resulting in both strength limitations and non-exertional limitations, the GRID rules are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, then using the GRIDS as a framework, the adjudicator

must consider how much the claimant's work capability is further diminished in terms of any types of jobs that would be contraindicated by the non-exertional limitations.

- In making the assessment as to whether a claimant can perform other work, the adjudicator also has the option of calling on the services of a vocational expert.
- The role of the vocational expert is twofold:

- Describe and classify, in terms of skill and strength level, the claimant's past relevant work.
- Determine, once presented with hypothetical questions reflecting an individual of the claimant's age, education, past relevant work experience and RFC, whether there is other work the claimant can perform.
- A claimant's age is classified as follows:

- 49 years old or younger = Younger individual
- 50-54 years old = Individual closely approaching advanced age
- 55-59 years old = Individual of advanced age
- 60 + years old = Individual closely approaching retirement age

- A claimant's past relevant work is classified taking into account its strength demands and required skill level. A skill is a knowledge of a work activity that requires the exercise of significant judgment that goes beyond the carrying out of simple job duties. Skills are acquired in past relevant work that was not unskilled, and may also be learned in recent education that provides for direct entry into skilled work. Skill levels are classified as follows:

- Unskilled– Simple, routine, repetitive work which can be learned in 30 days or less. No skills are gained by performing unskilled work. SVP 1-2
- Semi-skilled– Work which needs some skills but does not require doing the more complex work duties. May require alertness and close attention to work process and may be applicable where coordination and dexterity are necessary. SVP 3-4
- Skilled– Requires qualifications in which a person uses judgment, makes sophisticated adjustments, and deals with people, facts, figures or abstract ideas at a high level of complexity. SVP 5 or higher.

20 C.F.R. § 404.1568

- If a vocational expert finds that a claimant's skills can be transferred to other work, a finding of not disabled would apply.
- Skills can be transferred when:
 - The same or lesser degree of skill is required. The SVP is lower than the one related to the claimant's past relevant work.
 - The same or similar tools and machines are used.
 - The same or similar raw materials, products, processes, or services are involved.

- A complete similarity of all three factors is not required for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (such as mining, agriculture or fishing), they are considered not transferable.

SUPPLEMENTAL SECURITY INCOME BENEFITS

- Title XVI, SSI, or SSID
- A welfare based Social Security program based on financial need.
 - Unlike Title II, SSI is not based on eligible quarters or how much a claimant worked.
 - Must be financially eligible.
- Contributed to by federal and state funds, but not all states contribute and those that do contribute are not always the same. As of 2014, the federal amount for one person is \$721 and for a couple is \$1,082. Currently, most states have higher SSI payments due to their separate contributions, and are administered either through the Social Security Administration or through the individual state.
- Unlike Title II, an application for Title XVI cannot be completed online and must be made by the claimant in person or over the telephone.
- **Two-Prong Test—Must meet both prongs.**
 - **Financial Eligibility**
 - Resources must be less than \$2000 for an individual and \$3000 for a married couple.
 - The claimant's home and land home is on is excluded, as well as furnishings within the home.
 - One car that of the household is excluded. Other cars in claimant's or spouses name will be counted as a resource.
 - Cash value of all other assets, including investments and life insurance are counted as resources.
 - Income that is earned (wages) or unearned (worker's compensation payments, investment income, etc.) from the claimant or spouse will affect financial eligibility. Earned income and unearned income are treated differently. Income may also be defined as services received in lieu of payment (in-kind support and maintenance).
 - In-kind support and maintenance means any food or shelter that is given to you or that you receive because someone else pays for it. See 20 CFR § 416.1130
 - There is spouse to spouse deeming as well as parent to child deeming (until the child reaches age 18). Deeming is when another person's income is considered the claimants whether or not the income of the other person is actually available to the claimant. See 20 CFR § 416.1160.

- There are many items that can be excluded from countable income. This gets very technical.
 - Note: Watch concurrent claims. Title II check will be counted as other income which will reduce SSI benefit or eligibility.
- **Age or Disabled Eligibility**
- Must either be age 65 or older, or
 - Must be blind or disabled.
 - Disability Eligibility is based on the same rules as in Title II.
- Citizenship or legal resident status will also affect eligibility, but this will vary depending on when the claimant applied. After August 22, 1996, the claimant must either be a citizen, national, or a qualified alien. POMS SI 00502.100
- If the claimant is a qualified alien (i.e. legal resident) the claimant must also meet one of the following additional requirements to be eligible for SSI:
 - Was receiving SSI on 8/22/96 and is lawfully residing in the U.S. (grandfathered qualified alien) (POMS SI 00502.150); or
 - LAPR (lawfully admitted for permanent residence) with 40 Qualifying Quarters (QQs) of earnings. (NOTE: There is a 5-year bar to eligibility for individuals who entered the United States on 8/22/96 or later unless certain exceptions apply. See POMS SI 00502.135); or
 - Veteran or active duty member of the U.S. Armed Forces, a spouse of veteran/active duty, or a dependent child of veteran/active duty (POMS SI 00502.140); or
 - Lawfully residing in the United States on 8/22/96 and is blind or disabled (POMS SI 00502.142); or
- Alien is in one of five designated alien status classifications, and the status was granted within 7 years of the date he/she filed for SSI (POMS SI 00502.106). The 5 classifications are:
 - Refugee under section 207 of the INA.
 - Asylee under section 208 of the INA.
 - Alien whose deportation is being withheld under section 243(h) of the INA or whose removal has been withheld under section 241(b)(3) of the INA.
 - Cuban/Haitian entrant under one of the categories in Section 501(e) of the Refugee Education and Assistance Act of 1980 or alien in a status that is to be treated as a Cuban/Haitian entrant for SSI purposes (see POMS SI 00502.108B.)
 - “Amerasian immigrant” under section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988. “Amerasian immigrants” are by definition LAPR, thus they are qualified aliens. If an individual is an “Amerasian immigrant,” and meets no other condition permitting eligibility, then

he/she is potentially eligible for 7 years beginning with the date “Amerasian immigrant” status was granted. Amerasians who enter as nonimmigrants, (e.g., foreign students pursuing studies in the U.S.), cannot be qualified aliens.

- Benefits will vary by state and can be reduced based on income or in-kind income, including living in the home of another. There are no dependents’ benefits.
 - When a claimant meets both of the criteria for SSI, and is found to be entitled to benefits but then falls out of financial eligibility, benefits will not be paid during the months where income or resources exceed the limit. Once the money is spent down, benefits will commence the next eligible month. If benefits are paid during an ineligible month, this can cause an overpayment.
 - Entitlement to SSI benefits starts with the full month after the month in which a claimant is found to be disabled, or the date of the application, whichever of the two yields the less amount of benefits.
- Entitlement to SSI benefits also entitles the recipient to Medicaid. There is no waiting period for such benefits.

CHILDREN’S CASES

Title II—Childhood Disability Benefits (formerly known as Disabled Adult Child benefits) or regular DIB on own earnings record.

- **Childhood Disability Benefits**

- Adult child can only receive benefits if fully insured parent whom the claimant is dependent on is retired, deceased or disabled.
- Adult child must be 18 or older and disability must have started prior to age 22.
- Adult child must be unmarried at the time of application. Marriage during entitlement will terminate benefits (unless marriage is to another Social Security beneficiary) and benefits will not be reinstated by divorce. Annulment or a void marriage, however, will be acceptable for benefits to be reinstated.
- Disability evaluation is the same as for Title II or Title XVI adults.
 - See SSR 11-2p: Documenting and Evaluating Disability in Young Adults.
 - The abilities, skills, and behaviors that young adults use to do basic work activities are essentially the same as those that older adolescents use for age-appropriate activities. Thus, the evidence we consider when we make disability determinations for young adults is generally the same as, or similar to, the evidence we consider for making disability determinations for older adolescents under title XVI. Because the abilities, skills, and behaviors are essentially the same, the same considerations for evaluating limitations in an older adolescent also apply to young adults.
 - Evidence from school programs, including secondary and post-secondary schools, can also help us evaluate the severity and impact of a young adult’s impairment(s).

- We consider how independently a young adult is able to function, including whether the young adult needs help from other people or special equipment, devices, or medications to perform day-to-day activities. If a young adult can function only if he or she receives more help than would generally be provided to people without medical impairments, we consider how well the young adult would function without the extra help. The more extra help or support of any kind that a young adult receives because of his or her impairment(s), the less independent he or she is in functioning, and the more severe we will find the limitation to be.

- **Benefits on own earning record**

- It is possible for a child to have his/her own earnings record and for that child to have fully insured and currently insured status. If this is the case, the child can apply for Title II benefits on his/her own account.
- Child must have 6 out of the last 12 quarters ending in the period of onset. POMS RS 00301.140
- Earnings that are paid by a family member may be excluded and not considered employment. 20 C.F.R. §404.1015
- Disability evaluation is the same as for Title XVI children.

Title XVI—Child can receive benefits if meets disability requirements and financial requirements.

- Parents income and assets can affect child. Deeming applies until age 18.
- Child will receive reduced amount as they are living in the home of another.
- **Sequential Evaluation**
 - **Engaged in SGA?** Same test as for an adult
 - **Severe Impairment?** Same test as for an adult
 - **Meet, Equal or Functionally Equal Listed Impairment.**
 - Meeting and Equaling are the same as adult definitions, but Listings are different.
 - 20 C.F.R. § 404 Subpart P Appendix 1 part B. Listings 100.00 through 114.00
 - **Functional Equivalency** (20 C.F.R. §416.926a)
 - Must have either an extreme limitation in one functional domain or two marked limitations in two different domains.
 - Extreme is defined as a very serious limitation and marked is defined as a serious limitation.
 - **SSR 09-1p: “Whole child” approach:**

- We always evaluate the “whole child” when we make a finding regarding functional equivalence . . . The functional equivalence rules require us to begin by considering how the child functions every day and in all settings compared to other children the same age who do not have impairments. After we determine how the child functions in all settings, we use the domains to create a picture of how, and the extent to which, the child is limited by identifying the abilities that are used to do each activity, and assigning each activity to any and all of the domains involved in doing it. We then determine whether the child’s medically determinable impairment(s) accounts for the limitations we have identified. Finally, we rate the overall severity of limitation in each domain to determine whether the child is “disabled” as defined in the Act.
- How does the child function?
- Which domains are involved in performing the activities?
- Could the child’s medically determinable impairment(s) account for limitations in the child’s activities?
- To what degree does the impairment(s) limit the child’s ability to function age-appropriately in each domain?
- **SSR 09-2p: Documenting Limitations**
 - What activities is the child able to perform?
 - What activities is the child not able to perform?
 - Which of the child’s activities are limited or restricted compared to other children of the same age who do not have impairments?
 - Where does the child have difficulty with activities—at home, in childcare, at school, or in the community?
 - Does the child have difficulty independently initiating, sustaining, or completing activities?
 - What kind and how much help does the child need to do activities, and how often does the child need it?
 - Does the child need a structured or supportive setting, what type of structure or support does the child need, and how often does the child need it?
- We consider all relevant evidence in the case record to determine whether a child is disabled. This evidence may come from acceptable medical sources and from a wide variety of “other sources.”
 - Usually best to send functional capacity forms to teachers, unless the child is younger than school age.

- **Domains**
 - Acquiring and Using Information—SSR 09-3p
 - Attending and Completing Tasks—SSR 09-4p
 - Interacting and Relating with Others—SSR 09-5p
 - Moving About and Manipulating Objects—SSR 09-6p
 - Caring for Yourself—SSR 09-7p
 - Health and Physical Well-Being—SSR 09-8p
- The degree of limitation is dependent on age of child. Each domain lists what an average child at that age would be able to do and each lists what could be considered marked or extreme limitations.

INITIAL DEVELOPMENT

Initial Contact

- The initial contact from a potential client will usually be a telephone call in response to an advertisement or a referral from a former or current client.
- If the person has not yet applied, find out when he/she last worked, what the disability is based on, and if he/she has been receiving continuous treatment.
- If the person has already been denied, find out why he/she was denied (medical or non-medical). When the denial was issued, time to appeal, and get basic info on what the caller's disability is so that you are prepared during consultation.
- You or your staff must find out the date of the last denial prospective client received and to set up an appointment BEFORE the 60 days or other given time for appeal lapses. It is common for a person to call the day before their appeal is due.
- If it is impossible to get the prospective client in to your office prior to an appeal time lapsing, make sure the prospective client knows to file the appeal on his/her own and to get a date stamped copy of receipt from the district office. Follow up the telephone call with a letter to the prospective client advising that you are not yet his/her representative and that he/she must file the appeal on his/her own to protect appeal rights.
- Send a letter to the prospective client with appointment reminder and location of office. We send forms for the prospective client to complete which lists various information about client (a sample is attached). Advise prospective client to bring these forms to the appointment, as well as any other forms from social security, especially any denial notices, and any medical records in chronological order.

Initial Consultation

- Ask the prospective client why they disagree with Social Security (if denied) or why they cannot work.

- Read through all material that the prospective client has brought in. Sometimes the information provided in the intake forms completed by the prospective client may raise a red flag as to important issues, such as whether or not this person would be eligible for benefits, if there would be a bar to benefits due to an outstanding felony warrant, or if there would be a reduction of benefits due to offsets. The medical records brought in can also provide key information. Does the evidence support disability?
- Compare prospective client's list of doctors and hospitalizations with the denial notice(s). Are there records missing from the Social Security file? Even if all doctors' reports appear to be listed in the denial notice, do not assume all records are there. Social Security will only tell you they have a record or report from Dr. Smith received 1/1/07. This may be either medical records consisting of hundreds of pages with a detailed report or a one page submission from the doctor stating that the records cannot be found.
- Determine if the case is Title II (Disability Insurance Benefits) or Title XVI (Supplemental Security Income benefits) or a combination of both. Is it an adult or child who is applying. If this is for a new application, determine DLI (date last insured) or financial eligibility for SSI.
- How old is the prospective client? This will help determine if he/she would likely "grid out," or if there are any other benefits available, such as early retirement benefits or survivor's benefits.
- Go through the sequential evaluation
 - Is the prospective client working? When did he/she last work? Why did he/she stop working?
 - What are the impairments? How do they affect him/her? Is he/she getting continuous treatment for these impairments?
 - How long can he/she sit, stand, walk? Determine all of the limitations, both physical or mental. What does he/she normally do on a typical day?
 - Ask the prospective client if he/she believes there is any way he/she could work on a full time basis at any type of job that person did within the last 15 years.
 - Ask if he/she believes he/she could work at any job on a full time basis. You will be surprised at how many people say, "well, yeah, I can flip burgers, but I am used to making \$100K a year!" Doesn't matter for Social Security. I explain that even at a low wage job, they will likely get more money working than they will with Social Security.
- Determine fee considerations. Most fee agreements are on a contingent basis with the fee being 25% of the retroactive benefits, with a cap of \$6,000 that can automatically be sent to the attorney or qualified non-attorney representative. Will there be sufficient retroactive benefits to compensate you for your work? If there are only a couple of months worth of benefits involved, your fee may be very little. Are there any offsets from Worker's Compensation or State Disability benefits that would offset the benefits? Attorney's fees are computed by the adjusted benefit amount, after all of the offsets. However, attorney's fees may be increased if there are auxiliaries that are entitled to benefits, such as minor children. If you take the

case at the federal court level, it may be important for you to know whether the claimant has any federal debts, such as owing taxes, federal student loans, or child support, as this will cause an offset of a potential Equal Access to Justice Act fee. These concerns are not only important for the prospective client to know, but also may factor in to whether or not you feel you are able to take on representation.

- Determine if there is enough information to represent the prospective client. Sometimes more information will be needed before you determine you can represent him/her. Advise the prospective client to get any additional information needed, such as copies of medical records or an assessment form from a doctor. Watch the deadlines. If the appeal is due prior to when the prospective client can obtain all of the information, advise him/her to file the appeal on his/her own and to get a date stamped copy. We do not sign up every prospective client who walks through our door. Taking claims that you know you cannot win will lessen your credibility in the eyes of the ALJs.
- If you determine you can represent, advise the prospective client of all of the office policies and the fee agreement.
- When signing up a new client, have him/her sign fee agreement (there should be duplicates with original signatures on each), 1696, appeal forms, authorization forms for your office and for social security to obtain medical information, and authorization forms for your staff to talk to social security.
- Advise your new client to keep in touch with you and to advise you to any new condition, treatment, pending surgeries, and any other important medical information, as well as if he/she moves, changes phone numbers, goes out of the country, or if he/she goes on an extended vacation. Some attorneys include a provision in their fee agreement that the client is to inform the attorney of address changes.
- Advise new client of expected time frame based on level and location. Give your new client business cards for future use or referrals.
- When submitting all of these forms, make sure to submit a 1695, if appropriate, and make a notation to obtain a receipt and acknowledgment that it has been entered and the original destroyed. If the case is taken at the hearing level, the forms should be sent to the district office and then forwarded to the ODAR.

PRE-HEARING PREPARATION

Once a case reaches the Hearing Level, every practitioner should be concerned with the following:

1. Case Preparation
2. Obtain a copy of the Exhibit file CD or access through ARS.
3. Contact with client that a hearing will be forthcoming
4. Explaining delays involved
5. Developing the case
6. Preparing your client

- Attorneys should warn their clients about is the lengthy delays that the Social Security Administration is experiencing at the moment. At every initial interview, this is a critical piece of information that every client should be made aware of.

- The inevitable questions that will arise are as follows:
 - How much longer is it going to take?
 - Do you think I will be alive before SSA gives me my benefits?
 - Why so long? I am disabled and have been working all my life. I want what I am entitled to.
 - If I call my Representative in Congress, would that make a difference?
 - My friend got it in two weeks, why is mine taking a year?
 - I was told if I hire a lawyer, it would go a lot faster.
 - The longer it takes the better for you because your fee will be more.
- The best one of all is when you get a phone call from a colleague who advises you that your client called him/her seeking representation because the case is taking too long and you are not doing anything.
- Preparation of a Social Security Disability claim begins the moment your client walks into your office for the initial interview. Clients often come to our offices after they have filed the application on their own, and received the initial denial. Others, will file the Request for Reconsideration on their own, and will call your office after it has been denied. Others, unfortunately, prefer to wait until a hearing date has been scheduled and call you then. In this last instance, unless you are able to pull a lot of resources and manage to review the file, copy it, and medically develop the evidence within 20 days, you are better off requesting a continuance to properly prepare for a hearing. However, some ALJ's would rather hold the hearing and then keep the record open.

During the initial interview, at whatever stage it takes place, inevitably every client will ask the same question, how long will this take? The answer depends on the stage the claim is at that time. I often times start to answer that question providing my client with the estimate that the Commissioner gave us a few years back, at a previous conference of the National Organization of Social Security Claimants' Representatives (NOSSCR), that the national average for a DIB claim is over 1,000 days. Inevitably, the response from my client is not favorable, and I always let them know that it could be less or more, depending on the local ODAR or DDS/ODD delays.

Oftentimes, if at the time of the initial interview with my client, the next step in the claim is to file a Request a Hearing, I will place a phone call to the ODAR that will be handling my client's claim, turn on the speaker on the phone, and ask for the scheduling clerk. Every ODAR will have one or two, depending on the number of ALJs, and I think it is important to for every practitioner to foster good relationships with them, as well as any staff member from your local ODAR. Then, I ask the clerk how long the cases are taking to go to hearing, or the month and year of the Request for Hearings that they are currently working on. Sometimes I even ask the number of claims pending at the office. I always get the same answer, "We are working on Request for Hearings that were file over one year ago. So If you file one now, it will take over a year before it is looked at to schedule, and then it will

be scheduled two to three months later. We have over 3,500 cases waiting to be scheduled” By placing this short phone call, you have shown your client that you are not lying about the delays. Also, knowing the number of cases that are pending, justifies the delay that the local ODAR is experiencing.

We all know that there are clients that you will never satisfy, no matter what you do. They hate the legal system, and they hate the fact that they have to deal with lawyers. Therefore, it is important to maintain this type of client always informed of the progress of their case. I often diary these clients to call them every two to three months and let them know that everything is proceeding OK, and that we are currently awaiting information from SSA. If any information is received, make sure you consult with your client and, if forms are required to be completed, complete them over the phone with your client.

Here are a few tips that every practitioner should follow when their case reaches the hearing level:

1. Be civil and friendly to ODAR staff, regardless of your personal opinion regarding their competence, or their work product. If you are not, you will suffer the consequences that will undoubtedly hurt you and your client.
2. Make certain that ODAR has you down as the representative of record. Often times I get a phone call that a particular component of the Administration failed to forward something. Sometimes I have to re-submit our Appointment of Representative form (SSA-1696) and our fee agreement. This is important as clients sometimes do not call because they assume we receive copies of anything mailed to them.
3. If it will take a year before the case is before an ALJ, check with your clients periodically. Diary the file to make a phone call to follow up on medical treatment, possible work activities, or any other new developments. Stress to your clients the importance of ongoing treatment.
4. If evidence has been submitted, follow up and verify that it has made it to the Exhibit file. If evidence has been submitted close to the hearing date, do not assume that it has made the Exhibit file. Go to the hearing with extra copies for the ALJ and, if applicable the ME and VE.
5. When submitting anything to ODAR, if you are hand-delivering it, take an extra copy of your submission letter, stamp it with a “copy” stamp, and have the clerk at the front window stamp it with the date it was submitted.
6. If evidence is submitted by mail, enclose a self addressed stamped envelope and request that the additional submission letter stamped copy be returned in the enclosed envelope, once it has been stamped with ODAR’s date stamp. If you are lucky, you will get some of these back.
7. Most evidence will be submitted electronically to each electronic folder. This is done by obtaining the appropriate bar codes for each individual claimant and submitting the evidence via fax or online through the ERE process. ODAR will provide you with several bar codes for each client and

the one used will depend on the type of evidence submitted. If ODAR only sends an “attorney/representative supplied evidence” bar code, either try to obtain the correct one or submit the evidence with this bar code and call ODAR and have them transfer the record to the appropriate section of the file. Do not assume that because records were submitted electronically that they will actually be in the file. Always check.

8. If a medical expert has been scheduled to testify, and you have new evidence to submit only a few days prior to the hearing, call the ALJ and request if you can directly mail the new evidence to the medical expert. The ALJ can verify what evidence you have sent to the ME when the ME brings your package to the hearing. Most ALJ’s will agree to this since it will most likely not result in a continuance of the hearing for the ME to review the evidence, thereby saving money and time.
9. If you feel your client may not be a good witness, try scheduling a meeting with him/her a few days before the hearing, and play ALJ with your client. Ask the type of questions the ALJ will ask, and see what your client’s response will be. We have often dealt with clients who are not responsive, and who will go into a long ½ hour speech when asked only how long can you sit. This can make for a long hearing and an unhappy ALJ. For instance, I have had ALJs upset at clients because they can’t remember dates of past relevant work. An ALJ went as far as asking me whether I had discussed and gone over these issues with my client, as he felt any good attorney would have. Consider bringing in a witness to testify, if your client will be non-responsive. Someone who spends a lot of time with your client would be appropriate.
10. Take a picture of your client and attach it to the file. You can buy an inexpensive digital camera and print as many copies, on regular paper, as you need. If your client made a good impression on the ALJ, and the record was kept open to obtain additional evidence, submit a copy of the picture with the evidence. This will refresh the ALJ’s memory of who the client was, and it may help your case. Also, when clients call the office, we don’t always remember their faces. It helps to open the file and see a picture. Also, if you have not seen your client in months, and you are now scheduled to meet at the hearing office, the day of the hearing, it looks good when you show up and immediately recognize him/her, as opposed to showing up at the ODAR waiting room and asking, is John Doe here?
11. Always review file prior to hearing. If you have ARS (Appointed Representative Services) access, it is best to review the ARS file the same day of the hearing. If you do not have access to ARS, review the disc provided by the hearing office, however, take note this disc may have been burned prior to the submission of all the evidence. I have found additional records added to the file, including new hire/work records, sometimes showing recent SGA or unemployment earnings, recent consultative examination reports and MSS forms, as well as an occasional CDI investigation report. If you do not have

access to the ARS file, make sure to compare the list of exhibits with those that are noted by the ALJ at the beginning of the hearing. (For instance, the ALJ will note the record contains Exhibits 1A-4A, 1B-10B, 1D-5D, etc.)

Remember that at any level of the appeals process, all of the Commissioner's Regulations, Rulings and Policy statements are applicable.

VOCATIONAL EXPERTS AT HEARING LEVEL

FOR REFERENCE READ SOCIAL SECURITY REGULATIONS RELATING TO VE TESTIMONY AT 20 C.F.R. §§404.1560 - 404.1569a

- Reliance on vocational expert testimony is proper only if the hypothetical posed to the vocational expert comprehensively describes the claimant's impairments.
- The vocational expert's response to a hypothetical question that does not include each of the limitations that are medically established cannot constitute substantial evidence to support the ALJ's decision.
- Where the vocational expert has been insufficiently questioned, the expert's testimony is insufficient to support a finding against the claimant.
- Mental impairments are considered to be, for the most part, non-exertional impairments. For this reason, an ALJ should usually solicit evidence from a vocational expert. See 20 C.F.R. Pt. 404, Subt. P, App. 2.
- HALLEX 1-2-557 states that "live testimony with opportunity to question the VE is the preferred method for obtaining VE testimony. If interrogatories are used, HALLEX cautions that "before releasing the interrogatories to the VE, the ALJ must transmit the proposed interrogatories to the representative with a copy to the claimant, or the claimant if not represented, to determine if they object to the use of the interrogatories in general, object to any particular interrogatory, or wish to propose other interrogatories. " (HALLEX 1-2-557 C1). The ALJ must rule on any objections (HALLEX 1-2-557 C 2).
- Make sure that if the VE identified any jobs, that the DOT number and number of jobs in the local/national economy are provided in testimony and the question the source and basis for the number of jobs that the indicated.

MEDICAL EXPERTS AT HEARING LEVEL

- An ALJ may also solicit evidence from a medical expert, either by interrogatories or in person at the hearing. If the ALJ chooses the former method, HALLEX 1-2-542 requires the prior transmittal of the proposed interrogatories to the attorney and/or claimant
- Since live testimony is always preferred, the practitioner should consider requesting a subpoena for the author of the interrogatories if they prove to be non-responsive or incomplete. (20 C.F.R. 404.950 (d) (1)). The request must be in writing and filed at least five days before the hearing date. (20 C.F.R. 404.950 (d) (2)).

- When an ALJ decides that a consultative examination is necessary, the ALJ must follow the provisions of HALLEX 1-2-520. The HALLEX states that “the ALJ usually will not need to specify a particular physician or psychologist to conduct a C.E. or test. Because SSA considers a claimant’s treating source (s) to be the primary source of medical information about a claimant’s impairment, the State Agency will, if possible, select a treating source that is qualified, equipped, and willing to perform the C.E. or test for the amount allowed under their fee payment schedule.” HALLEX 1-2-420 C.
- If an ALJ requests a State Agency to use or not use a particular treating or nontreating physician or psychologist to conduct a CE or test, the ALJ must:
 - Provide the physician’s or psychologist’s name, address, and telephone number, and explain the reason(s) for the special request; and
 - Place a copy of the special request in the CF. HALLEX 1-2-520 C.
- “When an ALJ admits a medical opinion into the record from a State Agency medical or psychological consultant that was considered a finding at any earlier level in the Administrative Review process, the ALJ will also admit into the record a statement of the medical source’s professional qualifications as required by SSA’s operating instructions” (65 Fed. Reg. 11872, March 7, 2000). (Response to comments to final rules regarding evaluation of opinion evidence).

DEVELOPING THE RECORD PRIOR TO THE HEARING

- Needless to say that developing the medical evidence of record is extremely important in a disability case. Few things should be taken into account when undertaking this most important task in a Social Security disability claim.

A. ACCEPTABLE SOURCES OF MEDICAL EVIDENCE

1. Licensed physicians (M.D.)
2. Osteopathic doctors (D.O.)
3. Psychologists (Psy.D, Ph.D. or even Ed.D)
4. Psychiatrists (M.D.)
5. Optometrists

B. OTHER ACCEPTABLE SOURCES

- In order to show either the severity of the symptoms, or how the impairment affects a claimant’s daily living, the Administration will also consider the opinions of other sources, such as nurses, nurse-practitioners, chiropractors, mental health therapists, social workers, and even non-medical individuals as well. See 20 C.F.R. 404.1513 for medical and other evidence that can be considered when evaluating a claimant’s impairment.

- Social Security Ruling 06-3P provides explanation how the opinions of sources, not considered “acceptable medical sources,” will be evaluated.
 - This Ruling provides that oftentimes a non-medical source, such as a school teacher, a social worker, a mental health therapist, a school counselor, will have closer and more frequent contact with the claimant than an “acceptable Medical Source.” Thus, their frequent interaction with the claimant places them in a better position to opinion to opine as to the claimant’s impairment, and resulting limitations, than a medically accepted treating source, who may see the claimant with much less frequency.
 - The opinion of non acceptable medical sources will be weighed taking into account the factors set forth in 20 C.F.R. § 404.1527(d). These are the same factors used to evaluate the opinion of an acceptable medical source.

C. MEDICAL ASSESSMENT FORMS

Most practitioners like to create their own medical physical and mental assessment forms. Most of them will tailor each assessment form to fit the claimant’s individual impairment. It is extremely important that the medical evidence of record be thoroughly reviewed before undertaking to medically develop a case. However, the medical assessment form should, at the very least, establish the following information:

1. The expertise of the doctor, and whether he/she is board certified
2. The period of treatment (dates of first and last visit)
3. The total number of examinations
4. The diagnosis
5. The objective findings to support the diagnosis
6. The symptoms related to the physician by the claimant
7. Credibility of the claimant
8. Claimant’s ability to sit in an eight hour work-day
9. Claimant’s ability to stand in the same eight hour work-day
10. Claimant’s ability to lift occasionally, frequently and constantly
11. Claimant’s ability to use his/her hands on a sustained basis
12. Claimant’s ability to use his/her feet for pushing and pulling of leg controls on a sustained basis
13. The effect pain has on claimant’s ability to work
14. Claimant’s ability to perform postural activities such as bending, crawling, stooping, kneeling, or climbing
15. Side effects of medication

D. FOLLOWING UP ON YOUR REQUEST

It is important to timely follow up on your request to the treating physician. Often times, doctors are not too happy to get these forms in the mail, and most of them would rather never have to deal with a lawyer. However, a letter of introduction,

sent together with the medical assessment form, can alert the doctor that this is a Social Security disability matter, that there is no opposing attorney involved (although sometimes the ALJs are), that his/her opinion is very important to the Social Security Administration and that his/her patient needs his/her assistance in this matter.

Be sensitive to the doctor's time. His/her time is worth money, as they could be seeing patients during the time it takes them to review a file and complete a medical assessment form. An introduction letter should contain a paragraph dealing with this matter and advising how this will be handled. Some attorneys like to send money in advance, some would rather wait for the doctor to bill them and, in some instances, clients prefer to personally deal with the doctor in this matter. Whatever the case may be, always mention it in the intro. letter.

E. SUBMISSION OF EVIDENCE

Once the medical assessments have been received, it is important to review them so that there are no inconsistencies between the doctor's answers in the assessment and the medical evidence of record. If they are, the doctor should be re-contacted and clarification of the conflict or inconsistency should be resolved prior to the hearing.

The fastest and most secure method of submitting evidence is through the ERE system of the ARS site. You can submit records, briefs, forms, etc. directly into the electronic folder and obtain a submission receipt. If you are not signed up for ARS access, contact your local ODAR and ask how you can sign up.

F. POST HEARING ISSUES

- After the hearing, a decision will be issued by the ALJ.

If the decision is favorable

- Call and/or write to your client and explain same.
- Advise your client that a Notice of Award will follow.
- Once received, review Notice of Award and make sure everything is correct.
- Review Notice of Award with client.
- If claimant has children under 18 years of age, or 19 and still in high school, make sure auxiliary applications have been filed.
- If claimant has children over 18 years of age, but who were under 18 during the disability period awarded, make sure child applies for auxiliary benefits.

If decision is unfavorable

- Review decision with client.
- 60 days to file Request for Review of Hearing Decision/Order

- 60 days start after the date decision was received.
- SSA assumes same was received within 5 days of the date of issuance.
- Discuss with client issues for appeal and time involved in same.
- SSR 11-1p: SSA will no longer process a subsequent disability claim if you already have a claim under the same title and of the same type pending in our administrative review process.
 - If you want to file a new disability claim under the same title and of the same type as a disability claim pending at any level of administrative review, you will have to choose between:
 1. pursuing your administrative review rights on the pending disability claim, or
 2. declining to pursue further administrative review and filing a new application.
 - EXCEPTION: The AC will determine if the FO should take a new application for the same title and benefit type before issuing action on the prior claim when:
 1. The claimant has additional evidence of a new critical or disabling condition with an onset after the date of the hearing decision, AND
 2. The claimant wants to file a new disability application based on this evidence, AND
 3. The AC agrees the claimant should file a new application before the AC completes its action on the request for review.

APPEALS COUNCIL LEVEL

- If denied at the ALJ level, a claimant has the right to file an appeal with the SSA's Appeals Council.
- The appeal must be filed within 60 days of the ALJ's decision (plus 5 mailing days, since the Appeals Council assumes the decision was received within 5 days after it was issued).
- You have the option of requesting copies of the entire Exhibit file and a copy of the recording of the hearing. If you request same, make sure you request an extension of time, upon receipt of same, to submit any additional legal arguments.'
- Also note that the Appeals Council has the right to review any decision on their own accord within 60 days of the decision.
- If the claimant is denied by an Administrative Law Judge for a second time, and was previously at the Federal Court level on the same claim, the claimant has a right to choose between filing exceptions to the written decision, which must be submitted within 30

days of the decision (or an extended date approved by the Council), or can skip the Appeals Council level and directly file with the Federal District Court within 60 days of the Administrative decision becoming final, as such, the complaint must be filed between the 61st and 120th day after the date of the Administrative Law Judge Decision.

FEDERAL COURT LEVEL

- If denied at the Appeals Council level, a claimant has the right to file suit in Federal District Court.
- Suit must be filed within 60 days of the Notice of Appeals Council Action.
- Equal Access to Justice Act—If the claimant is successful at the Federal Court level, Social Security may be able to pay for the attorney fee or part of the attorney fee for the Federal Court work.
 - For more information attend and/or review the material for the Friday session: Money Matters in Federal Court: The Costs and Reward of Filing in U.S. District Court by Wiebke Breuer, Esq.

CONCLUSION

As a reminder to our colleagues engaged in this area of the law, traditionally, most of the Social Security practitioner's time was devoted to steering the claim through the myriad levels of appeal—and developing and presenting the evidence in a manner consistent with the Social Security Act, governing regulations, rulings, policy statements and case law. However, obtaining a favorable decision is not the end of the battle in many cases. You still must ensure that your client has received the proper amount of benefits to which he or she is entitled. Please make sure that their award notices are properly reviewed, and that, when applicable, minor children receive the benefits they are entitled to as a result of the parent receiving disability benefits.

You must use all your knowledge and available tools to get your client's case through the system successfully. And, don't forget, often times obtaining a favorable decision for your client is only half the battle. Getting them the right amount of benefits can often time take longer. Incorrect award notices, workers' compensation offsets, public disability benefits offsets, and other problems can often complicate, and lengthen the amount of time it takes for a claimant, and auxiliaries, to get the right amount of benefits.

Good luck!

**ACRONYMS AND OTHER TERMS YOU SHOULD KNOW
FOR THE SOCIAL SECURITY PRACTICE**

SSA	–	Social Security Administration
SSDI	–	Social Security Disability Benefits
SSI	–	Supplemental Security Income
ALJ	–	Administrative Law Judge
ODAR	–	Office of Disability Adjudication and Review
DO / FO	–	District Office / Field Office
RECON	–	Reconsideration
AC	–	Appeals Council
ARS	–	Appointed Representative Services
ERE	–	Electronic Records Express
C.F.R.	–	Code of Federal Regulations available at http://ssa.gov/regulations/
HALLEX	–	Hearings, Appeals and Litigation Law Manual available at http://ssa.gov/regulations/
POMS	–	Program Operations Manual System available at http://ssa.gov/regulations/
SSR	–	Social Security Ruling available at http://ssa.gov/regulations/
AR	–	Acquiescence Ruling available at http://ssa.gov/regulations/ or Administrative Record.
1696	–	Appointment of Representative Form (submitted with each case)
1695	–	Form for Direct Payment of Fees (submitted with each case)
1699	–	Registration for Direct Deposit Form (only submitted once)