

CHAPTER 11

SOCIAL SECURITY DISABILITY PRACTICE IN LOUISIANA

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About The Author

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1. INTRODUCTION

The Social Security Administration operates two disability benefits programs. Supplemental Security Income (SSI), also known as Title XVI, provides income to individuals that are indigent that have either attained age 65, are blind,¹ or disabled.² Social Security Disability Insurance Benefits (SSDI), also known as Title II, provides income to blind or disabled people who have contributed sufficient payroll taxes to the Social Security system.³

2. THE DIFFERENCE BETWEEN SSI AND SSDI

The rules governing how to prove disability are the same for Supplemental Security Income (SSI) and for Social Security Disability Insurance (SSDI). However, the financial eligibility rules and the amount of benefits paid are quite different.

An SSI recipient must be indigent, meeting certain income and resource rules. SSI benefits are paid to the claimant only, and not to his dependents. SSI has no earnings requirement. In contrast, in order to receive SSDI, a person must have worked long enough, paid sufficient payroll taxes to SSA and recently enough under Social Security to qualify for SSDI.⁴ If a person qualifies for SSDI, SSDI is available regardless of indigence. There are certain circumstances where a spouse, widow/widower, children and even parents of a person who has paid sufficient payroll taxes may also be able to get benefits from a worker that has become disabled under SSDI rules, has retired or is deceased, *see infra* Section 2.2.

The source of payment for SSI benefits is general revenue. The SSI monthly benefit is a standard federal benefit rate set by Congress (\$710 for a disabled individual in 2013, with the possibility of an annual cost-of-living increase). The benefit amount paid may be decreased if the recipient has other income and based on his or her living arrangement. The amount of SSI is also affected by the income of a spouse (even if the spouse's income is SSI).

The SSDI source of payment is the Social Security trust fund. The monthly benefit amount is based on how much the worker earned. An individual may receive both SSDI and SSI benefits if the SSDI benefits are low enough and SSI eligibility requirements are met. When an individual receives both kinds of benefits the total amount paid is the SSI benefit amount plus \$20 (\$730 for a disabled individual in 2013).

2.1 SUPPLEMENTAL SECURITY INCOME

2.1.1 SSI Eligibility Rules

There are five types of eligibility criteria for SSI: 1) categorical, 2) residence, 3) citizenship and alien status, 4) resources, and 5) income. Categorical eligibility means being elderly (age 65 or older), blind or disabled. The residence eligibility requirement is that the applicant must be a resident of the United States for at least 30 days.⁵ The citizenship/alienage, resource, and income requirements will be addressed immediately below. Establishing disability as a means to meet the categorical requirement will be addressed extensively further in Section 4.

¹ Blind is defined as having corrected vision no better than 20/200 or limited to a visual field of 20 degrees in the better eye.

² 42 U.S.C. § 1381. The laws and regulations governing SSI can be found at 42 U.S.C. § 1381 *et seq.*; 20 C.F.R. Part 416.

³ The laws and regulations governing SSDI can be found at 42 U.S.C. § 401 *et seq.*; 20 C.F.R. Part 404.

⁴ 42 U.S.C. § 423; 20 C.F.R. § 404.315.

⁵ See 20 C.F.R. §416.1603 for definition of U.S. resident and acceptable types of evidence to prove residency. 20 C.F.R. §416.1610 provides acceptable types of evidence to prove citizenship or a national of the United States.

2.1.2 Citizenship and Alien Status Eligibility Rules

The citizenship and alien status eligibility rules state that an SSI recipient must be a citizen or national of the United States or have an alien status required by the Social Security Act. Not everyone with a green card is eligible for SSI under current law.⁶ SS eligibility rules restricting certain immigrants is complex. It is strongly suggested that if you have a client that is an immigrant you should review POMS SI 00501.400, POMS SI 00502.100⁷ and 20 C.F.R. § 416.1610- 416.1618. The following is a general list of people who may be eligible for SSI:

1. Citizens or nationals of the United States⁸; or
2. an alien lawfully admitted for permanent residence in the United States⁹ ; or
3. an alien permanently residing in the United States under one of the qualified alien categories found in POMS SI 00502.100; or
 1. an alien who meets the definition of a resident of the U.S. under color of law (PRUCOL) prior to August 22, 1996 and who was considered to have been receiving SSI benefits on August 22, 1996 as stated in SI 00502.150B.1; or
 2. an alien who is lawfully present in the U.S. pursuant to Section 203(a)(7) (Refugees-conditional entry) if admitted prior to April 1, 1980; or
 3. an alien who is paroled under Section 212(d)(5) of the Immigration and Nationality Act and the parole status is issued for a minimum of one year (see POMS SI 00501.450);¹⁰ or
 4. an Iraqi or Afghan Special Immigrant admitted to the U.S. pursuant to Section 101(a)(a)(27) of the INA; or
 5. an alien who is deemed to be a Victim of Severe Forms of Human Trafficking who was admitted to the U.S. pursuant to Section 101 (a)(15)(T) of the INA.¹¹

2.1.3 SSI Resource Rules

2.1.3.1 Definition of resource:

A “resource” is defined as cash or other liquid assets or any other personal property or real property that the SSI recipient (or his spouse) has an ownership interest in and right or power to convert to cash for his/her support and maintenance.¹² If an individual lacks legal capacity to convert the resource, it nonetheless counts unless litigation would be needed to access its value.¹³

⁶ Since August 22, 1996 most aliens must meet 2 requirements to be eligible for SSI: 1) must be a qualified alien and 2) meet an exception condition for qualified aliens. Aliens who are lawfully admitted for permanent residence must have worked long enough to have at least a total of 40 qualifying quarters of work. An alien may get the 40 quarters of work himself. Also, work done by a spouse or parent (during the periods the alien was under 18) may count toward the 40 quarters of work for getting SSI only. Any quarter of work acquired after December 31, 1996 cannot be counted if the alien or the worker received certain types of federally funded assistance during that quarter. See POMS SI 00502.135, POMS SI 00502.100A(2) and POMS SI 00502.100A(3).

⁷ The POMS are Social Security’s manual of policies used by its District Office staff. The URL for accessing them is given in § VII., Resources For The Advocate, *infra*.

⁸ 20 C.F.R. §416.1600.

⁹ See with POMS GN 00303.420 and POMS SI 00501.400.

¹⁰ *Id.*

¹¹ See, POMS SI 00501.400.

¹² 20 C.F.R. § 416.1201.

¹³ POMS SI 01120.010 B.2., C.2., C.7.b.

2.1.3.2 Resource limit:

The SSI resource limit is \$2000 in countable resources for an individual and \$3000 for an eligible couple.¹⁴ If the applicant's resources exceed the limit, he is ineligible for SSI. He may become eligible again the month after he "spends down" his resources below the limit. Similarly, if a couple's combined resources exceed the resource limit they would be ineligible for SSI until the month after resources fall below the limit.

2.1.3.3 Valuation:

Resources are valued at the amount of the SSI recipient's equity in the property. Equity value is the amount at which the item reasonably can be expected to sell for on the open market in the recipient's geographic area, minus any encumbrances such as liens.¹⁵

2.1.3.4 When resources are counted:

Resource determinations are based on the resources the individual has at the first moment of the first day of the month for which eligibility is being determined.¹⁶ This means that if an individual receives something of value, it may be considered "income" in the month in which he receives it. If he still has any of it at the first minute of the first day of the following month, whatever he has will then be considered a "resource."¹⁷ If an individual is over-resource at the beginning of the month, the individual cannot be eligible for the rest of the month.

2.1.3.5 Excluded resources:¹⁸

Examples of excluded resources are: 1) the home in which the applicant lives, and the land on which it sits (including all adjoining land he owns)¹⁹; 2) one car used to provide necessary transportation, regardless of value;²⁰ 3) personal or household goods valued at under \$2000 for an individual or \$3000 for a couple²¹; 4) life insurance policies owned by an individual (or spouse) with face values under \$1500²²; 5) burial funds of \$1500 or less, if the person does not own any excluded life insurance. (These funds must be identified as burial funds and kept in a separate bank account. Interest which accumulates in the account is not treated as income, even if it results in the account exceeding \$1500. If funds are mixed with resources not intended for burial the exclusion is lost. If any portion of the funds are withdrawn and used for other purposes, SSA will reduce monthly benefits by a penalty equal to the amount of the withdrawal, unless burial account exclusion was immaterial to the recipient's eligibility.²³); 6) burial plots or spaces; 7) property used in a trade or business which is essential to the means of self-support for the applicant. Social Security excludes as essential to self-support up to \$6000 of an individual's equity in income-producing property if it produces a net annual income to the individual of at least 6% of the excluded equity. If the individual's equity is greater than \$6000 SSA counts only the amount that exceeds \$6000 toward

¹⁴20 C.F.R. § 416.1205.

¹⁵20 C.F.R. § 416.1201(c)(2).

¹⁶20 C.F.R. § 416.1207.

¹⁷20 C.F.R. § 416.1207(d).

¹⁸20 C.F.R. §§ 416.1210-1239.

¹⁹20 C.F.R. § 416.1212.

²⁰20 C.F.R. § 416.1218.

²¹20 C.F.R. § 416.1216.

²²20 C.F.R. § 416.1230.

²³20 C.F.R. § 416.1231.

the allowable resource limit if the net annual income requirement of 6% is met on the excluded equity. If the activity produces less than a 6% return due to circumstances beyond the individual's control, and there is a reasonable expectation that the individual's activity will again produce a 6% return, the property is also excluded. If the individual owns more than one piece of property and each produces income, each is looked at to see if the 6% rule is met and then the amounts of the individual's equity in all of those properties producing 6% are totaled to see if the total equity is \$6000 or less. The equity in those properties that do not meet the 6% rule is counted towards the allowable resource limit.²⁴ 8) non-business property essential for an individual's self-support that is used to produce goods or services essential to daily activities (e.g., land for a vegetable garden used solely to feed the applicant's household). Property is excluded if the individual's equity in the property does not exceed \$6000²⁵; 9) proceeds from the sale of a home, if they are used within 3 months to purchase another residence²⁶; 10) retroactive lump sum payments of SSI or SSDI for nine months after receipt²⁷; 11) resources deemed necessary to fulfill a Plan to Achieve Self Support (PASS)²⁸; 12) assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States or comparable assistance received from a State or local government, or from a disaster assistance organization. Interest earned on the assistance is also excluded from resources.²⁹

2.1.3.6 Disposing of Resources:

An individual who disposes of assets for less than fair market value for the purpose of establishing SSI within a 36-month "look back" period will be penalized.³⁰ The penalty is SSI ineligibility for the number of months equal to the uncompensated value of the transferred asset, divided by the maximum monthly SSI benefit payable to that individual after considering his living arrangement. The penalty begins to run at the date of the transfer (unless the person is already under another penalty).

The penalty does not apply in the following circumstances:

- 1) The individual or her spouse disposed of the resource exclusively for a purpose other than qualifying for SSI; or
- 2) The individual or her spouse intended to sell the asset for fair market value; or
- 3) All transferred assets have been returned to the individual; or
- 4) Denial of eligibility would result in undue hardship. The POMS limits "undue hardship" to situations where the individual would be deprived of food or shelter and where his total available funds (income and liquid resources) are less than the federal benefit rate.

²⁴20 C.F.R. § 416.1222.

²⁵20 C.F.R. § 416.1224.

²⁶20 C.F.R. § 416.1212.

²⁷20 C.F.R. § 416.1233.

²⁸20 C.F.R. §§ 416.1225-27.

²⁹20 C.F.R. § 416.1237.

³⁰42 USCA § 1382b(c) and POMS SI 01150.110.

The SSA presumes that the following transfers are for fair market value:

- 1) spending of cash for goods or services unless there is evidence to the contrary;
- 2) property sold on the open market even if it is sold for less than the asking price;
- 3) contract for the prepayment of food and shelter if amount is reasonable;
- 4) contract for prepayment of services if current market value is corroborated.

2.1.4 SSI Income Rules

2.1.4.1 Basic eligibility rule:

To calculate eligibility for SSI, first add all income received during the current month. Second, subtract all applicable income exclusions (\$20 a month exclusion is always available) and income deductions to arrive at countable monthly income. Finally, deduct countable monthly income from the maximum benefit amount (\$710 for an individual in 2013). If the amount is \$0 or less, the individual is not income-eligible. However, if income drops enough in subsequent months, eligibility may be reestablished.

2.1.4.2 Calculating the amount of benefits due:

Payment amount determinations are based on the monthly income received two months prior to the payment month. During the first two months of entitlement, special rules apply. To calculate the amount of benefits due, follow the procedures described above for determining income eligibility: 1) add all income received during the month in question; 2) subtract all applicable income exclusions and deductions to arrive at countable income; 3) deduct countable income from the maximum benefit amount. The final number is the amount of the monthly benefit.

Money received is counted as income in the month in which it is received. If it is retained, it is then counted as a resource in the following month. If an individual is ineligible for SSI during one month because of high income, she may re-establish income eligibility the following month if her income drops sufficiently.

2.1.4.3 Definition of income:

Income is anything the applicant receives in cash or in-kind that could be used directly, or by converting it to cash, to meet basic needs for food and shelter.³¹ Almost all income is countable, but there are certain deductions and exclusions. Countable income reduces the amount of the SSI check. If income is large enough, the individual is not entitled to SSI.

2.1.4.4 Countable income³²

- 1) Earned income³³ as well as unearned income³⁴ (alimony, child support, SSDI, veterans benefits, long-term disability benefits, workers compensation, etc.³⁵).
- 2) In-kind income (the value of food, clothing or shelter received for free or at a reduced charge counts as income). SSA does not count the value of free or low-cost services which are not food, clothing or shelter (e.g., medical supplies, entertainment). HUD housing subsidies do not count as income.

³¹20 C.F.R. § 416.1102.

³²20 C.F.R. § 416.1104.

³³20 C.F.R. § 416.1110-12.

³⁴20 C.F.R. § 416.1120-24.

³⁵20 C.F.R. § 416.1121.

- 3) Garnished income (even though it is not available to the SSI applicant),³⁶
- 4) Overpayment recovery (money withheld to recover an overpayment of SSDI or other benefits is counted as if the individual actually received it).³⁷

2.1.4.5 In-Kind Income Rules:

SSA has two rules for valuing the in-kind support and maintenance:

- 1) **1/3 reduction rule**³⁸: When an SSI recipient lives in the household of another person who provides both food and shelter without charge; the SSI grant is reduced by one-third of the federal benefit rate.³⁹ This reduction does not apply, however, to food or shelter that a homeless claimant receives from a soup kitchen or homeless shelter.⁴⁰ This rule also does not apply to children who are fed and sheltered by their parents.⁴¹
- 2) **Presumed maximum value**: This rule applies when an SSI recipient lives in the household of another person and that person provides a) free food but not free shelter, or b) free shelter but not free food, or c) food and/or shelter at a rate which is less than a pro rata share of the expenses. In such cases, the SSI grant is reduced by the actual value of the in-kind income or by 1/3 the federal benefit rate plus \$20 (the presumed maximum value), whichever is less.⁴² This rule does not apply if every member of the household receives public income maintenance benefits.⁴³

☞ **PRACTICE TIP**: It may be advantageous for your client to enter into a loan agreement while her application is pending, if she is living in another person's home and is unable to pay her pro rata share of room and board. If your client can show that she is expected to pay retroactive rent once her benefits are received, SSA will not consider this advance as income. If the latter arrangement applies, encourage your client to put the agreement in writing and to report it to SSA. Loans of in-kind maintenance or support are not considered income for purposes of calculating SSI. No interest need be charged but the loan must be subject to repayment. The claimant must show that there is a bona fide loan agreement.⁴⁴ While it is preferable to have written proof of a loan arrangement, an oral one is equally valid and can be accepted.⁴⁵ If the loaned payment is sufficient, this can prevent the client's back benefits from being reduced by one-third based on the "in-kind income."

2.1.4.6 Excluded Income⁴⁶:

Examples of excluded income include: 1) income tax refunds; 2) proceeds of a loan; 3) bills paid directly to supplier by others for goods or services that are not

³⁶20 C.F.R. § 416.1123.

³⁷20 C.F.R. § 416.1123.

³⁸20 C.F.R. §§ 416.1131-33.

³⁹20 C.F.R. § 416.1131.

⁴⁰See POMS SI 00835.060 and 20 C.F.R. § 416.1132 and 20 C.F.R. § 416.1102.

⁴¹20 C.F.R. § 416.1132.

⁴²20 C.F.R. § 416.1140.

⁴³20 C.F.R. § 416.1142.

⁴⁴SSR 92-8p, *Hickman v. Bowen*, 803 F.2d 1377 (5th Cir. 1986). SSRs are policy decisions published in the Federal Register which are binding on all SSA adjudicators.

⁴⁵See POMS SI 00815.350, SI 00835.480 and SI 01120.220 regarding Social Security's process of reviewing loans.

⁴⁶20 C.F.R. § 416.1103 and 20 C.F.R. § 416.1112 *Excluded Earned Income*; 20 C.F.R. § 416.1124 *Excluded unearned income*.

food or shelter;⁴⁷ 4) any portion of a grant, scholarship or fellowship, payable on or after June 1, 2004, used for paying tuition, fees, or other necessary educational expenses are excludable for 9 months from receipt⁴⁸; 5) 1/3 of child support paid by an absent parent⁴⁹; 6) assistance based on need from a state or local government, including rent subsidies; 7) in-kind income based on need provided by nonprofit organizations; 8) payments for impairment-related work expenses; 9) domestic commercial airline tickets received as gifts, so long as they are not cashed in⁵⁰; 10) food stamps; 11) weatherization assistance; 12) medical and social services⁵¹ 13) assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster;⁵² and 14) payments by credit life or credit disability insurance made on the recipient's behalf.⁵³

2.1.4.7 Income deductions:

An income deduction is a partial deduction of a type of income from countable income. Examples of income deductions are:

- 1) **General/unearned income deduction:** \$20 of income is deducted per month.⁵⁴ If this exclusion is not used up on unearned income, then it may be used to exclude earned income.
- 2) **Earned income deduction:** Subtract \$65 plus one-half of the remainder of gross monthly earned income.⁵⁵ (For example, if an individual earns \$565 in gross monthly wages, his earned income deduction is \$65 plus \$250, totaling \$315. That results in countable income of \$250.)

2.1.4.8 Income deeming⁵⁶:

Income deeming is the process of considering income received by another person as the income of an SSI recipient.⁵⁷ The deemed income is considered countable income, whether or not it is actually available to the SSI recipient.⁵⁸ The income of an ineligible spouse or parent of a minor child is deemed to the SSI recipient if they live in the same household, and a sponsor's income is deemed to an alien.

2.2 SOCIAL SECURITY DISABILITY INSURANCE (SSDI) ELIGIBILITY

SSDI is available to disabled wage earners who have worked the required number of quarters in covered employment (employment which paid payroll or self-employment taxes into the Social Security trust fund). An SSDI claimant must be both "fully insured" and "currently insured."⁵⁹ To be fully insured, a wage earner must usually have 40 quarters of covered employment (employment which paid payroll taxes). Quarters of coverage are calculated as follows:

⁴⁷ An example of an excluded service would be paying for lawn services.

⁴⁸ 20 C.F.R. § 416.1250.

⁴⁹ 20 C.F.R. § 416.1124.

⁵⁰ 20 C.F.R. § 416.1124.

⁵¹ 20 C.F.R. § 416.1103(a), (b). *Also see*, POMS SI 00815.050.

⁵² 20 C.F.R. § 416.1124(c)(5). *See* 20 C.F.R. § 416.1150 for a detailed discussion of assistance and how in-kind support and maintenance are treated.

⁵³ 20 C.F.R. § 416.1103(e).

⁵⁴ 20 C.F.R. § 416.1124 and 20 C.F.R. § 416.1112.

⁵⁵ 20 C.F.R. § 416.1112(c)(5) & (7).

⁵⁶ 20 C.F.R. §§ 416.1160-69.

⁵⁷ 20 C.F.R. § 416.1160.

⁵⁸ *Id.*

⁵⁹ 20 C.F.R. § 404.110 and 20 C.F.R. § 404.130.

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1. Before 1978, a worker was credited with one quarter of coverage for each calendar quarter in which \$50 was earned.⁶⁰
2. After 1978, the worker is credited with one quarter of coverage for a certain dollar amount earned during each year, ranging from \$260 in 1979 to \$1,160 in 2013.⁶¹ A maximum of four quarters can be credited in a year.

To be “currently insured,” an individual generally must meet the “20/40 rule,” which requires the wage earner to have 20 quarters of coverage in the 40 calendar quarters immediately preceding the onset date of disability. This translates generally into a rule of thumb that the wage earner must have worked five years in covered employment during the 10 years before becoming disabled.⁶² There are several exceptions to the 20/40 rule.⁶³ For example, the 20/40 rule does not apply at all to the statutorily blind, who need only be fully insured.⁶⁴

A worker can request his earnings record to determine his quarters of coverage and the date he was last insured. If the earnings record is incorrect, e.g., it does not include an employer, the claimant can request a correction of the earnings record.⁶⁵

SSDI is also available to certain dependents or survivors of these wage earners:

1. Dependent children⁶⁶ of the wage earner who younger than 18, or between 18-19 years old and a full-time student, whether or not the child is disabled. The wage earner must be disabled, retired, or deceased.⁶⁷
2. The spouse, in certain circumstances.⁶⁸
3. Disabled widows and widowers (between age 50 and 60) of wage earners.⁶⁹ The wage earner must be deceased and be fully insured.⁷⁰
4. Widow and widowers age 60 and over (the widow and widower does not have to be disabled). The wage earner must be deceased and fully insured.
5. Disabled adult children of wage earners if:
 - a. the son or daughter’s disability began before age 22 and
 - b. the wage earner is disabled, retired or deceased.⁷¹
6. Adult parent that is at least 62 years old, has not married since wage earner died, and the parent was receiving at least one-half of his/her support from the deceased wage earner.⁷²

⁶⁰20 C.F.R. § 404.141.

⁶¹For updated information go to www.ssa.gov and in the search box put COLA and the year you are looking for.

⁶²20 C.F.R. § 404.130.

⁶³*Id.*

⁶⁴20 C.F.R. § 404.130(e).

⁶⁵See 20 C.F.R. §§ 404.820-823.

⁶⁶This also includes adopted children.

⁶⁷20 C.F.R. §§ 404.350, 404.352, 404.367.

⁶⁸20 CFR § 404.330.

⁶⁹20 C.F.R. § 404.335.

⁷⁰20 C.F.R. § 404.336.

⁷¹20 C.F.R. § 404.350.

⁷²20 C.F.R. § 404.370.

3. THE APPLICATION AND APPEALS PROCESS

3.1 STAGE ONE: THE INITIAL DECISION ON THE APPLICATION

The SSA has moved away from having paper files for disability claims to an electronic system.⁷³ A claimant can apply for an SSDI claim online, but not for SSI. Claimants can also call SSA to make an appointment with a local office. After the applicant files her application at the nearest SSA office, the SSA first determines whether, regardless of disability, she meets the other eligibility rules for SSI and SSDI.

Once non-disability eligibility is determined, if a claim has a high degree of probability that the individual is disabled, the application will be go through a process called a quick disability determination (QDD). The determination is based only on the medical and nonmedical evidence in the file. If the QDD examiner cannot make a determination that is fully favorable, or there is an unresolved disagreement between the disability examiner and the medical or psychological consultant, the claim will be adjudicated using the regular process.⁷⁴

In 2008, SSA started a Compassionate Allowance program. Just like QDD, CAL was created to expedite the disability determination process.⁷⁵ CAL includes a list of diseases that would trigger the CAL process. Examples of some of the diseases on this list are: early-onset Alzheimer's disease, Esophageal Cancer, Gall-bladder Cancer, Inflammatory Breast Cancer, Liver Cancer, Pancreatic Cancer and Salivary Tumors. The most recent list can be found in POMS DI 11005.604. If a CAL claim is denied, it continues to have priority status at all levels of adjudication.⁷⁶ Note that even ODAR can reclassify a claim as falling under the CAL process.⁷⁷

Practice Tip: If a client comes in and he/she has applied and there has been no initial determination in the case, during your interview with the client determine whether he/she may meet one of the CAL listings or whether it could be processed under the QDD process. If so, write a letter to the SSA field office that is processing the claim and request that the claim be processed under CAL or QDD and explain and produce any evidence that supports either process.

If a claim does not qualify for the expedited processes, QDD or CAL, then SSA will send the case to the Disability Determinations Service (DDS) of the Louisiana Department of Children and Family Services, for development of the medical evidence and a decision on whether the claimant is disabled. DDS is required to obtain medical records for the 12 months prior to the application.⁷⁸ Typically DDS also sends the claimant to a physician paid by the SSA to conduct a "consultative examination."⁷⁹ If she is found not disabled, the claimant will receive a notice informing her of her appeal rights. In Louisiana, the overwhelming majority of applications are denied at this stage, so representatives should inform their clients to expect to have to appeal a negative initial decision.

⁷³71 Fed. Reg. 16424.

⁷⁴20 C.F.R. §§ 416.1019 and 404.1619 and POMS DI 23022.040.

⁷⁵See POMS DI 11005.604 and DI 23022.017 for similarities and differences between QDD and CAL.

⁷⁶*Id.*

⁷⁷*Id.*

⁷⁸20 C.F.R. §§ 404.1512(d) and 416.912(d).

⁷⁹20 C.F.R. §§ 404.1519(a) and 416.919(a).

3.2 STAGE TWO: THE HEARING

After receiving a decision denying benefits, the claimant has 60 days in which to request a hearing before an Administrative Law Judge (ALJ), assuming that their case—like most—no longer utilizes the reconsideration stage.⁸⁰ The SSA assumes that the claimant received the notice five days after the date written on the notice unless the claimant shows otherwise.⁸¹ This means that, in the absence of good cause for late filing of an appeal, the claimant ordinarily has 65 days from the date written on the notice denying benefits in which to file an appeal at a SSA office.⁸² The appeal must be in writing.⁸³ A claimant may go in person to the local SSA office to appeal, or she may fax or mail the appeal to the local SSA office. If possible, in order to ensure processing and to avoid delays, a request for a hearing should be made on the SSA's form. The form used is number HA-501.⁸⁴ However, if a form is not available, a letter requesting a hearing before an Administrative Law Judge may be sent. This letter should include the claimant's name, social security number, statement of additional evidence to be submitted and briefly state the reason the claimant disagrees with the decision.⁸⁵

The local SSA office then sends the claims file to the Office of Disability Adjudication and Review (ODAR) where the case is eventually assigned to an ALJ and scheduled for a hearing. See Section 5 for advice on handling a hearing. Once the file has been sent to ODAR a client or representative can request a copy of the file, which is usually a CD. If a representative has signed up for electronic access to a claimant's records, the representative will have access to the claimant's electronic file once the request has been processed by the ODAR office. A CD or electronic access to the file should be obtained early on in order to determine what records may be missing and to see Social Security's analysis of why the Claimant was initially found not to be disabled.

 **Practice Tip:** At all stages of the decision-making and appeal process, the SSA often neglects to send copies of decisions to the claimant's representative. Therefore, it is recommended that you advise your client to call you whenever he receives correspondence from the SSA and that you periodically contact whichever entity of the SSA is currently handling the case to determine if a decision has been made.

3.3 STAGE THREE: APPEALS COUNCIL REVIEW

If the ALJ issues a decision adverse to the claimant, she is ordinarily entitled to request review by the Appeals Council, which is located in Falls Church, Va. Again, unless there is good cause for late filing of an appeal, the claimant has 60 days after receipt of written notice of the decision to request review by the Appeals Council, and the SSA assumes that the notice is received five days after the date appearing on the notice.⁸⁶ Requests for review can be made by letter or by use of a form, and can be filed either with the local SSA office or the Appeals Council.⁸⁷

⁸⁰20 C.F.R. §§ 404.933(b) and 416.1433(b).

⁸¹See claimant's denial notice for a description of the 65-day period for appealing.

⁸²"Good cause" for late filing is liberally defined. See 20 C.F.R. §§ 404.911 and 416.1411.

⁸³20 C.F.R. §§ 404.933 and 416.1433.

⁸⁴<http://www.ssa.gov/online/ha-501.html>.

⁸⁵*Id.*

⁸⁶20 C.F.R. §§ 404.968 and 416.1468.

⁸⁷*Id.*

The Appeals Council can also decide to review cases on its own motion, although this is rarely done, and must decide whether to do so within 60 days after the date of the notice.⁸⁸

The Appeals Council decides cases based on the record and any additional information submitted by the claimant. Evidence submitted must be “new and material” and must relate to the period on or before the date of the ALJ decision.⁸⁹ Whether reviewing on its own motion or by request of the claimant, the Appeals Council has the power to review the entire case, not just the aspect complained about by the claimant. The Appeals Council may affirm, modify, reverse or remand an ALJ decision.⁹⁰ This includes portions both favorable and unfavorable to a claimant, so if your client has a partially favorable decision (such as one granting a later onset date or a closed period of benefits) this risk should be discussed with her before any appeal is filed.

The Appeals Council has instituted a triage system to screen cases immediately. As a result, it is a good idea to include with the request for review a brief summary of the errors made by the ALJ, noting that additional arguments and briefing will be forthcoming at a later time if that is the case. If your office did not handle the hearing below, you probably will want to include a request for a copy of the hearing transcript, audio file (this used to be a cassette tape it is now a CD), and the exhibits and request that you be given 30 days after receipt of these materials in which to submit a brief. Furthermore, during an initial interview with a client that you did not represent in the hearing below, ask him/her if they know whether all medical records were submitted and whether their condition has worsened; if so obtain those medical records and include them with your request for review and mention these records in the summary that is submitted.⁹¹ Since you should reserve your client’s right to supplement the arguments initially presented to the Appeals Council, you can later on submit these records. Additionally, ask your client to bring in the CD (copy of the record) that they were given at the hearing level below. This will help you start analyzing and determine what is missing from the record while you wait for the audio of the hearing.

Be aware, however, that requests for a copy of the record and audio will delay the decision-making on the case.⁹² If you request a copy of the hearing transcript, audio file, and/or the exhibits, you should be notified, at the time they are sent, of a deadline for submitting additional materials. This will often be less than the time that had you requested, so it is important to always check and make sure of exactly how much time you have.

Important Note: The Social Security Administration has tested whether to eliminate Appeals Council review. Initially this experiment included many claimants whose initial application were filed between Jan. 1, 2000 and July 31, 2000; however, according to the regulations this experiment may still be ongoing.⁹³

⁸⁸20 C.F.R. §§ 404.969 and 416.1469.

⁸⁹20 C.F.R. §§ 404.976 (b)(1) and 416.1476(b)(1).

⁹⁰20 C.F.R. §§ 404.979 and 416.1479.

⁹¹If you did not represent the client at the hearing below, remember to submit the Appointment of Representative Form, also known as the 1696 form with your request for review and summary. <http://www.socialsecurity.gov/online/ssa-1696.html>.

⁹²While time frames for Appeals Council review have improved, it still generally takes from six months to a year for a case to be reviewed. Occasionally (especially where Appeals Council does own-motion review), this can be faster. It is also sometimes slower.

⁹³20 C.F.R. §§ 416.1466 and 404.966.

The cases are randomly selected. The claimant will receive a Notice of Decision which informs them that if they wish to appeal, they must do so by filing a complaint in federal court and not by requesting review at the Appeals Council. Although most of these cases have already worked through the system, some may still be in the pipeline due to remands or the severe delays in the Social Security adjudication process. It is critical, in every case, to read carefully the claimant's Notice of Decision which is attached to the ALJ decision because the Notice informs the claimant whether to appeal to the Appeals Council or by filing a complaint in federal district court.

As of July 28, 2011, claimants can no longer have a new application adjudicated while their appeals are pending at the Appeals Council.⁹⁴ Note that this does not apply if a claimant subsequently files a claim under a different title (SSI versus SSDI), different benefit type, a Continuing Disability Review or age 18 redetermination, or in federal court or was remanded from federal court to the hearing office or AC.⁹⁵ There is also a limited exception. When a claim is pending at the appeals council, the claimant may file a new application if: 1) the claimant has additional evidence of a new critical or disabling condition with an onset after the date of the hearing; 2) the claimant wants to file a new disability application based on this evidence; 3) and the appeal council agrees the claimant should file a new application before the appeals council completes its action on the request for review.⁹⁶

If the protective filing date for the subsequent claim is prior to July 28, 2011, but the claim appointment is after July 27, 2011 these rules do not apply.⁹⁷ If you have a case that does not fall under the new rules, should a claimant be certified for SSDI or SSI while their appeal is pending, you should inform the Appeals Council of this decision. While technically not relevant to the claimant's disability during the earlier time period, such a certification will often carry the implication of an error in the old decision, especially if the claimant's condition has not changed dramatically. If a claimant case falls under the new rules and his condition has worsened, the claimant should still go ahead and file even though his new claim may not be processed. This will allow the claimant to preserve his/her application date.

3.4 STAGE FOUR: FEDERAL COURT REVIEW

If the Appeals Council denies review or issues an unfavorable decision, the claimant has exhausted her administrative remedies and may proceed to U.S. District Court. The federal court complaint must be filed within 60 days of receipt of the notice of the Appeals Council's action.⁹⁸ If there is good cause for late filing, the advocate immediately should contact the Appeals Council by phone, fax, and certified mail, and request additional time in which to file the federal court petition.⁹⁹

⁹⁴SSR 11-1p and 76 Fed. Reg. 45309-03, EM-11052 REV2.

⁹⁵EM-11052 REV2.

⁹⁶*id.*

⁹⁷*id.*

⁹⁸20 C.F.R. §§ 404.981 and 416.1481.

⁹⁹20 C.F.R. §§ 404.982 and 416.1482.

4. PROVING DISABILITY: THE SEQUENTIAL EVALUATION

4.1 ADULT CASES

The Social Security Act defines “disability” as “the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment 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 twelve months.”¹⁰⁰ The SSA has adopted a five-part sequential evaluation to determine whether an adult claimant is disabled. A finding that the claimant is disabled or is not disabled at any point in the five-step evaluation is conclusive and terminates the analysis.¹⁰¹ (A significantly different sequential evaluation applies as to whether someone who was previously found disabled no longer is.)

- Step One: Is the claimant employed in substantial gainful activity? If yes, he is found not disabled. If not, go on to Step Two.
- Step Two: Does the claimant have an impairment or a combination of impairments which are severe? If no, he is found not disabled. If yes, go on to Step Three.
- Step Three: Does the claimant have an impairment or combination of impairments which meets or equals an impairment listed in Appendix 1, 20 C.F.R. Part 404, Subpart P? If yes, he is found disabled. If no, go on to Step Four.
- Step Four: Is the claimant capable of performing work which he performed in the 15 years prior to his application for disability benefits? If yes, he is found not disabled. If no, go on to Step Five.
- Step Five: The burden of proof shifts to the Commissioner. A claimant is found not disabled if the Commissioner can prove that the claimant can engage in work existing in significant numbers in the national economy considering his residual functional capacity, age, education, and work experience. If the commissioner cannot meet this burden of proof, a claimant is found disabled.

On September 13, 2011 SSA filed a proposed action that would give adjudicators the discretion to skip to Step Five of the process if there is insufficient information about a claimant’s past relevant work history to make a finding under Step Four. If the adjudicator at Step Five finds that the claimant may be unable to adjust to other work existing in the economy, the adjudicator would return to the fourth step to develop the claimant’s work history and make a finding about whether the claimant can perform his/her past relevant work.¹⁰²

Under this sequential evaluation, in order to be disabled, a claimant must either:

- Not be performing “substantial gainful activity” and have an impairment that: meets or equals a “Listed Impairment”

Or

¹⁰⁰ 20 C.F.R. §§ 404.1505 and 416.905.

¹⁰¹ 20 C.F.R. §§ 404.1520 and 416.920.

¹⁰² 76 Fed. Reg. 56357-01.

- Not be performing “substantial gainful activity,” AND have a non-minimal (severe) impairment, AND be unable to do the work they have performed in the last 15 years AND be unable to perform other work available in significant numbers.

4.1.1 Step One: SGA

At Step One, the SSA automatically denies disability benefits to a claimant if he is engaged in “substantial gainful activity” (SGA). At Step One, the SSA presumes SGA if the claimant is earning more than \$1010 in gross monthly wages, whether or not his work is full-time.¹⁰³ This amount is changed every year to account for inflation; \$1010 is the figure for work done in 2012. There are three major exceptions to this rule: 1) if the earnings include a subsidy (the employer is paying an employee more than the reasonable value of his services or someone else is performing some of the employee’s work), thereby reducing the actual earnings to \$1010 or less¹⁰⁴; 2) if the individual’s impairment caused him to stop working within three to six months¹⁰⁵; and 3) if the claimant has unreimbursable impairment-related work expenses, such as medications or counseling services, that reduce monthly wages to \$1040 or less.¹⁰⁶ These exceptions also include when a claimant is in a supportive or sheltered work environment (for example, if he requires a job coach or rehabilitation counselor to work, or if reduced output is accepted). A statement from a claimant’s supervisor or counselor can be helpful in proving that their work does not constitute SGA.

The SSA presumes that all work at or under the \$1040 threshold is not SGA.¹⁰⁷ Note, however, that this presumption has no applicability at Step Five. Any employment or volunteer work, no matter how little the earnings, can be used as evidence tending to show an ability to work at Step Five. For example, a person working a half-time, minimum-wage job as a cook would survive Step One but his ability to handle the exertion and stressors of that job could be used against him at Step Five.

4.1.2 Step Two: Severity

Step Two is intended to be only a *de minimis* test to screen out groundless claims, yet some claims are still wrongly denied at Step Two. An impairment is to be found “non-severe” only if it is a slight abnormality having such minimal effect that it would not be expected to interfere with a claimant’s ability to work even if she were of advanced age, had minimal education and limited work experience.¹⁰⁸ SSA must take into consideration the combined effect of all impairments at Step Two.¹⁰⁹

¹⁰³ See POMS DI 10501.015 for SGA Table for other years. There is a higher SGA level for those who meet the statutory definition of blindness. The SGA level is adjusted every year by multiplying the current SGA level by the ratio of the national average wage index for the two previous years; that figure becomes the new SGA level if it is greater than the current SGA level. 65 Fed. Reg. 82905 (Dec. 29, 2000).

¹⁰⁴ 20 C.F.R. §§ 404.1574 and 416.974.

¹⁰⁵ *Id.* and SSR 84-25. SSA generally considers work which was terminated because of the impairment in less than three months to be an “unsuccessful work attempt” (UWA). Work attempts terminated after six months may qualify as UWAs in certain circumstances.

¹⁰⁶ 20 C.F.R. §§ 404.1576 and 416.976.

¹⁰⁷ 65 Fed. Reg. 82905 (Dec. 29, 2000).

¹⁰⁸ *Loza v. Apfel*, 219 F.3d 378 (5th Cir. 2000), *reaffirming Stone v. Heckler*, 752 F.2d 1099 (5th Cir. 1985).

¹⁰⁹ 20 C.F.R. §§ 404.1521-1523 and 416.921-923. The rules for applying the Grids are found in Appendix 2 of Subpart P of 20 C.F.R. Part 404.

Historically, Social Security has failed to properly apply this very low standard, and will frequently wrongly deny cases at step two. This problem grew so endemic during the mid-'80's that the Fifth Circuit went to far as to demand that one of its opinions explaining step two—*Stone v. Heckler*, 752 F.2d 1099 (5th Cir. 1985)—be specifically cited in every ALJ decision. This requirement still exists, and ALJs will occasionally forget to cite *Stone*. Although an ALJ may forget to cite *Stone* it is not reversible error unless there is an indication that the ALJ did not apply the correct standard in his opinion. The 5th Circuit in *Hampton v. Bowen*, 785 F.2d 1308, 1310 (5th Cir. 1986), clarified the decision in *Stone* by stating that “a case will not be remanded simply because the ALJ did not use ‘magic words.’ [The Court would] remand only where there is no indication the ALJ applied the correct standard.” Recently, the 5th Circuit in *Taylor v. Astrue*, 2012 WL 2526921 (5th Cir. June 28, 2012), held that although the ALJ did not identify the specific applicable legal standard, there was substantial evidence in the record to support that the proper standard had been used.

4.1.3 Step Three: Meeting or Equaling a Listing

The listed impairments are specifically described physical or mental conditions of such severity that SSA has determined that persons suffering from those impairments are disabled without considering any vocational factors, including whether they can return to past work or do other work. An impairment or combination of impairments is medically equivalent to the listings if it causes the same degree of limitations and duration that a listed impairment would.¹¹⁰ The listings for adults are generally arranged by body system: musculoskeletal, special senses and speech, respiratory, cardiovascular, digestive, genitourinary, hematological disorders, skin disorders, endocrine disorders, impairments that affect multiple body systems, neurological, and mental disorders¹¹¹.

4.1.4 Step Four: Ability to Do Past Relevant Work

At Step Four, the SSA determines the claimant's physical and mental Residual Functional Capacity (RFC), or what he can still do despite the limitations imposed by all of his or her impairments.¹¹² The claimant's RFC is compared with the functional requirements of his past work performed during the last 15 years.¹¹³

4.1.5 Step Five: Ability to Do Other Work

To determine whether the claimant can do other work that exists in significant numbers in the regional or national economy, the SSA first looks at the Medical Vocational Guidelines, known as the “Grids.”¹¹⁴ The Grids are a set of three charts, based on RFCs for sedentary, light, and medium work, designed to match the availability of jobs with the claimant's age, educational level, and the type of work he has done.¹¹⁵ They are generally not helpful for people under 50 years of age.¹¹⁶

¹¹⁰ 20 C.F.R. §§ 404.1526 and 416.926.

¹¹¹ Child listings also include growth impairment, endocrine disorder, immune disorders and malignant neoplastic diseases.

¹¹² 20 C.F.R. §§ 404.1545 and 416.945.

¹¹³ 20 C.F.R. §§ 404.1546, 404.1565, 416.946 and 416.965.

¹¹⁴ 20 C.F.R. Part 404, Subpart P, Appendix 2; 20 C.F.R. §§ 404.1569 and 416.969.

¹¹⁵ 20 C.F.R. §§ 404.1563-1568, 416.963-968. The exertion levels for sedentary, light, medium, heavy and very heavy work are defined at 20 C.F.R. §§ 404.1567 and 416.967.

¹¹⁶ *But see* 20 C.F.R. Part 404, Subpart P, Appendix 2, § 201.00(h), giving examples in which a finding of disabled is appropriate when an individual under 45 years of age cannot perform the full range of sedentary jobs.

If the claimant's impairments are exertional only, i.e., interfering with the strength demands of the job, the Grid rules are determinative. If the claimant's impairments are non-exertional only (e.g., pain, fatigue, mental impairments, skin and sensory impairments), then the grid rules cannot be used and SSA must conduct an individualized assessment at Step Five. If the claimant's impairments are both exertional and non-exertional, the SSA must first determine if he can be found disabled on a Grid rule based on his exertional impairments alone. If not, the SSA must determine if his occupational base is significantly eroded because of his non-exertional impairments. If non-exertional impairments significantly erode the occupational base, then the SSA must perform an individualized assessment at Step Five. At hearings of cases requiring individualized determinations, the testimony of a vocational expert is usually considered necessary.¹¹⁷

4.2 CHILDREN CASES

As of Aug. 22, 1996, Congress adopted a more restrictive disability standard for children in the SSI program than had been in effect. The 1996 "welfare reform" law amended the Social Security Act to define disability in a child under 18 as "a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and 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 months."¹¹⁸ The SSA has adopted a different sequential evaluation process for determining whether a child is disabled.¹¹⁹ The evaluation contains three steps:

Step One: Is the child engaging in substantial gainful activity? If yes, the child is found not disabled. If no, go on to Step Two.

Step Two: Does the child have a medically determinable impairment or combination of impairments that is severe? If no, the child is found not disabled. If yes go to Step Three.

Step Three: a) Does the child's impairment(s) meet or medically equal the requirements of a listed impairment in Appendix 1, Part A or B 20 C.F.R. Pt. 404, Subpart P, or

b) Are the functional limitations caused by the impairments the same as the disabling functional limitations of any listed impairment and therefore functionally equivalent to that listing?

If yes to either question, the child is found disabled. If no to both questions, the child is found not disabled.

Under this sequential evaluation, the functional equivalence assessment provides the greatest flexibility for finding a child disabled. SSA takes a "whole child" approach by evaluating how the impairments functionally limit a child in 6 differ-

¹¹⁷ SSR 85-15.

¹¹⁸ 42 U.S.C. § 1382c(a)(3)(C)(i) (emphasis added). Under the previous standard mandated by *Sullivan v. Zebley*, 493 U.S. 521(1990), a child was found disabled if his impairment was of "comparable severity" to that which would disable an adult. The 1996 law eliminated Step Four of the *Zebley* sequential evaluation, in which an individualized functional assessment (IFA) determined the extent of a child's limitations in seven domains.

¹¹⁹ 20 C.F.R. § 416.924. For other considerations in evaluating disability see 20 C.F.R. § 416.924a (medical, educational and parental sources), § 416.924b (age as a factor), and § 416.929 (evaluation of symptoms).

ent domains.¹²⁰ Domains are broad areas of functioning intended to capture all of what a child can and cannot do.¹²¹ If the child does not meet or medically equal a listing in either Part B of Appendix 1 (the children's listings) or Part A (the adult listings), look at the 6 domains and see if you your client's condition has similar functional limitations.¹²² The child's impairment must be medically determinable, but it need not be medically related to the listed impairment to which it is being compared. What matters is that the functional limitations it causes are the same as those of the listed impairment. The regulations set forth examples of functional equivalence.¹²³ Additionally, if a child suffers from marked limitations in two or more specific functional spheres, or an extreme limitation in one such area, they will be found disabled based upon functional equivalence. A marked limitation is defined as more than moderate, but less than extreme. An extreme limitation means complete inability to function. These areas vary with the age of the child. For more information on these functional spheres, see 20 C.F.R. §416.926a. In preparing a child's case, you should review SSR 09-01p through SSR 09-08p for SSA interpretation of their policy.

The 1996 statute also imposed restrictions on use of the child's retroactive SSI payments. If the retroactive payments are more than six times the monthly benefit, the retroactive payments must be placed in a dedicated bank account.¹²⁴ The monthly benefits must not be kept in the same account. Monthly benefits may be used for rent, food or clothing. However, retroactive payments are reserved for allowable expenses to benefit the child. Allowable expenses are medical treatment, education, job skills training, personal needs assistance, special equipment, housing modification, therapy or rehabilitation, and other items or services such as personal aids, special dietary needs, special items of clothing, electric bills related to mechanical devices meeting special needs, and day care or recreation not included in a special education program.¹²⁵ If a representative payee wishes to spend the retroactive payment on anything not squarely included in the foregoing list, advise her to request the SSA's written approval. If the request is denied capriciously, she should appeal. Frequent uses for back benefits include tutoring, computers with educational software, and modifications to homes to accommodate mobility limitations (wheelchair ramps, rails for bathtubs or beds, etc.), among others. Each year SSA will require the representative payee, usually the parent, to complete a report on the use of the funds as well as the regular monthly benefits received on a child's behalf. It is very important that the representative payee maintain a record of the expenses in the account. He/she should keep all receipts and bank statements. A representative payee must be able to provide SSA with an explanation of any expenditure and how it relates to the child's disability.

¹²⁰ SSR 09-1p. "The whole Child approach recognizes that many activities require the use of more than one of the abilities described in the first five domains, and that they may also be affected by a problem that we consider in the sixth domain. A single impairment, as well as a combination of impairments, may result in limitations that require evaluation in more than one domain. Conversely, a combination of impairments, as well as a single impairment, may result in limitations that we rate in only one domain." See, *Hodges ex rel. M.H. v. Astrue* 2011 WL 4736312 (E.D. La. 2011).

¹²¹ SSR 09-01.

¹²² The 6 domains are: 1) acquiring and using information; 2) attending and completing tasks; 3) interacting and relating with others; 4) moving about and manipulating objects; 5) caring for yourself; and, 6) health and physical well-being. See 20 C.F.R. § 416.926a.

¹²³ 20 C.F.R. § 416.926a(m).

¹²⁴ 20 C.F.R. §§ 416.546 and 416.640(e).

¹²⁵ POMS GN 00602.140.

4.3 TERMINATION OF BENEFITS

SSA is supposed to redetermine the disability eligibility of most recipients at least once every three years.¹²⁶ Frequently, it will do so even more regularly than this. Those recipients deemed permanently disabled are reviewed less frequently. There is a great deal of variation in how regularly Social Security will opt to review a case. Often, ALJs will recommend times for review in their decisions, but these are not always followed. Recipients will not be reviewed if engaged in a work incentive program called Ticket to Work and Self-Sufficiency.¹²⁷ Children turning 18 will receive a redetermination under the adult disability standard.¹²⁸ Benefits may be terminated if the recipient is found to have medically improved and no longer to be medically disabled. There are different sequential evaluations used for continuing disability review (CDR) for adults¹²⁹ and children.¹³⁰

A recipient whose SSI or SSDI is terminated because of medical improvement is entitled to an appeal. If benefits are terminated because the claimant is engaged in substantial gainful activity (SGA), the termination also can be appealed by requesting reconsideration, if the case is eligible for this stage of review. Whatever the reason for termination, denials on reconsideration—or initial denials for cases that do not go to reconsideration—can be appealed by requesting a *de novo* hearing before an Administrative Law Judge.¹³¹

The SSA will continue benefits during the pendency of the appeal if the request for reconsideration or the request for administrative law judge hearing is filed within 10 days of receiving the termination notice or shows good cause for failing to meet the 10 day deadline.¹³²

4.3.1 The *Martinez* Settlement and the *Clark* Case—denials and terminations for “fleeing felons” and Parole/Probation violations

Social Security used to suspend individuals with outstanding warrants. Its initial application of the “Fleeing Felon” rule broadly applied it; a claimant did not have to be actually fleeing or even know that there was an outstanding warrant. In 2008, Rosa Martinez *et. al.* filed a class action suit against the SSA for its policy of denying or suspending benefits to individuals with an outstanding felony arrest warrant, and not permitting people with outstanding warrants to serve as representative payees.¹³³

As a result of the *Martinez* Settlement, effective April 1, 2009 SSA will suspend or deny a claimant’s SSA benefits based only on any of the following outstanding felony arrests: 1) escape from custody; 2) flight to avoid prosecution or confinement; and, 3) flight-escape.¹³⁴ There are two Classes: post 2006 group and pre-2007 group. To determine whether a client is eligible for either group see POMS GN 02613.860 to GN 02613.885.

¹²⁶ 20 C.F.R. §§ 416.990 and 404.1590.

¹²⁷ 20 C.F.R. § 411.160 and 411.165.

¹²⁸ 20 C.F.R. § 416.987.

¹²⁹ 20 C.F.R. §§ 404.1594 and 416.994.

¹³⁰ 20 C.F.R. § 416.994a.

¹³¹ 20 C.F.R. §§ 404.913 and 416.1413.

¹³² 20 C.F.R. §§ 404.1597a and 416.996.

¹³³ Stipulation contained in order approving class action settlement, *Martinez v. Astrue*, Case No. 08-CV-4735(N.D. Cal. Sept. 24, 2009). See, <http://www.ssa.gov/martinezsettlement/>.

¹³⁴ POMS GN 02613.860.

The *Martinez* Settlement did not address warrants due to probation and parole violations. In March 2011 the District Court for the Southern District of New York certified a nationwide class in *Clark v. Astrue*, 274 F.R.D. 462 (S.D.N.Y., 2011). SSA issued Emergency Message EM-11032, with an effective date of May 9, 2011. The Emergency Message stated that based on the class certification SS should no longer suspend or deny benefits or payments solely on a probation or parole violation. On April 13, 2012 an order of relief was signed by the District Court for the Southern District of New York.¹³⁵ It ordered SSA to pay individuals retroactive benefits to the date when the benefits were suspended because of the probation or parole violation. Note that benefits that were also suspended on another basis would not be paid back. An example would be if someone was in prison for a period of time during the retroactive period. SSA was also ordered to process all initial claims that were denied because of a probation or parole violation. If the person is eventually found disabled the date of disability would go all the way back to the initial date of application and not to the date SSA begins to process the claim. If overpayments were paid by an individual in this class, SSA is to pay back the entire overpayment amount that it collected. Additionally, an individual can avoid from getting his/her benefits suspended or terminated if they can show good cause.¹³⁶ This area of law continues to develop and representatives should check for new developments when faced with a claimant affected by these policies.

4.4 OVERPAYMENTS

Notice: SSA is required to issue a written notice of a decision that a recipient has been overpaid. The notice must explain the reasons for the overpayment, the amount overpaid, the time period covered by the overpayment, repayment options, and appeal rights.¹³⁷

Appeal procedure: A request for reconsideration (challenging whether there was an overpayment or whether the amount was correctly calculated¹³⁸) must be received by SSA within 60 days of receipt of the notice of overpayment.¹³⁹ A request for waiver (eliminating any obligation to repay the overpayment) can be requested at any time, even after the overpayment has been recouped. Waiver and reconsideration may be requested at the same time.¹⁴⁰ If a request for reconsideration and/or waiver is made within 30 days of notice, it is SSA policy to continue benefits without any deduction until a decision is reached on reconsideration after a personal conference. Even if waiver is not requested until more than 30 days after notice, SSA policy is to stop any recoupment until a decision is made on reconsideration after a personal conference.¹⁴¹

To receive a waiver, the recipient must show 1) that she was not at fault or that she appealed a termination of benefits with a good faith belief of continuing eligibility, and 2) that recovery would deprive the recipient of income needed for necessary living expenses or that recovery would be against equity or good conscience.

¹³⁵ http://www.socialsecurity.gov/clark_relief_order/.

¹³⁶ See POMS GN 02613.025; SS has a list of "mental disability diagnostic codes" that if applicable would indicate a person's lack of mental capacity to resolve a warrant. See, POMS GN 02613.910.

¹³⁷ 20 C.F.R. §§ 404.502a and 416.558.

¹³⁸ 20 C.F.R. §§ 404.522 and 416.582 and POMS GN 02201.025.

¹³⁹ 20 C.F.R. §§ 404.521 and 416.581.

¹⁴⁰ POMS GN 02201.017.

¹⁴¹ 20 C.F.R. §§404.506 and 416.558.

In SSI cases, recoupment by deduction from the monthly benefit check is limited to the total monthly SSI benefit, or 10 percent of total monthly income, whichever is less. Where the individual cannot meet “current ordinary and necessary living expenses,” recoupment may be reduced to less than 10 percent.¹⁴² The 10 percent rule does not apply if fraud is involved.¹⁴³ SSA can also withhold the lesser of the entire overpayment balance or the entire amount of past due benefits.¹⁴⁴

SSI overpayments can be recouped from SSDI benefits. Unless the overpayment was caused by fraud, recoupment of an SSI overpayment from an SSDI check is limited to 10 percent of the SSDI check.¹⁴⁵ In addition, SSI and SSDI overpayments can be recovered by intercepting tax refunds and also garnishing wages, if an individual is working.¹⁴⁶ If there is an SSDI overpayment there is no 10% rule. SSA will request full repayment; however, an individual can file a “Request for Waiver of Overpayment Recovery or Change in Repayment Rate.”¹⁴⁷

☞ **PRACTICE TIP:** Proving that your client is not at fault is an essential element of requesting a waiver. In proving that your client was not at fault, be sure to point out any mental, physical, educational or linguistic limitations she has, and whether she understood the reporting requirements. If your client is currently a recipient of SSI or welfare, it will be presumed that recovery would deprive her of needed income. Review the many SSRs which discuss overpayment.

☞ **PRACTICE TIP:** If waiver cannot be achieved, consider requesting a settlement. SSA has detailed rules for handling overpayment settlements, including how much can be accepted, by what level of the SSA, and under what circumstances. The POMS relevant to compromises are SI 02220.030, GN 02215.105-02215.125. The SSA may be encouraged to settle because discharging the overpayment in bankruptcy would normally eliminate the possibility of recouping any part of the debt (unless there are auxiliary beneficiaries receiving benefits on the account of the bankrupt person). However, a discharge can be defeated if the recipient engaged in fraud.

5. HOW TO HANDLE A DISABILITY HEARING

Prepare well in advance of an administrative hearing in order to maximize your client’s chances of getting all the benefits to which he/she is entitled. Winning a disability case is far easier at the hearing stage than it is in a subsequent appeal to the Appeals Council or in an action in federal court. The Appeals Council’s review power is limited, and that of the federal courts is more limited still.

5.1 DEVELOP THE EVIDENCE

5.1.1 Obtain and review records.

After accepting the case, immediately request a copy of the file and review the client’s medical records (and school or rehabilitation records, if relevant). You should also inquire into the claimant’s legal history. Records from prisons can be

¹⁴² 20 C.F.R. § 416.571; see also 20 C.F.R. §§ 416.572 and 416.573.

¹⁴³ 20 C.F.R. § 416.571.

¹⁴⁴ 20 C.F.R. § 416.573.

¹⁴⁵ 20 C.F.R. §§ 416.571 and 416.573.

¹⁴⁶ 20 C.F.R. §§ 416.580 and 416.586.

¹⁴⁷ 20 C.F.R. §§ 404.502-404.502a; See also <http://www.ssa.gov/pubs/10098.html#fa0=0> and <http://www.ssa.gov/online/ssa-632.pdf>.

useful, especially if a prisoner received treatment or accommodations while incarcerated. Additionally, even the fact of some arrests or convictions can serve as evidence of symptoms in cases of mental illness (a prime example of this is a schizophrenic with arrests for disturbing the peace). Send a letter and appointment of representative form¹⁴⁸ to the ODAR office to obtain a CD that contains the client's Social Security record or if it is in paper form set up a time to go to the ODAR office to copy the file. Additionally, if you have access to Online Services for representatives when you enroll in the case advise the ODAR office that you have access to Online Services so a CD will not be sent.¹⁴⁹ By interviewing your client and reviewing his electronic file you can determine whether your client made prior applications which could be reopened in order to obtain additional back benefits (see the practice tip on reopening prior claims in Part 11.6.8. If prior applications exist which could be reopened, request in writing that the local SSA office obtain the prior claims folders.

5.1.2 Develop a theory of the case.

Decide at an early stage how you plan to win the case. Begin by reviewing the sequential evaluation used in disability cases.

5.1.2.1 Review all relevant listings in the Listing of Impairments.

Decide if there is a realistic possibility of winning the case at Step Three by proving that your client's condition meets or equals a listing. Determine what additional evidence you will need in order to prove this. Try to show that your client meets or equals a listing if at all possible. In a child's case, you must win at Step Three, as there are no further steps.

5.1.2.2 For adults, prepare for the possibility that you may not win at Step Three.

If you do not win at Step Three, you must win at Step Five by showing that the claimant's impairments prevent him from continuing to do the work he did during the past 15 years and that his impairments prevent him from doing any other work which exists in significant numbers in the national economy.

5.1.2.3 Prepare a detailed job duty description of the jobs your client held in the 15 years prior to application.

This is necessary in order to show that your client cannot return to past relevant work.

5.1.2.4 Review the Grid rules (Medical-Vocational Guidelines).

If there is any Grid rule which would require a finding of "disabled" for your client, be prepared to show why it is applicable (for example, why the medical evidence justifies a residual functional capacity for "sedentary" rather than "light" work). If there is a Grid rule which seems to require a finding of "not disabled" for your client, determine how you can show it is inapplicable. Grid rules apply only if all the criteria in a rule match the characteristics of the claimant, and there

¹⁴⁸ <http://www.socialsecurity.gov/online/ssa-1696.html>.

¹⁴⁹ If you often handle Social Security cases at the ALJ level and have not been invited by SS to enroll to the Online Services, contact the ODAR office that you go to most often and request that you be enrolled with the Online Services. Once enrolled, you will have access to the claimant's ODAR file. You can upload evidence or fax it to a designated fax number using bar codes that are provided by Social Security that are specific to each case. You do not have access to Online Services if you are at the Appeals Council level or prior to an initial determination.

is substantial evidence of the individual's ability to perform sustained work activity at the exertional level of the grid rule. Most commonly, advocates will be trying to avoid application of a Grid rule mandating a finding of "not disabled." Common limitations to examine for this purpose include concentration, persistence, or pace, drowsiness caused by pain medications, the need for frequent breaks, a need for extra supervision, and others.

5.1.2.5 Determine how to evidence client's actual mental and physical residual functional capacity.

Get permission from your client to talk to his/her social workers, case managers, or family members. Testimony from a person other than the claimant is very useful in cases regarding mental impairments, such as schizophrenia. ALJs will usually only allow one witness, at most 2, to testify at a hearing. Pick the best witness that sees and/or interacts with the claimant the most. Determine what testimony will be needed from the client. If people with relevant information are unable or unwilling to testify, having them at least complete questionnaires is helpful. Even written statements from teachers, social workers, employers and others can be very compelling to Social Security.

5.1.3 Determine what onset date can be proved.

You may wish to discuss with your client amending the onset date to a date either earlier or later than what the claimant claimed when making the application, depending on what the evidence reasonably shows. The reason why you need to determine this prior to a hearing is because an ALJ may want to change the date to a later date and the representative will have to be able to argue and provide evidence in the record why he/she disagrees with the date proposed by the ALJ.

5.1.4 Request a letter or an evaluation form from a treating physician or psychologist spelling out how the claimant's condition meets or equals a particular listing or prevents him from holding a full-time job.

The letter should be addressed to the Administrative Law Judge or to the Social Security Administration. If the treating physician refuses to write such a letter (or speak with you so that you can prepare a draft based on what they say) or complete a form, a letter from a social worker, nurse or other medical or mental health professional can be helpful (although under the Social Security regulations their opinions will not be entitled to controlling weight). Many doctors have the mistaken belief that if they write a note stating that they think a patient is disabled, Social Security will accept this as proof of disability. This is incorrect. Disability is a legal conclusion, not a medical one. Thus, it is much more useful to have a doctor list specific conditions and limitations—even if only on a checklist prepared by the claimant's representative—than to have a note that just makes a conclusory statement that a person is disabled. Explaining this to a treating physician can make all the difference in the world.

5.1.5 If the record evidence clearly shows the claimant meets a listing, submit a brief requesting a decision on the record.

Submit exhibits consisting of additional medical records and letters from treating physicians or other professionals. If the ALJ decides to issue a favorable decision based on the brief and exhibits, no hearing will be necessary.

5.2 PREPARE FOR THE HEARING.

5.2.1 Request rescheduling if necessary.

You are entitled to have the hearing rescheduled if there is good cause. Good cause for rescheduling exists, for example, if counsel was appointed less than 30 days before the hearing and needs additional time to prepare. See 20 C.F.R. § 404.936 for the definition of good cause. ALJs are usually willing to grant extensions if they are requested as far in advance as possible. Do not wait for the last minute to ask for an extension! Even if granted, it aggravates the ALJ and can make them negatively disposed towards both the case and to an individual representative with a reputation for requesting last-minute continuances. ALJs tend to be more understanding about initial requests for a continuance than if a representative seeks additional ones on the same case. Thus, once a continuance has been granted, make sure that you are ready to proceed on the new date if at all possible.

5.2.2 Submit updated medical records, letters from treating sources, and pre-hearing briefs at least 10 days before the hearing if at all possible.

Because of the “hearing process improvement” procedures, most ALJs now strongly prefer (and often issue pre-hearing orders requiring) that briefs and new evidence be submitted at least ten days before the hearing. In order to maintain a good relationship with the ALJ and avoid the possibility of a continued hearing, it is wise to abide by the requirements of any reasonable pre-hearing orders. However, if you do not receive the evidence in time, you should submit it as soon as you get it.

5.2.3 Become thoroughly familiar with the medical evidence.

You need to know the evidence in order to effectively examine your witnesses, cross-examine the vocational expert and medical expert, and argue the case to the judge.

5.2.4 Write a pre-hearing brief. A good pre-hearing brief will greatly improve your chances of success.

It influences the ALJ’s perception of the case and makes it easier for the ALJ to write a favorable decision. The brief can be written in the form of a letter to the ALJ. Summarize the record evidence. Show how your client’s condition meets or equals a listing, or show that her residual functional capacity precludes her from doing any full-time work. Explain why any negative consultative examinations or reports by SSA should be disregarded or given little weight. Address any important legal issues such as alleged substantial gainful activity (SGA), drug addiction and alcoholism, good cause for failure to comply with prescribed medical treatment, or why prior claims should be reopened.

5.2.5 Try to line up at least one witness who could testify on client’s behalf.

A witness could be a social worker, case manager, family member, minister, neighbor, friend or former co-worker who can testify about symptoms, activities of daily living, social functioning, problems with concentration and pace, episodes of pain, and/or the claimant’s problems in school, in past jobs or in work-like situations. In some cases, physicians or psychologists may be willing to testify in person or by telephone. Avoid repetitive testimony. No more than two witnesses

in addition to the claimant should be necessary. If possible, let the judge's staff know in advance how many witnesses are planned. You can arrange with the judge's staff for testimony by phone by treating physicians.

5.2.6 Prepare the witnesses.

Meet with the witnesses a few days before the hearing to go over the questions you plan to ask. Also prepare him/her for questions the judge may ask and how he/she may be interrupted by the judge.

5.2.7 Prepare your client.

Arrange to have your client come in a day or two before the hearing to go over the questions you plan to ask. Prepare them not only for questions the judge may ask. Prepare the client to elaborate when they answer questions. Judges, often ask yes and no questions, especially when it comes to whether there is an improvement of impairments with medications or other treatment; if the client is not 100% better he/she should be able to explain any improvement and the limitations he/she is still having even with treatment. Furthermore, the ALJ will ask whether the client can carry 10, 15, 25 lbs. Become familiar with regular household items that may weigh this much. For example, ask your client if he can carry a bag of flour (5 pounds), a gallon of milk (8 pounds), small car tire (15 pounds), or whether he/she can carry a large bag of potatoes (25 pounds). Prepare the client for possible interruptions by the ALJ. Make sure the client knows about how long he/she can sit and stand for. How far he/she can walk (use blocks and not distances since a client will likely not know how far a quarter of a mile is). If they do not know, tell him/her to pay attention to this since this will come up at the hearing.

5.3 THE HEARING

5.3.1 Request a new hearing if client fails to show up.

Explain the possible reasons why client may have failed to appear, including those caused by his disabilities. If the reason that the client failed to appear was likely on account of his disabilities, request a new hearing as an accommodation of his disabilities under Section 504 of the Rehabilitation Act (which requires federal agencies to accommodate disabilities).

5.3.2 Tape the Hearing.

You may want to request that the ALJ allow you to tape the hearing (with your own recorder). The primary reason for doing so is to avoid having to ask the Appeals Council for a recording of the hearing because such a request considerably lengthens the time period for an AC decision, or to avoid a remand if the Appeals Council loses the official recording. You can also use the recording to assist in summarizing the testimony in a post-hearing memo. Additionally, it is not unusual for an ALJ to go "off the record" during a hearing, stopping the official tape to discuss some additional matter. If you tape the hearing yourself, these discussions will be preserved. Not all judges will allow taping, however, so you should check in advance to see if this will overly upset the judge hearing your case.

5.3.3 Opening statement.

Make a brief opening statement explaining that you are waiving your fee as per the policy of your office and explaining why your client is entitled to disability benefits. Ask that your memorandum and any medical records or doctor's letters be

included as exhibits in the record of the case. Request an onset date. If you want prior claims reopened, explain why your client is entitled to have them reopened. Some judges simply begin without offering the opportunity to make an opening statement; you may need to interrupt to tell them that you wish to have one.

5.3.4 Ask to examine your witnesses, if possible. In order to elicit the responses you want and present your case in the most favorable light, it is usually best to examine your own witnesses.

If you do not take the initiative, many judges will take the testimony themselves, relegating you to asking follow-up questions. Some judges always insist on first taking the testimony themselves.

5.3.5 Point out any non-verbal behaviors that support your case.

Note out loud for the record if the client is crying, rocking, pacing, unable to sit throughout the hearing, using assistive devices, or engaging in any other non-verbal behaviors that support the case for disability. If the ALJ is hostile and engaging in non-verbal behaviors which demonstrate bias or intimidate the client, you should point out these behaviors as well.

5.3.6 Prepare for cross-examination of the vocational expert (VE) and the medical expert (ME).

The Notice of Hearing will inform you whether a VE or ME is being called to testify at the hearing. The file should contain a statement of the qualifications of any expert being called to testify.

5.3.6.1 The ME's testimony.

The ME is a physician or mental health professional who has not examined the claimant before. Many ALJs do not regularly call MEs to testify, but some ALJs do. The ALJ will typically ask the ME whether she has examined all of the medical evidence in the file, whether the claimant's impairment meets or equals the listings, and what functional limitations are caused by these impairments.

If the ME's testimony is unfavorable, the best way to combat it is to have obtained a statement from the claimant's treating physician, to which the ALJ generally must defer. Object on the record if the ME attempts to testify on matters outside his specialty or on non-medical matters, such as what jobs the claimant can perform. Cross-examine the ME about favorable medical evidence he is ignoring. Ask the ME what further testing would be useful to more fully document the claimant's impairments, then request a consultative examination to conduct such testing.

Keep in mind that the ME is there to interpret the opinions and findings of examining doctors, not to substitute his own. Any opinion that they have based upon the claimant's behavior during the hearing, for example, is inappropriate and should be pointed out as such.

5.3.6.2 The VE's testimony.

VEs are called to testify on whether a client's work skills are transferrable and the specific occupations in which they can be used. If the ALJ agrees that the claimant meets a listing or that a grid rule is applicable, the VE's testimony is irrelevant. However, in the majority of hearings, the VE will testify and the representative should always be prepared for this.

The ALJ typically will pose hypothetical questions to the VE, asking what jobs the claimant can do based on specific assumptions about the effects of her impairments. Example: “Assume that the claimant can stand and walk for approximately four hours and lift 25 pounds. Can he return to his past employment or, if not, transfer his skills to perform other work?”

Note whether the ALJ’s hypothetical has addressed all of the claimant’s impairments and limitations and make sure your questions on cross-examination include all such impairments and limitations. The strategy for cross-examination should be to eliminate all possible employment based on evidence of all impairments from the medical records or testimony.

Example:

Counsel: Assume that the claimant also has restricted movement in his left arm which prevents him from lifting over 10 pounds. Would that limit the number of jobs he could perform?

VE: Yes, he could not perform the Sanitation Attendant job, since it involves lifting over 10 pounds.

Counsel: Assume that the claimant also suffers from major depression which causes him to have difficulty concentrating. Would that limit the number of jobs he could perform?

VE: Yes, but he could still perform the Porter I and II jobs and the Uniform Supply Cleaner jobs.

Counsel: Assume that the claimant’s major depression causes him to be unable to attend work regularly and to miss two to three days a month. Would that eliminate any jobs?

VE: Yes, that would eliminate all the jobs.

5.3.7. Make closing statement.

Very briefly summarize why your client meets the SSA’s definition of disability. You may wish to ask that the record remain open for 15 days or another specified period of time in order for additional medical records to be received or in order to file a post-hearing brief (if no pre-hearing brief was submitted or if additional issues were raised by the judge during the hearing which you wish to address). The post-hearing brief should summarize the record evidence and the testimonial evidence and explain why the claimant is disabled under the law. If your client agrees, request the appointment of a representative payee in cases where the client is unable to manage his own funds due to mental impairments or substance abuse. Even if your client does not want a payee, however, ALJs will almost always order one appointed in cases involving mental disabilities or if the claimant has a history of substance abuse.

6. PRACTICE TIPS

6.1 CITE SOCIAL SECURITY RULINGS (SSRS), HALLEX POLICIES, & POMS POLICIES WHERE FAVORABLE.

SSRs are policy decisions published in the Federal Register which are binding on all SSA adjudicators. They do not have the force or effect of law but the courts generally defer to them. They can be found on the SSA’s website and in West’s Social Security Reporting Service.

The Hearings, Appeals, Litigation and Law manual (HALLEX) contains instructions for ALJs and the Appeals Council. HALLEX does not have the force or effect of law but is binding on ALJs and the Appeals Council. The courts generally have given effect to HALLEX instructions. A copy of the HALLEX policies can be viewed online.

The Program Operations Manual Systems (POMS) is a massive policies and procedures manual for the field offices of the SSA. POMS does not have the force or effect of law. POMS provisions are not binding on ALJs but since the SSA argues that the POMS are consistent with the Social Security statutes and regulations, favorable POMS should be cited to the ALJ. The POMs can be accessed online.

6.2 IF RELEVANT, REMIND THE ALJ THAT A PERSON IS DISABLED IF UNABLE TO WORK FULL-TIME.

Social Security policy has defined the ability to work at Step Five as the ability to work 40 hours per week.¹⁵⁰ This also includes following a regular schedule and should take into account if a claimant would have frequent absenteeism due to doctor's appointments, treatments, etc.

6.3 TO SHOW THAT YOUR CLIENT CANNOT DO LIGHT OR SEDENTARY WORK, REMIND THE ALJ HOW THE DICTIONARY OF OCCUPATIONAL TITLES DEFINES "OCCASIONALLY" AND "FREQUENTLY."

Under the SSA regulations, "sedentary" jobs include those that require "occasional" walking and standing and "occasional" lifting or carrying of objects like docket files and small tools. "Light" jobs involve "frequent" lifting or carrying of objects weighing up to 10 pounds. "Medium" jobs include "frequent" lifting or carrying of objects weighing up to 25 pounds.¹⁵¹ The regulation also cites the Dictionary of Occupational Titles as the source of its exertional definitions. Point out to the ALJ (and treating doctors giving residual functional capacity assessments) that the DOT defines "occasional" as up to one-third of the work day, and defines "frequent" as one-third to two-thirds of the work day.

6.4 LESSEN THE IMPACT OF UNFAVORABLE NON-TREATING MEDICAL OPINION.

Explain why the opinion of the Consultative Examiner (CE) as to the nature and severity of the claimant's impairment should be disregarded (if it is unfavorable). Point out that the CE did not have the benefit of seeing later-acquired medical records or letters you have obtained from treating physicians. If the CE makes no mention of having reviewed medical records or if it is apparent that he did not read key medical records available at the time of his consultation, point this out. Point out the inadequacy of the CE's supporting explanation for his opinion. If the consultative examination was very brief or cursory, have the claimant testify to this. Under SSR 96-2p, the opinion of a medical source which did not treat the claimant is never entitled to controlling weight, although it may nevertheless be adopted if there is good cause.¹⁵²

¹⁵⁰ SSR 96-8p.

¹⁵¹ 20 C.F.R. §§ 404.1567 and 416.967.

¹⁵² 20 C.F.R. §§ 404.1527 and 416.927.

6.5 EXPLAIN WHY THE TREATING SOURCE'S OPINION SHOULD BE ADOPTED.

The regulations provide that more weight generally will be given to opinions from treating sources than opinions of doctors who have not treated the claimant. The regulations note that a treating physician is likely to be “most able to provide a detailed, longitudinal picture” of the nature and severity of the impairments.¹⁵³ Emphasize the length of time and frequency with which the treating physician has treated the claimant and the type of treatment and tests he has provided. Show how the treating source’s opinion is supported by the bulk of the record evidence. A treating source’s medical opinion as to the nature and severity of impairments must be adopted by the ALJ if it is 1) well- supported by medically acceptable clinical and laboratory diagnostic techniques and 2) not inconsistent with the other substantial evidence in the record. Even if the treating source’s opinion does not meet these two criteria for being given controlling weight, it is still entitled to deference if there is some reasonable support for the opinion.¹⁵⁴ If the facts on which the treating source’s opinion is based are not evident in the record, ask the ALJ to recontact the source, or allow you to recontact the source, to clarify the reasons for the source’s opinion. The ALJ is required to make every reasonable effort to recontact the source in such situations.¹⁵⁵

6.6 INFORM THE ALJ OF THE CORRECT STANDARD FOR EVALUATING CLAIMANTS WHO ABUSE SUBSTANCES.

Always be prepared for the possibility that the ALJ may ask your client about substance abuse. If the medical records reflect substance abuse, be sure to explain in your brief why the drug addiction and alcoholism (DAA) regulations do not bar your client from receiving benefits.

Some ALJs are under the mistaken impression that all claimants who abuse substances are ineligible for disability benefits, and some ALJs are simply biased against such claimants. Substance addiction is no longer a basis for getting disability benefits. However, disabled claimants who abuse substances can get benefits. Typically, those entitled to benefits are dually diagnosed with mental illness in addition to substance abuse, or they are disabled by irreversible impairments such as liver disease or dementia which were caused by their substance abuse but would likely remain even if they stopped abusing substances.

The legal standard: A person cannot receive benefits if drug addiction or alcoholism (DAA) is “a contributing factor material” to the disability determination. Drug addiction or alcoholism is “material” only if the claimant would not be disabled were he to stop using substances.¹⁵⁶ To determine whether DAA is material to the disability determination, SSA must follow a three-step analysis¹⁵⁷:

Step One: Is the claimant disabled? If yes, go on to the next step. It is improper for SSA to address DAA issue until it first finds that the claimant is disabled.¹⁵⁸

¹⁵³ 20 C.F.R. §§ 404.1527 and 416.927.

¹⁵⁴ SSR 96-2.

¹⁵⁵ SSR 96-5.

¹⁵⁶ 20 C.F.R. §§ 404.1535 and 416.935.

¹⁵⁷ 20 C.F.R. §§ 404.1535 and 416.935, HALLEX I-5-314A, POMS DI 90070.050.

¹⁵⁸ *Maggard v. Apfel*, 167 F.3d 376 (7th Cir. 1999).

Step Two: Is there medical evidence from acceptable medical sources that the claimant suffers from a substance abuse disorder? Statements by the claimant about his substance abuse, even if included in a physician's notes, are insufficient in and of themselves to establish drug addiction or alcoholism. Also, keep in mind that many treating sources will continue to diagnose substance abuse or dependence even after a person has stopped actually abusing alcohol or drugs. If there is not acceptable medical evidence of a substance abuse disorder, the claimant is entitled to benefits.¹⁵⁹ If there is acceptable medical evidence of such a disorder, go on to Step Three.

Step Three: Does the evidence establish that the claimant would not be disabled were he to stop abusing substances? If yes, benefits must be denied. If the evidence does not establish this, the claimant is eligible for benefits.

SSA has issued a policy statement indicating that DAA is not material if it is not possible to determine whether a person would still be disabled were he to stop using substances. "[W]hen it is not possible to separate the mental restrictions and limitations imposed by DAA and the various other mental disorders shown by the evidence, a finding of 'not material' would be appropriate."¹⁶⁰

Under the materiality definition, DAA obviously is not material where there are irreversible impairments caused by DAA, such as brain damage or HIV. Those conditions do not disappear when DAA stops. In the case of a dual diagnosis of DAA and mental illness, point out that the person's mental problems did not disappear during any periods of sobriety, if there were any such periods. Ask the treating psychiatrist to render an opinion as to whether the person's mental illness would continue were DAA to end.

If your client has a substance abuse problem and will agree to the appointment of a representative payee, particularly a non-profit organization such as the Louisiana Guardianship Service, asking the ALJ to order that a representative payee be appointed often facilitates a favorable disability determination. In addition, use of a non-profit representative payee in this situation increases the likelihood that the client's benefits will be used to provide him with the necessities of life.

6.7 IF YOUR CLIENT HAS FAILED TO FOLLOW PRESCRIBED TREATMENT, BE PREPARED TO GIVE A GOOD REASON WHY.

If a treatment is prescribed by a treating physician and can restore the ability to work, a claimant must follow the treatment unless there is good cause.¹⁶¹ If the prescribed treatment would not restore the ability to work, then a claimant's failure to follow it will not preclude a finding of disability. A claimant's mental impairment and the impact it may have on his ability to understand and cooperate with treatment must be considered in determining whether there is good cause.¹⁶²

¹⁵⁹ POMS DI 90070.050.

¹⁶⁰ Emergency teletype [EM 96-94], issued by the Office of Disability, SSA, 8/30/96, answer to question 29. The policy statement in the SSA teletype states that the SSA carries the burden of proof to show that drug addiction and alcoholism is material. But see *Brown v. Apfel*, 192 F.3d 492 (5th Cir. 1999) (apparently unaware of the SSA policy, the court held that the claimant bears the burden of proving that drug addiction and alcoholism is not material).

¹⁶¹ 20 C.F.R. §§ 404.1530 and 416.930; *Lovelace v. Bowen*, 813 F.2d 55 (5th Cir. 1987).

¹⁶² *Lucas v. Sullivan*, 918 F.2d 1567(11th Cir. 1990).

Additionally, failure to follow treatment should be excused if the claimant did not know of available free medical care, if they could not afford recommended treatment or drugs, if the treatment has substantial risks, or if they have had a history of unsuccessful treatment.

6.8 ALWAYS LOOK FOR PRIOR CLAIMS THAT CAN BE REOPENED IN ORDER TO MAXIMIZE YOUR CLIENT'S RECEIPT OF BACK BENEFITS.

The SSA has liberal *res judicata* rules and allows reopening of prior claims in several situations. Following are some of the most significant grounds for reopening.

- a. **Mental Impairments:** If a pro se claimant failed to appeal an unfavorable decision because his mental impairments rendered him incompetent to do so or made him unable to understand his appeal rights, the claim may be reopened no matter how long ago.¹⁶³
- b. **Within 12 months of initial determination:** Prior claims may be reopened for any reason within 12 months of the date of the notice of an initial determination.¹⁶⁴
- c. **Good cause reopenings.** Prior Title II claims may be reopened within four years of the initial determination if good cause is found. Prior SSI claims may be reopened within two years if good cause is shown.¹⁶⁵ Good cause may be established in at least three circumstances: 1) new and material evidence is provided; 2) a clerical error was made; and 3) the evidence used in making the prior decision clearly shows that an error was made.

7. COMPENDIUM OF FIFTH CIRCUIT CASE LAW

7.1 ONSET AND DURATION OF DISABILITY

Retrospective medical diagnoses uncorroborated by contemporaneous medical reports but corroborated by contemporaneous lay evidence can be used to establish disability onset date. *Likes v. Callahan*, 112 F.3d 189 (5th Cir. 1997).

SSR 83-20 requires that the claimant's stated onset date be used as the established onset date when it is consistent with available evidence. In some cases, it may be possible to reasonably infer that the onset of a disabling impairment occurred sometime prior to the date of the first recorded medical examination. In cases involving slowly progressive impairments, when the medical evidence regarding the onset date of a disability is ambiguous, it is grounds for remand if the ALJ failed to use a medical advisor to assist in making an informed judgment as to the onset date. The ALJ also must obtain all available evidence to determine the onset date. *Spellman v. Shalala*, 1 F.3d 357, 361-362 (5th Cir. 1993).

Where contemporaneous medical records are not available to show onset date, information may be obtained from family members, friends and former employers regarding course of condition, and non-contemporaneous medical records may be relevant to show onset date. *Ivy v. Sullivan*, 898 F.2d 1045 (5th Cir. 1990).

¹⁶³SSR 91-5p.

¹⁶⁴20 C.F.R. §§ 404.988 and 416.1488.

¹⁶⁵20 C.F.R. §§ 404.988-989 and 416.1488-1489.

A claimant is required to show that her impairment has lasted or is expected to last for 12 months, but need not show that it disabled her for 12 months or that it prevented her from working for 12 months. *Moore v. Sullivan*, 895 F.2d 1065 (5th Cir. 1990).

A claimant's impairment must last for 12 continuous months but there is no requirement that he be unable to work during the entire 12-month period. A claimant with a mental impairment does not have to show a 12-month period of impairment unmarred by any symptom-free interval. *Singletary v. Bowen*, 798 F.2d 818, 821 (5th Cir. 1986).

When finding a closed period of disability, SSA must make a finding of medical improvement and otherwise treat the end of the closed period as though it were a cessation on an ongoing disability review. *Waters Barnhart*, 276 F.3d 716 (5th Cir. 2002).

7.2 SEQUENTIAL EVALUATION

A finding that a claimant is disabled or not disabled at any point in the five-step process is conclusive and terminates the analysis. The burden of proof is on the claimant for the first four steps but shifts to the SSA at Step Five. *Bowling v. Shalala*, 36 F.3d 431, 435 (5th Cir. 1994).

7.3 STEP TWO: SEVERITY

An impairment is "non-severe" only if it is slight abnormality having such minimal effect that it would not be expected to interfere with claimant's ability to work, irrespective of age, education, or work experience. *Loza v. Apfel*, 219 F.3d 378 (5th Cir. 2000), reaffirming *Stone v. Heckler*, 752 F.2d 1099 (5th Cir. 1985)

7.4 STEP FOUR: RETURN TO PAST WORK

The ALJ must analyze the claimant's past job duties in order to determine whether he can return to past work. *Abshire v. Bowen*, 848 F.2d 638, 641 (5th Cir. 1988).

7.5 STEP FOUR AND FIVE: RESIDUAL FUNCTIONAL CAPACITY (RFC)

The ALJ is not at liberty to make a medical judgment regarding the ability of a claimant to engage in gainful activity where such inference is not warranted by clinical findings. *Loza v. Apfel*, 219 F.3d 378 (5th Cir. 2000).

When making a Step Four finding that a claimant can return to his prior work, ALJ must compare claimant's remaining functional capacities with the physical and mental demands of his previous work, and the ALJ must make clear factual findings on this issue. ALJ may not rely on generic classifications of previous jobs. *Latham v. Shalala*, 36 F.3d 482, 484 (5th Cir. 1994).

An RFC assessment that claimant could sit for six hours of an eight-hour work day was not supported by substantial evidence when it was based only on the opinion of a non-treating medical consultant and directly conflicted with the opinion of the claimant's treating physician. *Smith v. U.S. R.R. Retirement Bd.*, 85 F.3d 224 (5th Cir. 1996).

A claimant must be able to maintain employment in order to be found not disabled, regardless of whether the impairment is mental or physical or both. *Watson v. Barnhart*, 288 F.3d 212 (5th Cir. 2002), citing *Singletary v. Bowen*, 798 F.2d 818

(5th Cir. 1986). However, there must be a factual basis for any maintenance of employment issue in each particular case. A claimant's impairments must be shown to be episodic for this issue to apply. *Frank v. Barnhart*, 326 F.3d 618 (5th Cir. 2003).

7.6 STEP FIVE: VOCATIONAL-MEDICAL GUIDELINES ("GRID RULES")

An ALJ must use a vocational expert and may not rely on a grid rule if the claimant suffers from non-exertional impairments, such as pain, swelling and the inability to stand or sit for limited periods of time. *Newton v. Apfel*, 209 F.3d 448, 458 (5th Cir. 2000); see also *Carey v. Apfel*, 230 F.3d 131 (5th Cir. 2000).

Denial of benefits based on the "Grid Rules" is appropriate if the claimant suffers only from exertional impairments, or if the claimant's non-exertional impairments do not significantly affect his residual functional capacity. Where a claimant suffers from incontinence and side effects of medications, exclusive reliance on the Grid Rules is error. *Crowley v. Apfel*, 197 F.3d 194, 199 (5th Cir. 1999).

A grid rule may be used to establish that a claimant is not disabled only if the rule's evidentiary underpinnings coincide exactly with the record evidence of the impairments. Where a claimant was not capable of performing a full range of any particular category of work, a grid rule cannot be used to deny benefits. *Bowling v. Shalala*, 36 F.3d 431, 435 (5th Cir. 1994).

When claimant's back injury required her to alternate between sitting and standing as needed, her exertional capabilities did not fit within the definition of sedentary work, and grid rules were inapplicable. *Scott v. Shalala*, 30 F.3d 33 (5th Cir. 1994).

If the testimony of the VE as to a job's requirements conflicts with the Dictionary of Occupational Titles, the ALJ may nonetheless rely on the VE's testimony provided that the record reflects an adequate basis for doing so. Claimants should not be permitted to scan the record for implied conflicts between the VE testimony and the DOT when they failed to cross-examine a VE about such conflicts. *Carey v. Apfel*, 230 F.3d 131 (5th Cir. 2000).

In determining whether claimant could perform other work existing in the national economy, the SSA was not required to take into account a downturn in local economy or whether jobs were actually available to the claimant. *Harrell v. Bowen*, 862 F.2d 471 (5th Cir. 1988).

To be capable of performing sedentary work under the guidelines, claimant must have some reasonable chance in the real world of being hired and, once hired, of keeping the job. *Wingo v. Bowen*, 852 F.2d 827 (5th Cir. 1988).

A VE need not consider the specific working conditions of jobs in determining whether a claimant can perform those jobs. *Vaughan v. Shalala*, 58 F.3d 129, 132 (5th Cir. 1995).

If an individual's medical treatment significantly interrupts the ability to perform an eight-hour work day, the ALJ must determine whether the effect of treatment precludes work. The ALJ's failure to consider the effect on the ability to work of frequent medical appointments and hospital visits, and of treatment causing the claimant to sleep for several hours a day, is grounds for remand. *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000).

ALJ used the Guidelines (also referred to as Grids) at step 5 to find claimant disabled without first determining whether claimant's non-exertional limitations would preclude claimant from performing light work. Court found that this was harmless error since the claimant's substantial rights have not been affected. *January v. Astrue*, 400 Fed. Appx. 929, 931-32 (C.A.5 La. 2010).

7.7 DISABILITY TERMINATIONS

The ultimate burden of proof lies with the SSA in proceedings to terminate disability benefits. The SSA must provide substantial evidence that 1) there is medical improvement related to the ability to work and 2) the individual is now able to engage in substantial gainful activity. *Griego v. Sullivan*, 940 F.2d 942, 943-944 (5th Cir. 1991).

7.8 CHILDREN'S DISABILITY EVALUATION

The 'comparable severity' standard required by *Sullivan v. Zebley*, 110 S.Ct. 885 (1990), is more lenient than the 'marked and severe functional limitations standard' established by federal statute in 1996, which applies to child claimants whose claims are subject to final adjudication on or after Aug. 22, 1996. Any case that would have been denied under the *Zebley* standard would also be denied under the new standard. *Harris ex rel. Harris v. Apfel*, 209 F.3d 413, 418-419 (5th Cir. 2000).

7.9 MENTAL ILLNESS

When information suggests a mental impairment exists and medical findings do not substantiate the existence of physical impairments capable of producing alleged pain and other symptoms, the ALJ must investigate whether a mental impairment is the basis of the symptoms. *Latham v. Shalala*, 36 F.3d 482, 484 (5th Cir. 1994).

In any case where there is evidence that indicates the existence of a mental impairment, the ALJ may not make a determination that the claimant is not disabled unless the ALJ has made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed a residual functional capacity assessment. *Bowling v. Shalala*, 36 F.3d 431 (5th Cir. 1994).

A mentally ill claimant who is capable of performing work is nonetheless disabled if his impairments prevent him from remaining employed for a significant period of time. Occasional symptom-free periods and sporadic ability to hold a job are symptomatic of a claimant's mental disability. *Leidler v. Sullivan*, 885 F.2d 291 (5th Cir. 1989).

A finding that a mentally ill claimant is able to engage in substantial gainful activity requires a determination that the claimant can hold whatever job he finds for a significant period of time. *Singletary v. Bowen*, 798 F.2d 818 (5th Cir. 1986).

7.10 PAIN AND OTHER NON-EXERTIONAL IMPAIRMENTS

An ALJ cannot ignore altogether a claimant's subjective complaints of pain but has a duty to develop testimony and other evidence of pain and of the adverse effects of pain medication. *Bowling v. Shalala*, 36 F.3d 431, 438 (5th Cir. 1994).

An ALJ's unfavorable credibility evaluation of a claimant's complaints of pain will not be upheld on judicial review where the uncontroverted medical evidence

shows a basis for the complaints, unless the ALJ weighs the objective medical evidence and assigns articulated reasons for discrediting the complaints. *Abshire v. Bowen*, 848 F.2d 638, 642 (5th Cir. 1988).

Pain constitutes a disabling condition when it is constant, unremitting, and wholly unresponsive to treatment. An ALJ must articulate reasons for rejecting the claimant's complaints of pain. *Falco v. Shalala*, 27 F.3d 160, 163-164 (5th Cir. 1994) (affirming denial of benefits where claimant's activities of daily living inconsistent with his pain allegations).

An ALJ is required to consider the type, dosage, effectiveness, and side effects of any medication the claimant takes to alleviate pain or other symptoms. *Crowley v. Apfel*, 197 F.3d 194, 199 (5th Cir. 1999).

Incontinence is a non-exertional impairment which may significantly limit a person's ability to perform sedentary work; remand is appropriate if an ALJ fails to determine the effect of a claimant's incontinence on his ability to work. *Crowley v. Apfel*, 197 F.3d 194, 198-199 (5th Cir. 1999).

Remand is required where an ALJ ignores evidence of non-exertional impairments such as fatigue, weakness, swelling and pain and rejects claims of these impairments without citing any contrary evidence in the record. *Newton v. Apfel*, 209 F.3d 448, 459 (5th Cir. 2000).

7.11 FAILURE TO FOLLOW PRESCRIBED TREATMENT

An otherwise remediable condition may be considered disabling if claimant is unable to pay for prescribed treatment. *Tamez v. Sullivan*, 888 F.2d 334 (5th Cir. 1989).

7.12 TREATING PHYSICIAN RULE

Absent reliable medical evidence from a treating or examining physician controverting the claimant's treating physician, an ALJ may reject the opinion of the treating physician only if the ALJ performs a detailed analysis of the treating physician's views under the criteria set forth in 20 C.F.R. § 404.1527(d)(2) and gives good reasons for the weight given to the treating physician's opinion. Additionally, if the ALJ determines that the treating physician's records are inconclusive or otherwise inadequate to receive controlling weight, absent other medical evidence based on personal examination or treatment of the claimant, the ALJ must seek clarification or additional evidence from the treating physician in accordance with 20 C.F.R. § 404.1512(e). *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000).

An ALJ may not rely on the conclusory and unsubstantiated opinion of a non-treating, non-examining physician that a claimant is not disabled. An ALJ's conclusion that a claimant could perform sedentary work based on such an opinion is not supported by substantial evidence. *Newton v. Apfel*, 209 F.3d 448, 457 (5th Cir. 2000).

The ALJ may diminish the weight accorded a treating physician's opinion relative to that of other experts where the treating physician's opinion is unsupported by medically acceptable clinical, laboratory or diagnostic techniques or where it is otherwise unsupported by the evidence. *Paul v. Shalala*, 29 F.3d 208 (5th Cir. 1994).¹⁶⁶

¹⁶⁶The U.S. Supreme Court partially overruled *Paul v. Shalala* in *Sims v. Apfel*, 530 U.S. 103 (2000), holding that a claimant who exhausted her administrative remedies, was not required to also exhaust issues in a request for review by the Appeals Council in order to preserve judicial review of those issues.

An opinion of a specialist generally will be accorded greater weight than a non-specialist in a disability proceeding. *Paul v. Shalala*, 29 F.3d 208 (5th Cir. 1994).

When good cause is shown for diminishing reliance on a treating physician's opinion, that opinion may be given less weight, little weight, or even no weight. *Greenspan v. Shalala*, 38 F. 3d 232 (5th Cir. 1994), *cert. denied*, 514 U.S. 1120 (1995).

A treating physician's opinion that a claimant is "totally disabled" may be rejected if it is inconsistent with substantial evidence in the record. *Spellman v. Shalala*, 1 F.3d 357, 364 (5th Cir. 1993).

A treating physician's opinion that a claimant is disabled is not entitled to controlling weight where he failed to provide a medical explanation for his opinion and where his opinion is inconsistent with the opinions of examining physicians which were based on clinical test results. *Martinez v. Chater*, 64 F.3d 172, 176 (5th Cir. (1995).

The opinion of a treating physician is generally given "considerable weight in determining disability". However, this rule does not apply when a treating physician's testimony is "brief or conclusory, not supported by medically acceptable clinical laboratory diagnostic techniques, or otherwise unsupported by the evidence." *Foster v. Astrue*, 410 Fed. Appx. 831 (C.A.5 Tex., 2011) citing, *Perez v. Barnhart*, 415 F.3d 457 (5th Cir. 2005).

7.13 EFFECT OF OTHER STATUTORY DEFINITIONS OF DISABILITY AND OTHER AGENCIES' DETERMINATIONS OF DISABILITY

A ruling that a claimant has been found disabled by the Department of Veterans Affairs is evidence entitled to great weight and constitutes grounds for a remand. *Latham v. Shalala*, 36 F.3d 482, 483-484 (5th Cir. 1994).

SSA must consider the findings of other agencies that claimant is disabled but is not bound by them. *Kinash v. Callahan*, 129 F.3d 736 (5th Cir. 1997).

When the SSA determines disability, it does not take into account the possibility that an employer might make a "reasonable accommodation" of an employee's disability, thereby allowing him to work. *Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795 (1999).

A vocational expert should not base his determination of the availability of jobs on the assumption of employer compliance with the ADA and accommodation of a disability. Assessment of jobs available must be based on broad vocational patterns rather than on any individual employer's practices. However, it is not reversible error for a VE to testify as to whether allowing an employee to alternate sitting and standing is a prevalent workplace accommodation. *Jones v. Apfel*, 174 F.3d 692, 693-694 (5th Cir. 1999).

7.14 DRUG ADDICTION OR ALCOHOLISM

The claimant bears the burden of proving that drug or alcohol addiction is not a contributing factor material to disability. *Brown v. Apfel*, 192 F.3d 492 (5th Cir. 1999). (Note that the court apparently was not informed of SSA's own policy which states that the burden is on the SSA; the SSA failed to brief the issue of the burden of proof in this case.).

Substance addiction is material to disability if the ALJ would not find the claimant disabled if she stopped using drugs or alcohol. The fact that substance abuse exacerbated the claimant's depression is not sufficient to imply the reverse: that if she ceased using narcotics and alcohol, her depression would be abated. *Brown v. Apfel*, 192 F.3d 492 (5th Cir. 1999)(dicta).

7.15 ALJ'S DUTY

A Social Security hearing is investigatory rather than adversarial, and it is the duty of the ALJ to investigate the facts and develop the arguments both for and against granting benefits. *Sims v. Apfel*, 530 U.S. 103 (2000) (plurality opinion).

ALJ has duty to adequately develop the record. *Brock v. Chater*, 84 F.3d 726 (5th Cir. 1996).

When claimant is not represented by counsel, ALJ has heightened duty to scrupulously and conscientiously explore all relevant facts. *Brock v. Chater*, 84 F.3d 726 (5th Cir. 1996).

When a claimant is not represented, the ALJ has the duty to ensure that the claimant's relevant questions to the VE are answered. *Bowling v. Shalala*, 36 F.3d 431, 437-438 (5th Cir. 1994).

An ALJ's denial of the opportunity to cross-examine an adverse witness violates constitutional due process. When reports are received after an administrative hearing, the claimant's waiver of the right to cross-examine must be clearly expressed or strongly implied from the circumstances. When the claimant objects to post-hearing interrogatories to a vocational expert, the ALJ may not rely on the VE's responses to those interrogatories without giving the claimant an opportunity to cross-examine the VE. *Tanner v. Secretary of Health and Human Services*, 932 F.2d 1110 (5th Cir. 1991).

By requesting a subpoena, a claimant has the right to cross-examine an individual who submitted a report about the claimant's condition. *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990).

ALJ must order consultative examination when it is necessary to the determination of disability. No examination is necessary to evaluate an impairment which was alleged for the first time after the hearing and for which claimant never sought treatment. *Brock v. Chater*, 84 F.3d 726 (5th Cir. 1996).

When the record contains sufficient medical and non-medical evidence upon which to base a determination of the severity of a claimant's mental problems, an ALJ's decision not to order a consultative examination is within his discretion. *Sims v. Apfel*, 224 F.3d 380, 381 (5th Cir. 2000).

An ALJ's statement that a treating physician's opinion that his patient was disabled was an attempt "to help [her] get benefits because of his relationship with her" does not support a bias or partiality challenge because it does not reveal "such a high degree of favoritism or antagonism as to make fair judgment impossible". *Brown v. Apfel*, 192 F.3d 492, 500 (5th Cir. 1999) citing *Liteky v. United States*, 510 U.S. 540, 555 (1994).

Remand is appropriate where an ALJ fails to address the inconsistencies in the evidence. *Myers v. Apfel*, 238 F.3d 617 (5th Cir. 2001).

7.16 LEGAL EFFECT OF SOCIAL SECURITY RULINGS AND HALLEX POLICIES

Social Security Rulings are binding on all components of the SSA. *Spellman v. Shalala*, 1 F.3d 357, 360 n.7 (5th Cir. 1993).

Social Security Rulings are not binding on federal courts, but the courts frequently rely on them when the statute at issue provides little guidance. *Myers v. Apfel*, 238 F.3d 617 (5th Cir. 2001).

SSA procedures set forth in HALLEX must be followed, even where they are more rigorous than would otherwise be required. *Newton v. Apfel*, 209 F.3d 448, 459 (5th Cir. 2000).

The Fifth Circuit has expressed a strong preference for requiring the SSA to follow its own internal procedures such as HALLEX; however, the claimant must make a showing that he was prejudiced by the agency's failure to follow a particular rule before relief from the agency decision will be granted. *Shave v. Apfel*, 238 F.3d 592 (5th Cir. 2001).

7.17 APPEALS COUNCIL

The Appeals Council must follow its own procedures, set forth in HALLEX, that require it to specifically address additional evidence or legal arguments or contentions submitted in connection with the request for review. *Newton v. Apfel*, 209 F.3d 448, 459 (5th Cir. 2000).

7.18 FEDERAL COURT REVIEW

A Social Security claimant can raise issues in federal court even if they were not raised at the Appeals Council. *Sims v. Apfel*, 530 U.S. 103 (2000) (overruling contrary holding of *McQueen v. Apfel*, 168 F.3d 152 (5th Cir. 1999)). The Supreme Court left open the possibility that a federal court may be barred from considering issues which could have been raised, but were not, at the ALJ hearing.

Federal court review of SSA's denial of disability benefits is limited to determining whether 1) final decision is supported by substantial evidence and 2) the SSA used the proper legal standards to evaluate the evidence. The federal court may not reweigh evidence or try issues de novo. "Substantial evidence" needed to support denial of disability benefits is such relevant evidence as a reasonable mind might accept as adequate to support the conclusion. It is less than a preponderance but more than a scintilla. *Newton v. Apfel*, 209 F.3d 448, 452 (5th Cir. 2000).

The substantial evidence test does not involve a simple search of the record for isolated bits of evidence which support the SSA's decision. The court must consider the record as a whole, including contrary evidence. *Singletary v. Bowen*, 798 F.2d 818, 823 (5th Cir. 1986).

A federal court will reverse an ALJ's decision because of legal error only if a claimant shows that he was prejudiced as a result of the error. *Bowling v. Shalala*, 36 F.3d 431, 437 (5th Cir. 1994).

A federal court may reverse the SSA's judgment and award disability benefits in the absence of good cause to remand. Where the SSA failed to make a finding necessary to deny benefits and nothing in the record would support such a finding, reversal rather than remand is appropriate. *McQueen v. Apfel*, 168 F.3d 152 (5th Cir. 1999).

ALJ's decision denying benefits will be reversed for failure to develop the record only if claimant shows prejudice as result of the failure. *Bowling v. Shalala*, 36 F.3d 431 (5th Cir. 1994).

If the court is unable to determine if the ALJ used the correct legal standard in denying benefits, the case should be remanded. *Hughes v. Shalala*, 23 F.3d 957 (5th Cir. 1994).

A civil action must be instituted in federal court within 60 days after the Appeals Council's notice of decision or notice of denial of request for review is received by the claimant. There is a rebuttable presumption that the date of receipt of the notice is five days after the date of such notice. *Fletcher v. Apfel*, 210 F.3d 510, 512-513 (5th Cir. 2000).

The deadline for filing an action in federal court is tolled during a delay in stamping a complaint "filed" in a case in which in *forma pauperis* status is eventually granted. *Fletcher v. Apfel*, 210 F.3d 510, 513 (5th Cir. 2000) (declining to decide the question of whether the limitations period is tolled during the pendency of an unsuccessful IFP application).

Only two kinds of federal court remands to the SSA are permissible: 1) "sentence four" remands, in which a court issues a judgment affirming, modifying or reversing the agency's decision "with or without a remand," and 2) "sentence six" remands, in which there is new evidence and good cause for the failure to present the evidence in the earlier proceeding. A remand order to allow the SSA to perform a consultative examination is improper if the court makes no substantive ruling and no explicit findings of good cause to consider new evidence. *Istre v. Apfel*, 208 F.3d 517 (5th Cir. 2000).

Equitable tolling applies to disability claims. *Luna v. U.S. Dept. of Health and Human Services*, 948 F.2d 169, 173 (5th Cir. 1991).

A claimant is entitled to appeal a federal district court decision remanding her case to the SSA for further proceedings. *Forney v. Apfel*, 524 U.S. 266 (1998).

A federal court may review the SSA's refusal to reopen a claim only if there is a colorable constitutional claim. There is no constitutional violation when res judicata is applied to dismiss a claimant's request for a hearing on a subsequent claim in which medical reports show a degeneration of the claimant's condition since the prior unfavorable SSA decision. Nor is application of res judicata unconstitutional simply because the tape recording of the prior hearing was lost. *Torres v. Shalala*, 48 F.3d 887, 890 (5th Cir. 1995).

A federal court has no jurisdiction to review an ALJ's dismissal of a request for a hearing where there is no colorable constitutional claim and where the ALJ dismissal was authorized by the regulations and the claimant was given the required notice. *Brandyburg v. Sullivan*, 959 F.2d 555 (5th Cir. 1992).

7.19 FEDERAL COURT REVIEW-CONSIDERATION OF NEW EVIDENCE

Remand is appropriate when there is a showing of 1) new and material evidence, 2) good cause as to why the new evidence was not incorporated into prior proceedings, and 3) a reasonable possibility that the new evidence would have changed the outcome of SSA's determination. *Ripley v. Chater*, 67 F.3d 552 (5th Cir. 1995).

New evidence must pertain to the time period for which disability benefits were denied and not merely concern subsequently acquired disability or deterioration of a condition that was not previously disabling. *Legett v. Chater*, 67 F.3d 558 (5th Cir. 1995).

Evidence of a back surgery conducted after the SSA's denial of benefits was material in that it provided objective basis for claimant's previous complaints of back pain. *Ripley v. Chater*, 67 F.3d 552 (5th Cir. 1995).

Remand is inappropriate where new evidence submitted in federal court does not relate to the time period for which benefits were denied. *Falco v. Shalala*, 27 F.3d 160, 163 (5th Cir. 1994).

7.20 OVERPAYMENTS

When a claimant was overpaid benefits as a result of signing an application form which she failed to read and which erroneously stated that she was unmarried, an ALJ's decision that she was negligent and thus "not without fault" is supported by substantial evidence. *Austin v. Shalala*, 994 F.2d 1170, 1174 (5th Cir. 1993).

The limited education of a claimant can affect the determination of whether she is at fault in a request for waiver of an overpayment. *United States v. Phillips*, 600 F.2d 535, 540 (5th Cir. 1979).

7.21 OTHER SSI/SSDI RULES

An individual may apply for a disability determination, even if he does not meet the non-disability eligibility rules, in order to extend his insured status by eliminating from the "20/40 rule" quarters during which he was unable to work because of disability. However, a person cannot apply for SSDI benefits or a disability determination more than 12 months after his disability has ended. *George v. Chater*, 76 F.3d 675, 677 (5th Cir. 1996).

SSA must award survivor's benefits if state court would recognize minor child as intestate distributee under state law. *Garcia for Rodriguez v. Sullivan*, 883 F.2d 18 (5th Cir. 1989).

Under 42 U.S.C. § 407, SSDI benefits are not transferable or assignable. However, this provision does not bar deeming a child's SSDI benefits as available to support the child's family in determining eligibility for welfare and food stamps. *Williams v. Raiford*, 976 F.2d 942 (5th Cir. 1992).

Retrospective monthly accounting does not violate the Social Security statute. *Doyle v. Shalala*, 62 F.3d 740 (5th Cir. 1995).

Good cause does not exist for an ALJ to reopen a favorable finding of disability and change it into a closed period where there is a later discovery of possible substantial gainful activity after the original decision. *Cole ex rel. Cole v. Barnhart*, 288 F.3d 149 (5th Cir. 2002).

8. RESOURCES FOR THE ADVOCATE

8.1 SOURCES OF LAW

- Supplemental Security Income, or SSI (Title XVI benefits) 42 U.S.C. § 1381 et seq.; 20 C.F.R. § 416.101 et seq.
- Old-Age, Survivors, and Disability Insurance Benefits (Title II benefits) 42 U.S.C. § 401 et seq.; 20 C.F.R. § 404.1 et seq.
- West's *Social Security Laws: Selected Statutes and Regulations*. Includes the Listings of Impairments and the Medical-Vocational Guidelines, both of which are appendices following 20 C.F.R. § 404.1599.
- www.ssa.gov Social Security Administration's own website includes statutes, regulations, emergency bulletins and SSRs.

8.2 REPORTING SERVICES, NEWSLETTERS, TREATISES AND MANUALS

- West's *Social Security Reporting Service*. Includes the Code, Topical Index, Digest Index, Rulings, Regulations, and Cases. Updated annually.
- *NSCLC Washington Report* (published by the National Senior Citizens Law Center). Summary of new judicial, legislative, and regulatory developments in Social Security, Medicaid and Medicare law. NSCLC also has a website where you can sign up for alerts and other newsletters: <http://www.nsclc.org>
- Samuels, Barbara, *Social Security Disability Claims: Practice and Procedure* (2d. ed. 2012). Two volumes. Updated annually. Written by a long-time legal services attorney.
- *Social Security Practice Guide* (published by Matthew Bender). Multivolume. Periodic updates. Written under the supervision of the National Organization of Social Security Claimants' Representatives.
- Bazelon Center for Mental Health Law www.bazelon.org. Webpage focuses on Children SSI issues.
- McCormick, Harvey L., *Social Security Claims and Procedures* (6th ed. West 2011). 2 volumes. Updated annually.
- Bohr, Sarah H. and Ester O. Yip, *Bohr's Social Security Issues Annotated* (James Publishing 2012). Updated annually. Includes CD-ROM for key word searches. Written by a long-time legal services attorney.
- Peters, J. Douglas, *Social Security Disability Claims* (West 2012). Updated periodically.

8.3 ELECTRONIC RESOURCES

Social Security Administration

www.ssa.gov

Contains SSA forms, including Appointment of Representative and appeal forms, which you can download. Also contains the complete Social Security regulations, proposed regulations, Social Security Rulings and Acquiescence Rulings, the Social Security Handbook, and general information indexed by subject. You can access the Social Security Bulletin, a research journal, or subscribe to an on-line SSA newsletter (www.ssa.gov/enews).

HALLEX

HALLEX stands for Hearings, Appeals, Litigation and Law manual. It is the manual of policies and procedures governing the Office of Disability Adjudication and Review and Appeals Council. The HALLEX is now on SSA's website http://www.ssa.gov/OP_Home/hallex/hallex.html

POMS

POMS stands for Program Operations Manual System. It is a manual of policies and procedures governing the field offices of the SSA. It can be found on SSAs website. <https://secure.ssa.gov/poms.nsf/home!read-form>

Louisiana Pro Bono and Public Interest Web Page www.probono.net/la

This web page includes useful information in most areas of practice.

National Organization of Social Security Claimants' Representatives (NOSSCR) www.nosscr.org

Contains Advocate Alerts (recent developments) and links to related sites, including access to the Code of Federal Regulations and the Federal Register.

National Immigration Law Center www.nilc.org

NILC is a good source of information about immigrants' eligibility for SSI.

Bazelon Center for Mental Health Law www.bazelon.org

8.4 MEDICAL INFORMATION ON-LINE

The Merck Manual of Diagnosis and Therapy. www.merck.com

The entire Merck Manual, the most widely used medical text in the world, is online with a search engine. You can also search the Merck Manual of Medical Information - Home Edition, which translates medical language into plain English.

Pharmaceutical Information Network Pharminfo.com

Contains "DrugDB," a searchable database of medications. Explains what diseases they are used to treat and the side effects.

United States National Library of Medicine/MEDLINE www.nlm.nih.gov/

MEDLINE is the database of academic articles which is maintained by the National Institutes of Health. Searchable by key word. This website also contains MEDLINEplus, a consumer version of Medline, medical dictionaries, and links to other resources.

National Institutes of Health <http://search.info.nih.gov/>

The search engine for the NIH.

Electronic ICD (Yaki Technologies) www.eicd.com

Explains the meaning of the numerical diagnostic codes of the ICD-9-CM. Also contains a hospital locator.

Journal of the American Medical Association www.jama.com

Can search archives of JAMA and several other medical journals.

Stanford University MedWorld www.med.stanford.edu/medworld/home

This is an excellent site, sponsored by the Stanford Medical Alumni Association and maintained by Stanford Medical School students, with many links to medical information. Can Search MEDLINE. Contains links to and a comprehensive list of all medical journals available online, including the New England Journal of Medicine.

American Medical Association Doctor Finder www.ama-assn.org

Get background information on a physician.

School Psychological Resources Online www.schoolpsychology.net

This site is maintained by the Office of Psychological Services of the Baltimore County Public Schools. Can search for information on childhood illnesses and disorders.

American Psychological Association www.apa.org

American Psychiatric Association www.psych.org