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A. RECENT CHANGES

The most significant change which the agency has made pertains to electronic filing (known as “eDib”). Just as the Federal Bankruptcy Courts have introduced electronic filing, the filing of cases has changed, such that access to the internet will be an essential part of any attorney’s practice. If your office contemplates the filing of the initial application for a client, that can be done electronically.

Ultimately, it is expected that filing of exhibits will be done electronically, by transferring of data and medical charts and other materials from printed version to a disk, via a scanner onto your computer and then burned onto a compact disk. If you file exhibits on paper, you likely will get them mailed back to you, along with a bar code for facsimile transmission, for the receipt of materials all along the appellate process.

One change of minor note: the Office Of Hearings And Appeals no longer exists: it is now the Office Of Disability Adjudication And Review (ODAR). There are other changes proposed, such as the elimination of the Appeals Council; if accomplished, the next stage of the proceedings will be appeal to the Federal District Court.

For several years, the agency has talked of eliminating the second stage of the appellate process. The Reconsideration Review would be dropped; if the initial application is denied, the claim would be sent on to ODAR for hearing. SSA has made these proposals, subject to demonstrations in specific regions; it has yet to reach our area.

Under a program called Disability Service Improvement (DSI), the northeast states are the demonstration region, which will hopefully expedite the appellate process. If successful, DSI will be implemented nationwide. Reconsideration will be dropped; an appealing claimant must request a review by a federal reviewing official. Who those persons will be, whether employees
of SSA (just like the ALJs!), and how extensive their power, who knows? If this official issues a
denial, a request for an ALJ hearing is to follow. DSI hopes to standard decision-writing which,
considering the boilerplate used by ALJs (the current decision writers), doesn’t appear to show
much promise of institutional change for the better.

Under DSI, the Appeals Council will be replaced by a Decision Review Board. Its function
will NOT be the same as the Appeals Council. This board will be able to selectively review claims;
merely because one loses before the ALJ does not entitled the claimant to Board review. If,
within a 90-day period post-ALJ decision, the Board does not review it *sua sponte*, appeal to the
Federal District Court follows. My guess? The District Courts won’t like this, because their
disability caseload could increase geometrically.

For the law on this new process, see 20 CFR §§405.415 and 405.420.

B. Significant Rulings:

There are several sources of Social Security law, of which the disability practitioner must
be aware: the US Code contains the statutes; the Code of Federal Regulations contains materials
vital to a basic knowledge of disability law. The Federal Register is used by SSA to give notice of
changes to various aspect of Social Security law, on a periodic basis. Clearly, the Federal Reporter
system contains decisions of the federal judiciary, some of which will be reported on Westlaw, or
in the online reporters, issue-specific reporter systems, Lexis-Nexis, and the like.

Social Security has issued its own rulings, over the years. These rulings are very important
to specific issues, some of which appear in all disability cases, some of which are more specifically
directed to specific issues. E.g., I have a client with Interstitial Cystitis (IC); there is a specific
ruling applicable to this ailment. IC is dealt with at SSR02-2p. There are a set of rulings issued in
1996, with which all disability practitioners should be familiar: they govern all aspects of disability practice, the weight of evidence, how to approach pain as a symptom, and other issues vital to this practice.

There are other rulings, applicable to individual ailments, such as Chronic Fatigue Syndrome (CFS); there are rulings which establish standards for ALJs, to aid their decision-making. Many of them date back to the 1980s, but are still valid. A working familiarity with these rulings is very important, if only on a case-by-case basis.

In addition to the rulings, there are Acquiescence Rulings (AR), by which specific issues are addressed. These Rulings are not intended for a nationwide application. Familiarity with these Rulings is advised. Both types of Rulings can be found in the treatises available commercially, e.g. West Group and James Publishing are two legal publishing sources for such information.

There are other sources of law: e.g., SSA relies on the Dep’t of Labor’s Dictionary of Occupational Titles, in making vocational decisions. Unfortunately, the information in this work is largely out of date; it is not used by anyone else, unless a doorstop is needed. However, it is vital, even crucial, for the disability practitioner to know this work; more is mentioned later in this handbook, about law and sources.

C. TYPES OF CASES:

The Social Security Act (“The Act”) is found at 42 U.S.C. Chapter 7; this section commences Title II of The Act, at Section 401. There are two principal types of “Social Security Disability” - Title II is the original program: it is also called SSD, OASDI, DIB; there may be other names. The other program is almost forty years old: Supplemental Security Income (SSI). As it was added to The Act in Title XVI, it is known alternatively as SSI or as Title XVI. The two programs are almost
identical insofar as the handling by the Social Security Administration (SSA), and in the forms which SSA uses throughout the appellate process. Thus, if the attorney is familiar with those aspects of one title, that familiarity carries over. Here are some variants of the disability benefits available under The Social Security Act.

**CHILDREN as CLAIMANTS:**

The Act provides separate criteria for the claimant less than age eighteen. SSA had to be pushed by the U.S. Supreme Court into accurately assessing children, as compared to adults. The treatment of children is governed by, and the rules applicable to children, are found in those statutes and regulations pertaining to Supplemental Security Income. In the past few years, the guidelines applicable to children have been changed, toughening the requirements for the success of juvenile claimants. In effect, a child’s disability must either meet, equal or be the substantial equivalent of a Listed Impairment. SSA maintains a “Program Manual Operating System” (POMS) which is a policy guide for ODARs and ALJs: at DI 25201.005, the POMS addresses how SSA determines disability for children: beside finding the POMS itself, you can view this specifically online at [https://secure.ssa.gov/apps10/poms.nsf/lnx/0425201005](https://secure.ssa.gov/apps10/poms.nsf/lnx/0425201005). Additionally, there are a succession of Social Security Rulings, which address the significant children’s issues: they are found at SSR 09-1p through SSR 09-8p; they are interspersed throughout the 2009 Federal Register.

Juveniles are also treated differently in the mechanics of disability practice. As an example, there is a separate Listing Of Impairments for children, distinct from that applicable to adults. As few younger than eighteen have been gainfully employed for any period at all, it is the rare juvenile who qualifies for disability insurance benefits. The Listing Of Impairments is found in
the Code Of Federal Regulations, known as the Appendix 1 to Subpart P of Part 404, Part A (Adult Listing). The Children’s Listing is found in Part B of that Appendix. The Listing pertains to ALL disability cases, regardless of whether an adult or juvenile, Title II or XVI. It is a catalogue of human ailments, separated into body function, such as musculo-skeletal or cardiovascular or neurological. More will be added later, pertaining to The Listings, but it must be borne in mind that it is central to all cases, and its importance cannot be minimized.

SURVIVING SPOUSE/CHILD BENEFITS:

A spouse who survives a recipient of Title II benefits is eligible to claim his/her deceased spouse’s benefits only if the surviving spouse has a demonstrable, provable disability, independent of the deceased spouse. There is very little “wiggle” room, either for advocacy or interpretation. Primarily, the only reasons for pursuing the deceased spouse’s benefits would be if the survivor does not qualify for Title II benefits on the merits of the surviving spouse’s claim, or more money could be realized from the deceased spouse’s account, than on that of the survivor.

Along the same lines, SSA will award disability benefits to a surviving child born out of wedlock to a now-deceased father, but only if paternity were established, or could be established within a short period after the father’s demise. Elements of state law are important, to determine within how much time after the father’s death a claim could be made on his estate. For purposes of this issue, familiarity with Indiana paternity law is important: See Indiana Statutes §31-14-1-1, et seq.

In any of the SSA programs, the burden of proof never shifts away from the claimant, at least to demonstrate the claimant’s initial entitlement. The law applicable to any program is
basically the same, and can be found in Title 42 of U.S.C., as well as in the Code of Federal Regulations and the decisions of the federal judiciary. As The Act is federal law, Social Security cases are exclusively the domain of the federal government.

In either case, where the attorney makes his fee is from past-due benefits. Unless extraordinary circumstances exist, the maximum an attorney can earn is Twenty-Five per cent of the past-due benefits, which are due to a claimant. In both Titles II and XVI cases, the successful claimant will receive those past-due benefits, less the Twenty-Five per cent which the agency will withhold and pay direct to the attorney. The maximum fee which can be paid, without special approval, is now Six Thousand Dollars (effective June, 2009).

**PRACTICE TIP:** As with so many other federal programs, there are forms which are common to Social Security practice. Log onto the Government Printing Office or Social Security websites, and applicable forms are readily available. See the Appendix to these materials. It is good practice to submit a Fee Agreement or contract executed by you and your client, at the time of your appearance. If done and if you succeed, you need not file a Request For Permission To Charge a Fee. If you fail to do this, at the successful end of the case, you will be required to file such a Request, itemizing the time you’ve spent on the case.

**ANOTHER PRACTICE TIP:** ALWAYS bear in mind that you cannot charge or receive a fee in ANY dealings with Social Security, unless the fee is approved by the agency, or the last judicial authority [judge, Appeals Council, &c.] has approved it. In cases involving recipients receiving overpayments, and Social Security requesting reimbursal, there are NO past-due benefits, so there is no ready source of payment. If arrangements are made for an attorney fee, any money changing hands MUST be escrowed or put in a trust fund, pending approval by the agency.

**YET ANOTHER PRACTICE TIP:** SSA has implemented, effective in 2007, a requirement that if you want to receive either direct deposit of your successful DIB/SSI fee into your bank account, or if you want to receive a check, you MUST file the proper form with the agency. One of those forms is found in my Appendix: Form SSA-1699. Another form is supposed to be filed with each case in which you appear, also copied in my Appendix: Form SSA-1695.
SUPPLEMENTAL SECURITY INCOME:

SSI was originally intended to replace the individual states’ programs which funded aid to the disabled, blind and elderly. Indiana had such programs, which were allowed to expire once the federal SSI program was in place. The old Indiana Aid to the Disabled program paid a pittance, if that. As with welfare benefits (which SSI is often claimed to be), the disparity in payments between the wealthy and poor states was so great as be a gross embarrassment. Just as with the opportunity to abuse welfare, SSI has been abused, requiring agency and Congressional vigilance; just as with welfare, the SSI program has become the target for politically-inspired publicity. SSI is the source of disability benefits for children.

Other distinctions between the programs are that if the successful DIB claimant has children, SSA will pay not only monthly benefits to children of the claimant, but will also pay past-due benefits to the children. Generally, children (and spouses, if applicable) are entitled to one-half of that sum which the claimant receives; the one-half to which the children are entitled is divided amongst all of the claimant’s children, whether born in a marriage or out of wedlock (but only if paternity is established). The total of benefits payable to the disabled person and his dependents is called Family Maximum. However, the most significant difference between the two programs is money: SSI generally pays at most about two-thirds of what is paid to DIB recipients and pays nothing for children.

SSI has an asset limitation, such that a recipient can only own $3,000 in assets. There is no retroactivity of application in SSI cases, but is available for at least twelve months in DIB cases, if all requirements are met. DIB recipients are eligible for Medicare after 24 months of benefits; SSI
recipients are eligible for Medicaid coverage, in most states. DIB payments are based upon the Claimant’s earnings record; SSI payments are set by Federal mandate.

The primary distinction between the two disability programs, however, is the eligibility for DIB: to be eligible, a claimant must be currently insured, which requires working twenty of the last forty quarters prior to the onset date of the impairment or impairments which are claimed to be disabling. [The “onset date” is an important date, one significant at all stages of the disability process.] A “quarter” refers to a quarter of a year. In other words, to be eligible for DIB, a claimant must work five of the last ten years. For 2009, a Claimant must earn at least $1,090 in a quarter, for that quarter to count towards the 20/40 rule.

If not, even one quarter short of twenty, the claimant is not eligible for DIB. See 20 C.F.R. 404.130. In addition, SSI has an aspect which distinguishes it further from DIB: to be eligible for SSI, not only must the claimant be able to prove that he/she is disabled medically, but also that there is no source of income which can be “deemed” to be accessible to the claimant. 42 U.S.C Section 1382a. Thus, a claimant might well be medically eligible for the program, but because a spouse has income above the allowable maximum, no benefits will be paid. It is obvious that a dissolution or legal separation might be necessary for the SSI claimant to receive benefits, however distasteful.
DISABILITY DEFINED:
The definition of disability, for Title II purposes, is found at 42 U.S.C § 416(i):

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

The simpler definition is the inability to work due to any mental and/or physical impairment or combination of impairments which have lasted at least 12 consecutive months. Social Security law defines some of these terms specifically. For example, “substantial” and “gainful” are defined in both DIB and SSI regulations [20 C.F.R.,Sections 404.1510 and 416.910]; almost all significant terms used by SSA are further defined in the various decisions of the federal judiciary. Substantial, gainful activity may be significantly less than forty hours a week; it may include such as sheltered workshop employment. For example, as of January, 2001, the regulations specified that SGA was met with $740 per quarter; in 2009, the standard is $1,090 per quarter. As with so many areas of law, cases are judged on an individual basis; the facts of each case are almost as important as medical evidence of the claimant’s disability. As can be seen, any CFR section starting with “404” applies to Title II (Disability Insurance Benefits), while CFR sections starting with “416” apply to Title XVI (SSI).

Although the definition above does not so state, claimants with mental AND physical impairments may be just as eligible as those with only one type of impairment, just as claimants with multiple impairments (presumably physical) may be as eligible as claimants with only one impairment.
A “disabling impairment” is defined at 20 C.F.R. 404.1511 and 416.911:

... an impairment (or combination of impairments) which is so severe that it meets or equals a set of criteria in the Listing Of Impairments ... or which, when considered with your age, education and work experience, would result in a finding that you are disabled ...

As individual claimants may have what SSA calls “concurrent claims,” for both DIB and SSI, it is vital that the practitioner be aware that there are two separate and distinct titles of the US Code which apply, two separate and distinct sections of CFR. Although many are identical, as above, care must be taken to assure that requirements are met, for each program.

PRACTICE TIP: Bear in mind that regardless of whether a DIB or SSI case, or a concurrent case, the amount of past-due benefits will not be increased by the number or type of claims: only one past-due benefit total is used, and that total is the source of an attorney’s fee.

ANOTHER PRACTICE TIP: The maximum which an Administrative Law Judge can approve as your fee, is $6,000.00. However, the agency charges a small service fee, which was attacked successfully by practitioners. IF the time and work involved in your case exceed that amount, you can request whatever the amount, IF you and your client have agreed, OR if you are willing to pursue it through the Chicago office of the Regional Chief Administrative Law Judge, and however further your request goes, until paid or resolved. [That assumes that either the past-due benefits will cover the sum, or the client has independent sources of funds with which to pay.]
D. Abbreviations/Acronyms:

There are myriad abbreviations, acronyms, mnemonic devices, ad nauseum: here are some of the more important, in no particular order:

DIB/SSD: Disability Insurance Benefits/Social Security Disability
SSI: Supplemental Security Income
SSA: Social Security Administration
SSR: Social Security Ruling
AR: Acquiescence Ruling
L/I or LI: Listing of Impairments
OASDI: Old Age, Survivors & Disability Insurance
ODAR: Office of Disability Adjudication & Review (formerly “OHA”)
ALJ: Administrative Law Judge
Title II: DIB/SSD
Title XVI: SSI
EAJA: Equal Access to Justice Act
NOSSCR: National Organization of Social Security Claimant’s Representatives
ADLs: Activities of Daily Living
DDB: Disability Determination Bureau (the ‘state agency’)
GRIDS: The Medico-Vocational Guidelines (found in CFR)
ME: Medical expert – a doctor who appears & testifies (often) at hearings
VE: Vocational expert – hired to appear and testify at hearings
RFC: Residual functional capacity
RFCA: Residual Functional Capacity Assessment
PCP: Primary Care Physician
MSE: Mental Status Examination
PRW: Past Relevant Work
SGA: Substantial, gainful activity

E. SORTING THROUGH MEDICAL/VOCATIONAL ISSUES:

In all disability cases, there will be medical issues. The very definition of disability involves medical issues. Obviously, if your client does not have a recognizable ailment, even if esoteric and exotic and uncommon, SSA is not going to allow benefits based on a package of symptoms. Even if your client has a recognizable, known ailment, which can disable people, if he/she is not
under a doctor’s care, on an ongoing (or as SSA likes to say, a “longitudinal”) history of medical attention, there is not much chance that that client will prevail.

The same is true for vocational issues. All disability cases will involve them. In SSI cases, there will be just as much need to prove what the client formerly did, as in DIB cases. A work history is vital to the construction of a vocational profile, which should be done for all clients. This work history includes the client’s age, highest educational level attained and jobs held in at least the last 15 years. Each job can be categorized in terms of physical exertion required, skill level, and whether the job constitutes Past Relevant Work. That term is defined in the regulations. Throughout all of my materials, there are references to vocational issues, how to approach them, what can be done to confront these issues, &c.

F. REMEDIES UNDER ERISA

Frankly, I have no idea how ERISA [29 U.S.C. 1001] applies to disability practice. So, I googled it & cadged some information, which follows. The following two paragraphs are from a class action law firm, Lieff Cabraser of San Francisco and New York City:

The Employee Retirement Income Security Act of 1974 (“ERISA”) imposes obligations on employers who control or administer their employees’ pension plans. This is because an employer is generally a fiduciary, with the authority to control and manage the operation and administration of the plan.

ERISA sets minimum standards for the administration of plans and the investment of plan assets. It does not require employers to offer a certain level of benefits to its employees, or to offer employees any benefits at all. For this reason, the language of the plan document is often determinative. It is therefore extremely important to know what your plan says, and to insist on seeing a copy of the plan document yourself, rather than simply relying on assurances by your employer or your employer’s representatives.

Simply from a review of the websites and sources of information, including Wikipedia, there is no correlation between ERISA and Social Security Disability, except that if a Title XVI
claimant has ERISA rights from a former employer (by definition, more than five years before application), those rights might run afoul of SSI’s asset limitations for eligibility.

G. RESOURCES AVAILABLE TO YOU

Now that West Group publishes almost all legal treatises, statutes, hornbooks and periodicals, here is a list of Social Security materials which you might consider (if not published by West, it will be noted):

1. *Social Security Laws* – this is a West Group compilation of selected statutes and regulations, in a one-volume soft-cover handbook. It is essential for the practice of Social Security law. The alternative is to have the US Code, Code of Federal Regulations and lots more.

2. *Social Security Disability Claims, Practice & Procedure*, West Group, written by Barbara Samuels – a three-volume treatise, which includes Social Security Rulings, commentary and practice guides. A decent set; unfortunately, the cost of the set is not very low, but far exceeded yearly by the cost of the “cumulative” supplement (in 2008, the Supplement cost over $600 – in 2009, even more!).

3. *Medical Proof of Social Security Disability, 2d*, West Group, written by Ann G. Hirschman – it is essential to have a medical commentary, to aid in deciphering the ins and outs of medicine, impairments, etc. This set is written to coincide with the Listing Of Impairments and as such, details what is needed to establish impairments for disability purposes.

4. *The Merck Manual* – now in the umpteenth edition. It is far too specific to be of total use to an attorney handling disability practice, but it is a legendary book, detailing all kinds of human maladies, from the mundane to the lethal. A good background work. Several “home” medical
books, e.g., Merck and Columbia University and the Mayo Clinic publish works for “home” use – these books are equally useful in a disability practice.

5. *Stedman’s* or *Tabor’s*, or similar medical dictionaries. The legal publishers print medical dictionaries, in print or on CD-Rom. Having a medical dictionary at hand is a necessity. Or, log on to [http://cancerweb.ncl.ac.uk/omd/](http://cancerweb.ncl.ac.uk/omd/) - an online dictionary! Here’s another good one: [http://www.mondofacto.com/facts/dictionary](http://www.mondofacto.com/facts/dictionary).

6. Both West and Lexis-Nexis publish CD-Roms dealing with Social Security. The West version is excellent but very expensive, justifiable if you have a substantial practice. That disk includes various components, some of which are readily available, some are much harder to obtain. For example: the *Dictionary of Occupational Titles*, Federal cases pertaining to Social Security, some of SSA’s internal operations manuals and directives, all are available on the West disk.

7. *Diagnostic & Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV): published by the American Psychiatric Association. A most valuable tool to aid in the handling of mental health impairments, defining and describing the ailments, current treatment, etc. When it is ordered, the order includes a codification of the DSM-IV, more portable and cursory, but more easily *schlepped* to the OHA for a hearing. There is new edition now available.

8. *The Pill Book* – published in paperback by Bantam Press, now in the 13th Edition – another must. If you’d rather spring for the Physician’s Desk Reference, fine: that costs far more, is updated yearly, and contains information which is useless to normal mortals. Or, for $7.50, you can buy *The Pill Book*. 

10. James Publishing, Inc. publishes several valuable books pertaining to Social Security. In particular, Thomas Bush’s two-volume set, *Social Security Disability Practice*, is especially worthwhile. James also publishes at least four other sets, of which Morton’s *Medical Issues in Social Security Disability* and *Social Security Medical Tests* are also worthwhile. Another publication is James’ *Social Security Advisory Service*, which is most valuable when drafting briefs anywhere along the appeals process, when searching for judicial approval of a point which you wish to raise.

11. There are several internet sites which contain information vital to disability cases: for example, West Group’s MY FINDLAW allows access to decisions of state and federal courts, to Social Security forms (through the Government Printing Office). WebMD and Medline offer basic medical information in an encyclopedic form, useful to gain insight into the nature and complexity of the severe ailments which our clients present. Social Security operates its website, which is [http://www.ssa.gov/disability/](http://www.ssa.gov/disability/). From that website, you can get the HALLEX and POMS information, perhaps even some of the materials which SSA has prepared for vocational and medical experts. Cornell University has a site, pertaining to disability cases: [http://www.law.cornell.edu/socsec/](http://www.law.cornell.edu/socsec/). It includes materials of value, worth a look when you are scarping for information.

12. West Group issued a specialized Westlaw package, for the specific use of Social Security practitioners. The cost is not inconsiderable. Its principal advantage is that it can provide up-to-
the-minute case law reports, any new CFR or Federal Register postings applicable to disability practice, and the like.

13. If you wish to fully immerse yourself, you can purchase the *Dictionary Of Occupational Titles*, which is a heavyweight volume by itself. Also necessary, for full review of jobs which your client may have performed, is the companion work, *Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles*. Together, these two works will cure anyone’s insomnia; they will also give you invaluable information, perhaps to counter a vocational expert who doesn’t expect you to know a great deal about vocational matters. Bear in mind: the DOT is old – it won’t contain a lot of tech-heavy jobs which now exist as a direct result of the electronics revolution; no one but SSA uses the thing anymore – even the Department of Labor has abandoned it.

Your Social Security reference library may be small but that doesn’t mean that you are without sources. If the Nora Library in Indianapolis has the DOT, it is likely that the Central Library has it as well, and perhaps other branches, too. The City-County Building law library, on the 3rd floor of the center tower, has at least one treatise on Social Security. Whether a district office would allow access to the HALLEX or POMS manuals, I cannot say. Persons more conversant with computers and the worldwide web can certainly obtain more information.
A. DEVELOPING A NEW DISABILITY CASE:

Deciding which cases to accept is the same in disability practice as in any other practice area: the primary determinant in disability cases is, however, medical evidence. Has your client a continuing and ongoing relationship with doctors? Has he/she only been seen periodically and only at clinics or Hill-Burton hospitals, such as Wishard in Indianapolis? All disability cases turn on medical evidence: without it, a case is a tough slog.

To make a determination whether a potential case is acceptable, at your initial interview with a new disability claimant, with a case which you wish to pursue, ask:
Who is/are your physician(s)?
For how long have you had a physician-patient relationship?
How complete is your doctor’s file?
   a) Have you been referred to specialists by your primary care physician?
   b) Does your doctor have a copy of specialists’ reports?
How often do you see your doctor?
Has your physician expressed an opinion as to your ability to work, or to return to your former work?
Has your doctor refused to ‘release’ you to return to work?
Is the client still employed?
Get a work history from the client
6) Establish the date of onset and the last day of work. And the $64 question:
7) What prevents you from working? Or,
8) Why can you not go back to work? And, in this age of HIPAA rules:
9) Can the client easily get a copy of his doctor or hospital’s file?

PRACTICE TIP: The contract with your clients should include provision for how the cost of medical records will be handled: by the client, by the lawyer, by a division of the cost? Your client’s close relationship with the doctor(s) may relieve both of the not-inconsiderable charges for patient charts and files. A copy of the fee contract that I have used for years, is in my Appendix.

If the client has a “longitudinal history” [that is a phrase which resonates with Social Security!] with the same doctor(s), if the doctor(s) appears willing to go to the wall for your client, if the client’s medical history can be easily documented, and if cogent reasons can be expressed why the client cannot return to former work or any other work found in the region, then the case is well worth pursuing.

PRACTICE TIP: During your interviews with your client, separating the client from any other person (spouse, parent, child) may be necessary, to allow the client the opportunity to speak for him/herself. If he/she cannot speak for him/herself, there is a large problem – if there are medical reasons for the inability, it may be worth pursuing as a separate impairment, or symptomatic of such. If the client is reluctant talking frankly of his/her circumstances, you have a problem!
1) INITIAL INTERVIEW – ESSENTIALS

In conducting the initial interview with a new client, my format adheres to a certain formula: my questions *always* follow the same routine:

- Inquiry generally: name-address-telephone-Social Security number-
  marital status – minor children – total number of children, grandchildren – whether the claimant can read & write – ever in the military – height –
- weight (including whether claimant’s weight has fluctuated, up or down; whether the stated weight is the usual weight for this person.

Education: how far in school – any post-high school education- vocational training – if in the military, what training there – GED – when the claimant would have graduated high school.

3) Work history: name & location of jobs worked, starting with the most recent – what title, if any, to the work – what were the job duties, with special emphasis on lifting and carrying (what weights, how frequently) –
- why did the job end – any long gap between jobs – any specific training or skills learned at the jobs, which could be used later. You MUST get the LAST DAY WORKED: it is important to your later case development.

Medical history: prior to the onset (another important landmark: the ONSET DATE of the claimant’s disability – it may/may not be the same as the last day worked), did he/she have significant health problems – if so, describe. Include hospitalizations, with the name of the hospital, admitting/attending MDs, and why hospitalized.

Names, addresses, telephone & facsimile numbers for all doctors, counselors, psychiatrists, psychologists, therapists (including physical and occupational therapists) – how long has the claimant seen each MD and for what specific ailment –

The names and milligrams, dosages, prescribing physicians for all prescription drugs being taken by the claimant.

The claimant’s symptoms, including pain, fully described.

Physical Activities: what can/can’t the claimant do?
Activities of Daily Living (ADLs): how does the claimant spend an average day/what exercise does claimant get/what housework (if any) does he/she do.

This list of inquiries is one that I have used for years, as a pre-prepared set of questions, tracking the nine categories above; if answered properly, it is the first step in winning the case. They are intended to be used at an initial interview. There is a separate set of pre-hearing questions, to be used in preparing for the hearing, which the client should be prepared to answer, even if all of them will not be asked. This latter set is included in my Appendix.
B. EVIDENCE - MEDICAL

1) Your Doctors

The regulations discuss medical evidence at 20 C.F.R., Sections 404-1525 through –1546. An attorney’s need for medical evidence is never-ending. While SSA and the ALJs are usually content to ask just enough questions, which approach the disability issues in a tangential way, it is the attorney’s job to be certain that the questions are directly answered by the claimant’s physicians. Throughout the process, SSA relies upon that medical evidence which it obtains, independent of but also from the claimant’s doctors; the nature of the information gained by SSA depends upon where the case sits, in the appellate process. As claimant’s counsel, it is your responsibility to communicate with the claimant’s doctors, and TRY to obtain that information which will assure a win.

At 20 C.F.R. Sec. 404.1527, SSA describes how it will evaluate medical opinions. Further, SSR 96-2p, one of those 1996 rulings which are VERY important, talks directly of whether controlling weight should be given to treating physician’s opinions. A doctor who says only that the claimant is disabled and cannot work has failed to give any insight to the claimant’s medical condition, treatment, prognosis, much less the bases for the doctor’s opinion. The best information the attorney can obtain is the doctor’s file or chart: can it be copied? Can the doctor explain the ailment, in terms of its effect upon the claimant? What diagnostic tests and procedures were performed, which support the diagnosis? (Getting copies of the test results is as important as the doctor’s narrative.) To what specialists was the claimant referred and what were their findings? Specialists tend to charge far more for medical reports than general practitioners, internists and family practice physicians; however, specialists generally will, at the least, send a report to the referring doctor, stating the findings. If you are able to get a copy of the original physician’s file or chart, it may well contain valuable information at little or no charge. Convincing doctors, or their staff, to copy a file is a very tough chore, but ultimately, getting that copy may well be the single act which wins your case. Be prepared to pay for that copy; the wise practitioner mentions an expectation of receiving a bill.

If your client is indigent, however, obtaining medical evidence is a huge problem: dealing with public hospitals is very difficult. For example, Wishard Memorial Hospital in Indianapolis is the local facility charged with the responsibility for treating indigents; its staff consists in part of medical school professors, but more likely residents, interns and the like, some of whom are here today and gone tomorrow. The public, however, usually sees the doctors who rotate, such that your client could see a number of doctors, none of whom are available when you need a medical report. Moreover, the cost of the client’s chart will usually top Fifty Dollars – if your client has no money, guess who might be fronting for it?

2) Their Doctors:

At both the initial application stage and at the reconsideration review levels, SSA delegates the medical and vocational decisions to the Indiana Disability Determination Bureau (DDB), an arm of state government which is a sister of the Vocational Rehabilitation Services agency. This is common practice. When a client receives a rejection letter, the envelope may be postmarked from Baltimore (SSA HQ), when in fact the decision and letter were both generated locally.
At both application stages, the DDB uses physicians to review the written record, as it exists at the particular step in the process. A large number of these doctors are retired. The decision these physicians render is almost always determinative; it is rare, especially at the reconsideration stage, for a claimant to win. In forty years of practice, this writer has personal knowledge of only a few claimants who have won at that level. There is, however, no reason why you cannot submit medical evidence to the DDB, in the hope it might convince. These decisions are always based ONLY on the written record – at early stages of the process, it is unlikely that your client’s physicians have submitted anything of great substance or length.

Preparatory to reconsideration and more frequently, to a hearing, SSA will refer claimants to physicians of their choosing, for what is known as a consultative examination. See 20 CFR Sec 1517-1519t. The more conscientious consultative doctor treats the claimant as someone deserving of time and empathy. The longer in practice, the doctor realizes how a cursory review is the most advantageous from a dollars-&-cents standpoint, wastes the least time, and by not finding a demonstrable disability, means that he/she will get repeat business. The lawyer must confront these medical reports and be prepared to controvert them. If the claimant’s doctor can review the documents prior to hearing, and respond in a positive way, the lawyer is not merely doing his/her job, but taking strides towards success.

Underlying this is the necessity to see the Social Security file as soon as it is available. You can copy the file at the OHA, or there are persons who copy files for a nominal fee: L&W Printing & Disability Copying Service, Fax 738-4771, is a service I have used to copy files. The charge is usually about Fifty Dollars. Cheaper than your hourly. Over time, the file will be sent to you by ODAR, on a CD-Rom – if your computer can’t open the disk, send it to L&W.

3) Burden of Proof:

See 20 CFR Sec. 404.1512. The burden of proof is on the claimant. If in a hearing, it is possible that the burden might shift to SSA, but that requires certain facts be demonstrated. The claimant’s attorney must assume that the burden is always the claimant’s; one cannot be lulled into believing that SSA or the ALJ will work to make your case.

4) Vocational Evidence:

Vocational considerations are covered by 20 CFR Sec. 404.1560 through -1569a. The vocational factors (age, education, work history and residual functional capacity) appear again: this is the vocational profile. This profile recurs throughout disability cases, whether DIB or SSI. SSA generally is satisfied with proof of the claimant’s work over the past fifteen years; however, it is wise to go as far back as can be shown, even if back to high school days. Each job which the claimant has worked must be listed and catalogued at the initial interview, in terms of exertional level required, skill level attained and skills learned (to determine whether the skills are transferable to another job), why the job ended, whether some special attribute helped the claimant get the job or advance in it.

Earlier, mention was made of the Dictionary of Occupational Titles (DOT). It is vital that the lawyer know of and be familiar with the DOT. It was produced by the US Dept. of Labor. It catalogues jobs in various ways, including skill and exertion levels. Its importance in SSA cases is that in situations where the ALJ believes that a case for disability can be made, a vocational expert (VE) is brought in. Often, these are employment counselors, who have familiarity with the DOT; if the attorney can demonstrate error in the selection of proposed job alternatives, which
the claimant can supposedly do, the credibility of the vocational expert and worth of his/her testimony may be dented. The DOT can be found in local libraries, much less at a law library. It is possible to access it via the internet. Merely going through My Findlaw, the West Group online service, or going through the US Government’s websites, the DOT can be located. Along with a sister publication, Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles, you, too can converse intelligently with SSA’s vocational witnesses. Bear in mind: the DOT was last revised almost twenty years ago; its definitions of jobs are that old; our society has evolved since then.

PRACTICE TIP: if your client has not seen the Indiana Vocational Rehabilitation Services agency, it is a good idea to refer your client to that agency, for an evaluation and review of the client’s situation. This creates a win-win situation. If your client is disabled, the caseworkers for Vocational Rehab will so find: if that is the case, you have manufactured a witness, whose reliability is without question. If the result of your client being evaluated is that your client can be rehabilitated or retrained, all to the good. Comparing what a claimant can receive from employment vs. DIB, it is not much of a comparison.

5) Lay Testimony:

Obviously, the claimant is his/her own best witness. As evidence is given in an administrative, non-courtroom setting, as the rules of evidence are not adhered to by ALJs, your client can include hearsay, such as what the claimant was told by doctors or vocational rehab people, or by his employer or supervisor, are just as valuable as any other evidence. Your client should be counseled that putting on a show is not merely bad form, it is an invitation to disaster. However, there are certain things which clearly apply: for example, the “sit & squirm” rule. This unwritten, unstated “rule” assumes that if a claimant has a bad postural or musculo-skeletal problem, eg, a bad back, he/she won’t sit rooted to a chair – the claimant will sit & squirm.

Thus, it is your job to make certain your client understands that he/she cannot sit inert. If it occurs, it is your job to ask if the claimant is nervous, upset, tense, if he/she slept well, what pain level he/she is now experiencing and whether worse than yesterday. A “Good Day-Bad Day” comparison is important, sometimes used by ALJs. On a scale of 1 to 10, with a “1” being symptom-free and a “10” the absolute worst – ask your client what kind of day he/she is having today – describe the last week and compare it to the week before. AND, don’t let your client understate the severity of his/her circumstances!

PRACTICE TIP: Social Security judges will often inquire of claimants: “what is it that prevents you from working?” Or, “are there any jobs that you think you can do?” Your client MUST anticipate these questions; your pre-hearing preparation demands that your client know that by simply saying that he/she has a particular ailment, the question hasn’t been answered! The claimant MUST be prepared to detail the symptoms which the ailments produce, as well as the effect on him/her which those symptoms generate. Treat these questions as softballs which your client must know are coming, and be prepared to aggressively answer. If the ALJ doesn’t ask the questions, then you MUST.

ANOTHER PRACTICE TIP: No one knows the pain level endured as well as the claimant. Pain is curious factor in SSA law: because it is subjective, because it cannot be demonstrated by X-ray or other “objective” testing procedure, SSA has developed a body of law pertaining solely to
pain. Attached to these materials, at the back, is a form which has been adapted from an old, now-replaced Social Security Ruling, SSR 88-13, which detailed pain questions. Your client MUST know how to respond to these questions in detail. You MUST be prepared to ask these questions of your client, during a hearing, to assure that the ALJ hears the level and severity of the claimant’s pain. The judge will not inquire into detail: you MUST.

If your client’s last employer or supervisor is willing to come to the hearing, these are prime witnesses. This person can tell what the claimant could formerly do, what he/she was able to do at his last days at work, what deterioration the superior has seen over what time frame; whether your client can do the same work as before, or a job with fewer demands on the claimant. If you cannot produce these persons during a hearing, you are free to obtain written statements or letters from employers, supervisors, co-employees, &c., which evidence is admissible and which is very useful.

PRACTICE TIP: Assuming employers, supervisors or co-employees cannot appear in person at the hearing, you should correspond with employers, supervisors or co-employees, carefully drafting your letter to each person, eliciting what they have seen your client do or what your client cannot do, while on the job; the discomfort level which the client experienced on the job, whether that is pain, or shortness of breath, or inability to lift/carry, &c.. If these persons can relate what a great employee he/she was before the ailment struck him/her down, the deterioration in your client’s situation before finally stopping work, that is wonderful evidence to support your case!

It is imperative for the lawyer to ask the client about depression, if it or other mental impairments are not already listed as impairments suffered by him/her. The reason is simple: those who have worked their entire adult lives, especially if at arduous physical work, and they suddenly find that they are no longer capable of doing this, now encounter financial and perhaps marital distress, are spending their days sitting around incapable of functioning, these people will be depressed. They rarely see a psychiatrist, psychologist or mental health counselor. It is possible that a general practitioner might prescribe anti-depressants. However, ALJs tend to discount such prescriptions, because the doctor issuing it is not a specialist. Fair? No, but it regularly occurs. Attached at the back of these materials is a Depression Check List, which this writer has relied upon for years: it inquires as to many of those depression symptoms, common to those who suffer from it.

Familiarize yourself with the signs and symptoms of depression. A source which is of great value is the Diagnostic & Statistical Manual-IV (known as the DSM-IV); it has been revised and re-issued recently. It is published by the American Psychiatric Association, and is the bible by which mental illness is defined. Sleep disturbance, unexplained weight loss/gain, feelings of hopelessness, worthlessness, suicidal thoughts, anxiety, all are symptoms prevalent in disability cases, and often ignored by counsel. These symptoms are detailed in the Check List mentioned above.

The spouse or adult child of the claimant is a potentially valuable witness; he/she could do more than support, in terms of degree. Does the claimant understate his/her problems? Is the claimant unwilling to accurately testify as to how bad his/her symptoms are? Bear in mind that merely cumulative evidence will not assist; the spouse must be as well prepared as the claimant.
D. THE SOCIAL SECURITY FILE

1) Where to see it?

As soon as the Office of Disability Adjudication & Review (ODAR) receives the file from the District Office, a claimant’s attorney can request a copy. That may not always be advisable, because the file has not completed “work-up,” the papers have not been separated into sections, and it might be harder to follow without that separation. Work-up is the process by which ODAR personnel sort and collate the various documents, from the initial stages of the application through the most-recent evidentiary submissions.

Assuming it has not been shipped out of town for work-up, the attorney can see the file. Merely reviewing the file at the ODAR and not outside it, is tedious, uncomfortable and unnecessary. Either the attorney, his/her staff or third parties can copy the file; for a more leisurely, comfortable review in the office, let someone else do it for you. Prior to the setting of a hearing, ODAR will put case files on a compact disk and mail it to Counsel – be sure the disk is compatible with your computer’s programs, or else easy access is not easy at all!

2) How To Get A Copy?

Call the ODAR and ask for a time to go to that office and use their copier. Or, call one of the services which, for a modest fee, do the work for you. A couple of suggestions: if there are specific things which you do not want copied (as, for example, exhibits you have submitted and already made a copy), or if you want three-hole punch vs. two-hole punched paper, you can give instructions. The service I have used is mentioned earlier in these materials.

3) How Vital?
Do not attend a hearing without knowing its content!

E. HOW TO FILE A CLAIM

There are two or three ways to file a claim. First: your client can do the work him/herself. The client can: a) go in person to the nearest district office, or as in Indianapolis, the nearest branch district office. There are “branch” offices, for example, on Post Road, and another at about 4200 Lafayette Road, in Indianapolis. Or, b) the client can call Social Security’s toll-free line, and the information required for an application can be submitted to the agency. Or, c) if computer-literate, the claimant can log onto Social Security’s website and fill in an e-application. SSA will ultimately expect attorneys to file EVERYTHING electronically – if you are not computer-literate, make sure someone in your office is!

If the client would rather that you do so, the agency is switching to electronic filing. Again, if you aren’t computer-literate, you can have problems. There have been training sessions in the past; contacting the Manager of the Indianapolis area district, Maurice el-Amin, will likely get answers for you or your staff.
PRACTICE TIP: It is imperative that you know that there is a 60-day window between the stages of the appellate process: after every decision, the law allows sixty days in which to request the next stage. In fact, SSA allows an additional five days in which to proceed, on both receipt of the denial by the claimant, and five days for the agency to receive the request for the next stage of the process – this is to offset the vagaries of US Postal Service “service.”

F. PREPARING THE CASE – CLIENT AS WITNESS – WHAT ALL REPRESENTATIVES MUST KNOW PRIOR TO ODAR HEARINGS

At during either the initial application or reconsideration review stages, the Disability Determination Bureau [DDB] can send your client for consultative examinations by local physicians. The DDB is an agency of Indiana state government, a sister agency to the Indiana Vocational Rehabilitation Services agency, under the Family & Social Services Administration. It is wise to speak with your client prior to and after such examinations, largely because the attorney needs to know: a) how long was the exam; b) what did the doctor do; c) was there any physical examination done and if so, what; d) what if anything did the doctor say and what questions did he/she ask your client. The information gleaned might tell you what the DDB was looking for, or emphasized, in alerting the consultative doctor. Bear in mind also that this doctor has only the DDB medical file (if information has already been obtained by the agency from your client’s doctors): this will be the first in-person opportunity for your client to register a favorable impression on someone paid by SSA. Also, at an ALJ hearing, the judge could well inquire of you, as to how your doctors and your position differs from that taken by the “agency doctors.”

Before one gets to the hearing stage, it is imperative that counsel understand those steps in the process which precede the hearing. Those steps in the process are outlined immediately following:

a) INITIAL APPLICATION:

See above for the ‘how-to.” Other than discussing what the entire process entails, there is only a limited role for counsel at this stage. Too many applicants do not realize that the rejection of the initial application is not the end of the process; it is common to interview clients who have filed multiple initial applications, without any being pursued through the process. However, from an attorney’s standpoint, it is vital that, with knowledge of prior applications, in reviewing the SSA file on the claimant, the practitioner can know which of the ailments still exist, the level of severity, the impact on the claimant, and what additional evidence is necessary to adequately present the client’s case. Bear in mind: although hearings before the administrative law judge are “administrative” and not a court, certain trial court rules and legal theories still apply, e.g., res judicata. The initial application is filed with a local district office, as is the request for reconsideration. Although this may not seem related to preparing your client for a hearing
before an administrative law judge, complete familiarity with what has preceded the hearing will make thorough preparation of the client a much easier task.

PRACTICE TIP: The Social Security District Office will rarely give the claimant copies of the forms, which have just been filed. Because SSA routinely asks over and over about the claimant’s employment history, having reference to copies of the initial (and all later) SSA forms, including, for example, the Work History Report, will make future responses much, much easier. Also, it will allow claimants with faulty memories to easily retrieve information, allow for simpler hearing preparation (because the issue of work history will surface at the hearing), and assure consistency in claimant responses.

To be prepared for the initial application, the claimant should be ready with a list of his employers, how long the employment lasted, what the job duties were, what weights were lifted/carried occasionally and what lifted/carried frequently, what other physical requirements (bending, stooping, reaching, digital dexterity, twisting, use of hand and/or foot controls, climbing stairs/ladders, etc.). A list of jobs is very important; although SSA may not want it, why the jobs ended and how long the time space between jobs are important for the lawyer. A description of the “activities of daily living” (ADLs) is very important; they should be developed by the attorney, simply to keep these matters before the client. What housework, hobbies, chores are done? When? Do they take longer? Why? If done in ordinary time, what are the consequences? Assuming that your client is not much different from other claimants, assuming he will not prevail at the initial application stage and will need your services, by pursuing these matters at or about the time of the initial application, you prepare your client for future appellate steps, including the ALJ hearing.

The initial application is reviewed and if the person has not been disabled for at least twelve consecutive months, or is easily shown to be able to function, the likelihood is a denial. As with all SSA actions, the claimant has sixty days between the denial and the expiration of the right to proceed; there is generally an additional five days allowed, due to the unpredictability of the US Post Office. If your client calls with word that a denial letter has been received, your first words should be “when was the letter received?”

b) RECONSIDERATION REVIEW:

If the initial application was denied, you can file a Request For Reconsideration form for your client; along with that form, file a Medical Authorization form and a Disability Report - Adult. If you prefer not to do this, the claimant can go to any district office and file these; the disadvantage is that you have no input into what the claimant says, in response to the forms. Also, you might not get a clear, readable copy. The forms are a pain, it must be admitted, especially because they are more form than substance; the ALJs don’t put much credence in them, unless it allows some ghastly omission or admission on which an unfriendly ALJ can hang a negative decision. Thus, as hearing prep, it is important to know what was done in the earlier steps of the appellate process.

Both the initial application and reconsideration decisions in central Indiana are made at the Disability Determination Bureau, an Indiana state agency. There is no role for the attorney at either stage: no appearance is required, and legal advocacy is minimal. However, if medical evidence has been obtained, it can be submitted to DDB. The DDB sends informational requests
to persons designated by the claimant; family members are likely to be named. Those persons MUST BE PREPARED to give detailed answers; cursory responses hurt, especially because an opportunity to expand on the claimant’s ailments would be lost. Be certain to advise the claimant to have his designated third party call, or give you a telephone number for you to call: that third party can make a big difference.

c) ALJ HEARING

The Office of Disability Adjudication & Review [ODAR] calls attorneys of record, to schedule hearings. When the agency calls to set the date, counsel can inquire a) to which ALJ has the case been assigned and b) whether a vocational and/or medical expert is invited to attend. These are important, because knowing something of the ALJ and his/her conduct of the hearing is a part of your own preparation, and that of your client. The more your client knows about the hearing, knows what to expect, the better prepared he/she will be, the better he/she will be as a witness.

PRACTICE TIP: If you are not familiar with the judge, call other attorneys who handle disability cases. For example, one ALJ is notorious for conducting thirty-minute hearings. That judge cut me off in the midst of my examination of my client, called for my summation, and walked out of the room thereafter. The Appeals Council reversed him. If you don’t know other practitioners, ask the ODAR rep who calls to set the hearing.

1) Q+A

The ODAR sends the Notice of Hearing and a compact disk with the SSA file, about four to six weeks prior to the hearing. In the materials it sends will be a framing of the issues, as well as forms identifying any expert witnesses being called to assist the judge. Long before the ODAR calls, you should have seen and read the ODAR file. My practice is to read and review the file, taking notes on the file on my computer (if your handwriting is as hopeless as mine, this is a no-brainer!) – it organizes your notes, allows you to highlight those parts of the file which support the claim, and identify the sore points in the file which require a Q+A session with your client. It will certainly point out the huge disparities between what your doctors have said, and the forms filled out by agency doctors.

Once you have briefed the ODAR file and reviewed your notes, you should set a pre-hearing interview with your client. It is vital that the client be prepared: the pre-hearing interview cannot be conducted by telephone or email. Consequently, you must be prepared to interview your client.

Enclosed in my Appendix is a list of questions, a Q+A on which I have relied for years. You can adapt your client’s specifics into the forms: just as in paternity cases, the overall issues are always the same, as in disability cases, the issues are almost always the same. In preparing for the pre-hearing interview, I cross-reference the pages in my notes (the earlier interviews are conducted on my computer, for the same reasons as above: my handwriting wins no awards) and in the ODAR file with my Q+A sheets. That way, during the conduct of the hearing, I can instantly refer to my notes or to the correct page in the ODAR file. The claimant is ALWAYS given a set of my Q+A, along with a lot of other pages, such as the Depression check-list or the Pain questionnaire, so that he/she can review the lot prior to the hearing, so there will be few surprises.
2) BASIC INFORMATION

In all cases, there are basics which must be conveyed to the client: here are some examples.

I) If the claimant has back pain, or pain as a significant non-exertional limitation, the “sit and squirm” rule is involved. (“Non-exertional limitations” are a very important aspect of the case, in determining whether the claimant’s case is covered by The Grids, at Step Five of the Sequential Decision-Making process [see below for a description]. A list of these is included in my Appendix.) It is an unwritten rule, which most ALJs won’t acknowledge. The premise is that if your client has significant pain, he/she will not sit stock-still in the chair, but will sit and squirm – thus, if your client is uncomfortable sitting in place, you must tell him/her of this “rule.” Most clients are petrified of the hearing experience; letting the client know in advance is important, in large part to the client’s comfort level.

II) If the client claims that he/she needs to periodically shift from sitting to standing to walking, to relieve symptoms, tell the client that no permission is needed in order for him/her to stand, move about, stretch muscles, and the like. It is advisable, however, that if your client feels the need to stand, the client should excuse him/herself, saying something like “Excuse me, but I need to stand now.” The reason is that the hearings are recorded and unless the judge orally notes that the claimant has arisen, there will be no easy way of identifying when he/she stood. It spotlights the client’s need to move about. If your client fails to say anything about the need to stand, you MUST note the time and, when your time comes to inquire of your client, inquire of the client why he/she stood. If you are examining your client at the time of arising from the chair, you MUST state that the client has stood – that allows the opportunity to ask WHY he/she stood.

III) I believe it is important that the client be advised that this is an administrative hearing, not a court of record. Hearsay is permitted; the client can relate what his doctor told him. Expansive testimony is far preferable to simple yes-no responses. You want the client to talk as long as possible as to the reasons he/she cannot work, or cannot return to former jobs, or cannot do housework, or otherwise function. If asked “what keeps you from working,” the client must be prepared to answer in detail. Knowing the kind of detail that that inquiry requires, it is not a stretch for the client to understand that he/she is your side’s best witness!

IV) The client in ALL cases must be advised that if he/she doesn’t fully understand the questions posed, it is up to the client to ask the interrogator to restate the question. Disaster lurks for those clients who give the wrong answer; it requires the attorney’s diligence, to assure that if this happens, corrective action can be taken.

V) I believe that the more “human” you can make your client and his symptoms, the better. For example, I always inquire whether the claimant has children or grandchildren. If the client has back problems, inquire how young the youngest child/grandchild; if an infant or toddler, ask whether the client can bend at the waist to pick up the child; whether he/she can only pick up the child while the client is seated; or, no one trusts the client to pick up and hold the child because of physical problems, such that the child has to crawl onto his/her lap, or be handed to the client. Thus, taking events common to all of us and incorporating them into your routine questions, adds a dimension with which the ALJ can identify.

3) LISTING OF IMPAIRMENTS
BACKGROUND: ALJs use a five-step sequential evaluation process, to decide cases. The first step: is the claimant working? If so, except for special circumstances, the inquiry goes no further and the claimant loses. If not, the second step: does the claimant suffer from a severe impairment or combination of impairments? A severe impairment is one which significantly impairs the ability to work. If not, the case is over. If so, the third step: do the claimant’s impairments meet or equal the Listing of Impairments? If so, case is over, you win. If not, the fourth step is whether the claimant can do his former work. If the ALJ finds that he/she can, case over, you lose. If he/she cannot, the fifth step is whether, considering the claimant’s age, education, work experience and Residual Functional Capacity, he/she can do other work found in the regional economy. At the third step, the Listing is involved; at the fifth step, the so-called Grids are involved – more of The Grids in a moment.

The Listing of Impairments [L/I] is found in Appendix I of Subpart P of 20 CFR §404. Its purpose and definition are found at 20 CFR §404.1525. The Listing is a compilation of medical definitions of ailments and maladies common to mankind. Unfortunately, because medical science tends to precede legislative function in a geometric ratio, the L/I can often lag far, far behind current medical treatment. E.g., it was a long wait to get the L/I to cover HIV-AIDS. See L/I, Section 14. Familiarity with the L/I is just as vital as knowing the content of the OHA file: it pervades all aspects of disability cases, provides a framework for determining whether you accept or decline a case, whether you have adequate information, and a basis for asking your client’s doctors for information.

The L/I catalogues human ailments by body system; e.g., the first section covers musculo-skeletal impairments, including osteoarthritis, herniated disks, spinal abnormalities. The L/I describes that medical proof which is required to establish that a claimant’s ailment meets or equals the L/I definition. The standard is not absolute, however. If a claimant’s medical situation is “the substantial equivalent” of a listed impairment, the case can be won on that basis. In either situation, the claimant’s physicians are the only ones who can provide information about meeting-equaling-substantial equivalent.

PRACTICE TIP: You may want to consider copying the pertinent sections of the L/I and sending it to the client’s doctors, asking him/her to review the section and address how the patient’s situation fits.

To qualify as meeting or equaling the L/I definition, the medical signs and symptoms, as well as laboratory, X-ray and other testing procedures must fall within the ranges prescribed by the Listing. Otherwise, unless the substantial equivalent, the Listing doesn’t apply unless point-for-point, the claimant’s situation is on “all fours” with the definition. Without good medical evidence, the best attorney cannot succeed; with it, anything is possible.

There is a separate, distinct Listing immediately following Section 14 – it applies to children’s disability applications. It is identical, for the most part, except that the numbering system is in the “100s” rather than “10s,” and there are ailments applicable to children that might not occur in adults, and vice versa.

4) UNDERSTANDING POINT FIVE OF THE EVALUATION PROCESS & HOW TO PREPARE TO OVERCOME ITS TRAPS FOR THE UNWARY
a) The Grids

The Medico-Vocational Guidelines, known as The Grids, are found at Subpart P, Appendix 2 of 20 CFR §404. These came into existence about forty years ago, as a guide to assist ALJs in making decisions, when certain factors were present. Just as the Indiana Child Support Guidelines have been incorporated into Family Law, and presume to have flexibility inherent in its application, The Grids are just as flexible, and applied by ALJs in the same way that the presumptively-correct child support is ordered by divorce courts: Little flexibility, little room for advocacy. If you can develop a list of 'non-exertional limitations’ which exist in your client’s situation, you may be able to avert the inflexibility of The Grids.

As described above in the Sequential Evaluation process, after a determination is made by the ALJ, that the claimant’s ailments neither meet nor equal nor are the substantial equivalent of a Listed impairment, that the claimant cannot do his/her former work, the ALJ may review the facts and medical evidence to determine if The Grids apply. If so, and a particular Grids section applies, the case will end there.

The Grids are based upon the Physical Exertion Requirements, located at 20 CFR §404.1567. In that section, the definition of work is stated, in terms of the physical exertion requirements for various jobs. The definitions are taken from the Dictionary Of Occupational Titles (DOT) of the US Department of Labor. Despite SSA attempts to mask reality, the basic differentiating point from one exertional level to another, is the ability to lift and carry. The breakdown in the Exertion Requirements, from least strenuous to the highest, are: sedentary [Lifting/carrying up to 10 pounds]; light [Lifting/carrying from 10-20 pounds]; medium [L/C 20-50 pounds]; heavy [L/C 50-100 pounds]; very heavy [L/C over 100 pounds].

b) Vocational Profile

The Grids take into consideration other aspects of what SSA calls the ‘vocational profile’ of a claimant. See 20 CFR §404.1560 through 404.1568. The components of such a profile include the claimant’s age, educational level attained, past work experience, the physical exertion requirements of that work, the skill level (if any) attained, and the residual functional capacity. On the latter, more in a moment. The younger the claimant, the more difficult is success. The lawyer’s job is to draw very clear lines as to the vocational profile, and to not allow the ALJ to err at this stage.

The Grids are applied if the first four steps of the sequential decision-making process have not resulted in a decision. If the ALJ finds that his/her findings of fact fall within a specific rule in The Grids, the decision is mandated by that rule. See 20 CFR §404.1569 & 404.1569a. It is obvious from a review of The Grids that there are far more rules denying that granting benefits. In The Grids, “do” means “ditto” – that confused me until I looked at a dictionary.

What is apparent from a review of these last two CFR sections is that if your client’s case can be excluded from The Grids, you might have a better chance of success. Certain “non-exertional limitations” can remove a case from the mandatory decisions of The Grids; e.g., depression, intolerance for dust or noise, or debilitating pain. If excluded from The Grids, the sequential evaluation for your client’s case continues.

c) Residual Functional Capacity

A topic which isn’t specifically included in the Seminar’s description or its agenda, but very important, is a claimant’s Residual Functional Capacity (RFC). See 20 CFR §1545, -1546, and -1561. Briefly defined, RFC is what a person can do despite having severe limitations which are imposed by medically-determinable ailments. RFC is important because it is a determination made by consultative physicians, hired by either DDB or SSA, who after reviewing the file (AND NO MORE), make estimates of what they believe the claimant can
do. These estimates are made on forms called Residual Functional Capacity Assessments (RFCA); they carry a good deal of weight with ALJs. Because of this importance, it is vital that counsel demonstrate the errors inherent in the RFCAs, if such exist.

RFC is also very important in the fifth stage of the sequential evaluation process. If the case has proceeded through the first four stages, the last inquiry is whether he/she can do any work found in the regional economy, taking into consideration age, work experience, education level, and RFC. If the attorney can show that there is minimal RFC, that showing can demonstrate to the ALJ that the claimant is in fact disabled. If your relationship with the client’s doctors, derivative from your client, is strong enough, those doctors can show why the client’s RFC is not what the state agency or consultative doctors have stated (BEAR IN MIND: the state agency doctors only deal with the file, never seeing anyone!). Included in the Appendix is my list of non-exertional limitations, proof of which can remove the client’s RFC from The Grids.

In reviewing these concepts (The Grids, Vocational Profiles, Residual Functional Capacity), it is obvious that claimants’ attorneys must be able to evaluate a) how good is the medical evidence from treating physicians, to show that the claimant has little RFC left, or b) to show that the claimant has non-exertional limitations which will reduce the effect of a Grids-mandated decision. It is not likely that one can alter the claimant’s vocational profile, but if co-employees or employers or supervisors are available to describe the claimant’s inability to do former jobs, counsel can reduce the effects of an ALJ finding, at Pt Four, that the claimant can do his former work.

5) HIRING VOCATIONAL/MEDICAL EXPERTS

When you accept a disability case, you already have a medical expert in your corner: the claimant’s physician. Unfortunately, it is often impossible to get through the maze of office personnel, especially in large medical groups, to actually contact the doctor. Fax machines can help: they are immediate, hard to ignore, and the faxes might even be handed directly to the doctor. How assertive is your client? Willing to aggressively push the doctor into backing the client’s claim? Many doctors are so isolated from matters outside the immediate medical sphere, that there is no hope of getting in touch.

The first step in determining whether the doctor is really going to help, is to ask your client how long their physician-patient relationship has lasted, whether the doctor has a personal vs. impersonal relationship with the patient/client, and how frequently the patient/client sees his doctor(s). If the answers aren’t favorable, you must jump in with concise correspondence, designed to elicit the maximum information; who pays for this information is another vital question.

Would your client’s physician appear in Court? Probably only upon payment of large amounts. The impact of a claimant’s doctor, appearing to testify for the claimant, is immense! I’ve had it occur, but not in 20-25 years. Getting a copy of the client’s medical chart is not that tough, but will cost – I think it is a vital first step, opening avenues of inquiry to the doctor.

Hiring a vocational expert [VE] is always a possibility, except for one small matter. Unless you are footing the tab for the expert, you can be assured that your client has little money to pay for such a witness. Assuming that someone is able to pay the expert’s bill, a wise choice of such an expert is using one of those persons who appear regularly at ODAR hearings: Ray Burger, Gail
Corn, Stephanie Archer, Michael Blankenship, &c. If hired, the expert’s price would not necessarily involve a personal appearance: the expert could write a report, to be submitted into evidence; his/her experience at the ODAR gives a cachet which is hard to beat!

It seems obvious that if you submit your client to a vocational expert, you are in a position to NOT submit the VE’s report, if it is not helpful – you can always call it work product! However, you must take care that the VE you hire isn’t the same one who shows up for the ALJ hearing! Or, that the VE you hired isn’t a partner of the VE appearing at your hearing.

6) USE OF BRIEFS AND OTHER ARGUMENTS

First: included in my Appendix is a form which the late Hon. Marshall Williams, ALJ, devised and handed out to lawyers practicing before him. He wanted an opening argument, in line with the form. Whether used as an opening or as a closing statement, or even if not used as either, it focuses one’s attention on the salient issues, and if reference is made to the SSA file by exhibit and page numbers, directs the ALJ’s attention to evidence which supports your client’s claim to benefits.

Second: preparing a post-hearing brief can amplify on those issues which the opening statement has underlined. Some judges will accept it and, just as the ALJ can leave the record open for obtaining additional medical exhibits, the ALJ can give you a period of time to submit a brief, expanding on your arguments, allowing you to find pages of specific exhibits which support your position.

According to Thomas Bush, HALLEX I-2-8-13 encourages Claimant’s representatives to submit drafts of decisions. In fact, Bush cites a specific web address, providing suggested drafts: see http://www.ssa.gov/appeals/fit/index.html. Apparently, Bush knows of ALJs who have asked claimant’s reps to submit a favorable decision! Would this suffice to constitute a ‘brief?’ Probably better. Unfortunately, this writer has never heard of such a request from an ALJ. If a brief were proposed, brevity is a virtue – the longer the writing, the less likely an ALJ will read it favorably.

7) PREPARING FOR CROSS-EXAM of MEDICAL or VOCATIONAL EXPERTS [MEs & VEs]

This topic is last on the Agenda for this section, but I include the medical expert, as well as the vocational. It is vital that you know enough medicine, as well as the Listing Of Impairments, to talk intelligently about your client’s problems, with a doctor called as an expert by the ALJ. You can access medical information from the internet, from various “medicine for lawyers” texts, from NBI or ICLEF seminars pertaining to PI matters, or simply from going to the library and wading into the issue. Similarly, you must know enough about vocational issues to be prepared to ask hypothetical questions of a VE.

There is little to be gained from being belligerent when dealing with a doctor or vocational expert, appearing as an expert. He/she knows a great deal more about the medical or vocational field than you, unless you can so immerse yourself in the ailment/vocational arena, that you are comfortable. You should also bear in mind that although questions to either an ME or VE are supposed to be in hypothetical form, in fact that rarely happens.
Included in the Appendix is a set of hypotheticals that I have used with VEs – I have yet to find an effective way to cross-examine a doctor. SSA has always favored specialists: if the claimant is a diabetic with cardiac problems, the ALJ may have a cardiologist – whether that doc is capable of talking in depth about the effects of diabetes mellitus, might be a worthy target for your inquiry. I have never seen an endocrinologist at a hearing. Bear in mind always that the ME and/or VE is called by the ALJ; some of these experts are retired and look upon their continued relationship with the ALJs and support staff as being ‘among friends.’ The ALJ may well have a close relationship with the expert and consider the expert the judge’s witness.

Cross-examining a VE is dependent upon one’s knowledge of the Dictionary of Occupational Titles [DOT], which is the basis for the VE’s testimony about exertional and skill levels, availability of work, job characteristics and demands. If you can familiarize yourself with the type of hypotheticals which the ALJ SHOULD ask, you can be certain that the ALJ has included all the symptoms and ailments which your client presents. Often, the pain level, or the inability to breathe, or fatigue levels may be minimized by the ALJ – it is your job to take it a step further, to inquire hypothetically up to the limits of your client’s symptoms.

G. TIPS FOR ESTABLISHING THE CLAIM:

See above materials: there is no assurance that a claimant can succeed, without both attorney and client being well-prepared for dealing with not merely the district office (at times of initial application and reconsideration), but with preparation for the ODAR hearing. Moreover, if the client understands the nature of the entire process, he/she can involve his physicians, in aid of the case. If the client has contact with former employers, neighbors, clergy, teachers, anyone with whom he/she has had significant and direct contact over the last few years, the client can help the case by contacting these people, eliciting their assistance. Even if these people are unable or unwilling to attend an ODAR hearing, written testimonials are just as acceptable as in-person testimony (not as good, but far better than nothing).

H. USE OF READY-TO-USE FORMS & LETTERS

You are STRONGLY urged to purchase Thomas Bush’s Social Security Disability Practice, a two-volume work published by James Publishing. Contained in his work are sample letters, for use to your client, your client’s doctors, to ODAR. The most impressive and important aspect of Bush’s work is the collection of Residual Functional Capacity Assessment forms, which cover the major ailments common to humankind: lumbar spine problems, Diabetes Mellitus, coronary artery disease, etc. There are some esoteric RFCA forms, including ones for interstitial cystitis (IC), for systemic lupus erythematosus (SLE), for chronic fatigue syndrome (CFS) and fibromyalgia.

Once you have produced letters to doctors, save them on your computer for re-use. If you have handled paternity matters, you know that the issues are ALWAYS the same; so too, in disability cases. The ailment may change, client-to-client. However, the underlying issues are always the same. Thus, the letter you wrote to a client’s physician concerning cardiovascular problems will be the same letter you send to an orthopaedics specialist for your client with degenerative disk disease: only the Listing of Impairments’ sections and the factual requirements change, such as medications and symptoms.
Insofar as SSA forms, you can go to any district office and ask for copies of frequently-used forms: Request For Reconsideration, Request For Hearing, Appearance forms, all are available. If you log on to www.ssa.gov, you can find and print any and all forms used by the agency, in disability cases.

In the Appendix, I have reproduced a large number of forms, some of which are SSA forms, some are items I have generated, or filched from other sources. E.g., the Pain Questionnaire is distilled from a Social Security Ruling, SSR 88-13; the Ruling itself has been superseded, by one of the 1996 Rulings, but what is taken from SSR 88-13 is no less valid now than then.
IV. ETHICAL ISSUES

There are four separate items in the seminar outline; all of these issues and some others can be addressed in fairly short order, followed by some points that are valid, regardless of whether or not on the outline.

A) CONFLICTS OF INTEREST
It is difficult to imagine a conflict arising, at least insofar as attorney representation is concerned. One obvious conflict mentioned above: if you hire an expert, and that expert wrote a report as to your client’s medical situation, or ability to work, and you don’t submit it, then that expert is named as being the ME or VE, you must quickly notify the OHA of this conflict. There is statutory authority requiring attorneys to produce ALL information obtained, whether favorable or otherwise; knowing failure to produce information pertaining to the case, could subject the attorney to sanctions. See 42 USC§ 1320a-8(a), as amended in 2004. That has been tempered since, but this writer believes that full disclosure prevents the possibility of withholding adverse information, only to have the information surface at a later point and make the attorney appear in a bad light.

B) ATTORNEY FEE ISSUES
You should draft a contract for the claimant to read, review and sign, at the initial interview. You must sign it, also. If when you first appear in the case, using Form 1696, you should submit your contract along with it – by so doing, you alleviate the necessity of later filing a Request For Permission To Charge A Fee form, which will unnecessarily delay approval of your fee, meaning a delay in getting paid. The maximum fee which an ALJ can approve is $6,00.00, or 25% of past-due benefits, whichever is greater. If more than that sum can be justified, you must have time records, and expect the issue to be referred to the Chicago office of the Chief Regional ALJ. If you have a written contract, and have submitted it with your appearance, you need do only one other thing to get paid directly, whether a Title II or XVI case. That other thing is to either electronically or on paper submit Forms SSA 1695 and 1699 – see my Appendix.

If you succeed, the ALJ will almost always approve your contract, and authorize your receiving whatever fee is agreed to by you and your client, dependent on the amount of past-due benefits to which the client is entitled. The old bugaboo about lawyers taking SSI cases has vanished, that with no withholding of attorney fees, a successful attorney could get stiffed, and be left without a remedy from a judgment-proof client. As SSA withholds attorney fees from SSI, attorneys are protected.

You are prohibited by Federal law from charging and accepting a fee from a disability case, UNLESS that level of SSA which last decided your case has approved your fee. If you ask for administrative costs, such as copying charges, and routinely escrow such money, keep a paper trail FOREVER. If you have monies in your hands, to which you are not entitled by the terms of the contract AND PENDING the approval of your fees, you better turn it over to the client. Violations of the rules applicable to money can get you suspended from practicing before SSA, investigated by the US Attorney, and maybe reported to the Disciplinary Commission. Besides being unethical, it’s unlawful!

Concerning attorney fee considerations in advising a client who wishes to apply for both retirement and disability? Not sure that a claimant can do that! At age 62, SSA would convert disability benefits to early retirement benefits. To my knowledge, there is no attorney fee to be sought or paid for a claimant applying for early retirement at age 62. One solace: as a claimant
ages, at or closely-approaching age 60, the likelihood of success (all other ducks being lined up) is far greater than if he/she were approaching 50.

Last: for further Agency information, go to tinyurl.com/dk3qrw. This website connects you to POMS Section GN 03940.003 Fee Agreement Evaluation.

C) CONFIDENTIALITY

When one applies for disability benefits under the Social Security Act, he/she opens up his/her entire medical history, from the day of the OHA hearing backwards to at least the onset date of his/her ailment. It is inherent to the entire disability process that claimants are waiving as much of their Federal Right to Privacy as is necessary to make his/her case. I have included in my Appendix two different HIPAA release forms, and one from Wishard Hospital in Indianapolis, as examples of the nature of medical waivers. One ALJ routinely inquires of claimants, before beginning a hearing, whether the claimant is aware of his/her Federal Right To Privacy rights, and whether for purposes of the hearing, he/she is willing to waive that Right. Obviously, your client better approve, or the hearing will end abruptly!

D) ATTORNEY-CLIENT RELATIONS

This modest-sounding category is perhaps at the heart of ANY work we do as attorneys. If your client believes you are honest, hard-working, knowledgeable and competent, this is a non-issue. How does one develop these skills? Beats me – sorta like rhythm: you either got it or you don’t. But all is not lost: these skills can be developed. Some pointers: Answer all mail, return and/or take all telephone calls, especially from clients. Even if the news is discouraging, it is far better faced straight-on. Encourage emails and facsimile transmissions. Failure to communicate is the rock upon which relationships are destroyed.

E) APPLICATION OF DISCOVERY RULES:

Some of the agonizing truths of this entire area of practice are that the ALJ and his/her employer (SSA) hold all the cards: they shuffle and deal the cards, they set the ante, they even determine the game you’re playing, AND they make the rules! There are some points which should be borne in mind: if you have difficulty obtaining information from your doctor(s), you can request that the ALJ issue a subpoena, compelling the physician to respond (if he/she will do so). The issuance of a subpoena is NOT an option for an ALJ: if the request is reasonable and timely, the ALJ should issue it. Whether you can ask an ALJ to issue a subpoena, compelling an SSA-selected consultative physician to answer your letter or request for information, I do not know. Why one could not inquire of a consultative doctor, I also do not know – I have not done it, but those doctors should be fair game.

Can an attorney complain to The Appeals Council that his/her unsuccessful attempts to obtain information from a consultative physician, paid for by SSA, scuttled the case? Don’t know why not. It is obvious that the ODAR file is available to claimant’s counsel; little more could be obtained.

Concerning information in your file, which you obtained from a physician or employer, which is adverse to your case: are you obligated to submit it? Formerly, there was law which mandated the submission. Presently, it could be withheld, but at some risk: if the information could be obtained by ODAR or the ALJ, it could embarrass you, affect the handling of the instant or later case in that ODAR, and adversely affect your credibility. This is clearly an issue which must be decided on a case-by-case basis.

IF you discover information in the ODAR file which is significantly adverse to your client, which information can not be overcome by your physicians, then an entirely-different situation arises. Considering the adverse effect of res judicata, and if your physicians cannot/will not respond to
trump the adverse evidence, should you advise your client to dismiss the case, to seek other medical care and evidence? If proceeding through a hearing, knowing that this adverse information will mandate a loss, that that loss will be applied to future applications for DIB, should your client withdraw to fight another day? Another case-by-case decision.

F) HARMFUL EVIDENCE ONLY DISCOVERED AT THE HEARING

If you are discovering evidence just before or during the hearing, you have to quickly back and fill. Likely your only recourse would be to ask the ALJ to keep the record open for at least thirty, and perhaps forty-five days, to allow you to elicit a response from your client’s former employer or physicians. If you are only locating evidence at a very late date, you may have failed to review the ODAR file adequately.

If your claimant’s doctors have submitted chart notes + narrative letters + filled out Thomas Bush’s RFC Assessment forms, there should be no new evidentiary issues other than from a medical or vocational expert. There are doctors used by the Indianapolis ODAR who are well-known to be hostile to claimants; if one of these is assigned to your case, you must prepare to counter his/her hostility (and certain finding that your client is capable of working) BEFORE the hearing. IF the medical expert testifies about the claimant’s ability to do a certain level of work, you can object that it is not within the purview of the witness’s role or expertise to render a decision which usurps the ALJ’s role.

G) HOW DOES ONE REPRESENT A MENTALLY-IMPAIRED CLAIMANT WHO DOES NOT HAVE A GUARDIAN?

This issue presents a problem which can easily be addressed: many if not most claimants whom we see, who suffer from mental impairments, do not have a guardian. There is a distinct difference between having a guardian and a representative payee. One of the questions ALWAYS asked in mental status exams is whether the examiner feels the claimant can manage his/her own funds.

SSA does not require the appointment of a guardian, before allowing that person to proceed as a claimant. How does one determine whether your claimant should be subject of a guardianship? State law: Indiana Statutes, Sections 29-3-1-1, et seq. Specifically, Section 29-3-5-1 covers the content of a petition for appointment of a guardian. The Marion Superior Court, Probate Division, requires the submission of a Physician’s Report, a copy of which is included in my Appendix: a treating physician must certify that the claimant is not capable of managing his/her own affairs, for a medically-determinable reason.

Is it your responsibility to inquire as to your client’s mental status, beyond whether he/she suffers from a medically-determinable mental impairment? Good question, for which only a case-by-case review can produce an answer. A good case can be made that ALL disability clients suffer from mental impairments, of one sort or another: merely being unable to do things which formerly were done, in all settings, is sufficient to produce a depressed state. As mentioned elsewhere, in 35-40 years’ experience, almost all of my clients suffered from some level of mental impairment; yet, finding a client whose situation necessitated a Guardian is something I have not seen.

Ethically, however, IF your client is already under a Guardianship at any stage of your representation, you MUST deal with that Guardian as well as with the impaired person; to do otherwise would open doors that could find the Disciplinary Commission on the other side. And
from your standpoint, if your client is impaired sufficient to warrant a Guardianship, your client’s signature on a contract for your fee would not be enforceable!

VI. ADVANCED CHALLENGES & OPPORTUNITIES

A. TRIAL WORK PERIOD

The concept of a Trial Work Period (TWP) is defined and discussed in the Social Security Regulations, found at Section 404.1592. The first subparagraph says that a disability recipient can test his/her ability to work, by working as many as nine months, not necessarily consecutive, to determine whether he/she is still disabled. During these test months, the payment of DIB will (or should) continue. Obviously, if a recipient is able to work more than those nine months, his/her continued receipt of DIB is in jeopardy. The claimant should always bear in mind, and it bears upon the prior discussion concerning ethics: it NEVER pays to mislead SSA or an ALJ (just as it never pays to mislead anyone!). Unless the recipient is being paid under the table, SSA will know that the recipient is working; the employer will report his/her income and accompanying OASDI taxes withheld.

The maximum that a recipient can earn, under a claim of a TWP, is $670/month for 2008; the amounts are adjusted annually, if appropriate. Standards for self-employed individuals are slightly different. Routine household chores, or things done for prescribed therapy or training, or ‘work’ done without remuneration, are generally excluded from the TWP definition. Starting January 1, 1992, a recipient can claim only one TWP in any 60-month period. It is very important that the recipient understand the hazards of telling SSA that things have improved, or that he/she is feeling better, etc. The agency will likely draw a conclusion that the recipient is no longer disabled. Thus, a claim of a TWP must be carefully crafted to avoid giving away the farm. A lawyer handling disability cases must distinguish between those cases in which a fee can be made and one in which fees are a will-o-the-wisp: if your client has received DIB and has worked, or if SSA finds that he/she is no longer disabled, there is no pool of past-due benefits on which to rely, no ready source of money to pay your fees. Sorry to be crass: we do these cases because there is a fee available. This topic runs naturally into one of the next in this section of the seminar: how does one represent a claimant whose DIB or SSI has been terminated?

A seemingly-related matter to the issue of TWP is the Unsuccessful Work Attempt (UWA). This issue is dealt with at Sections 404.1574(a) and 416.974(a)(1) of the CFR, and is addressed directly in Social Security Rulings 84-25 and 05-02. The issue of an UWA is connected to the issue of whether a claimant is doing “substantial, gainful activity” and if so, whether that claimant is eligible for DIB or SSI. One of the initial questions is whether an applicant is working, and if so, whether that work is both substantial and gainful. In fact, these are disparate issues, not actually related.

B. DOES YOUR CLAIMANT LACK SUFFICIENT QUARTERS?

One of the first areas of inquiry, on initial interview with your client, is where and for how long he/she has worked. For 2009, the claimant must earn $1,090 in earnings, in a three-month period (one quarter); if you recall, a claimant must work twenty out of forty quarters, or five of the last ten years, to be eligible for Title II (DIB). The amount which must be earned in a quarter has slowly increased with time; in 2007, the minimum/quarter was $1,000. If he/she has not
worked a sufficient number of quarters, he/she is only eligible for SSI. Your client won’t understand this test; SSA does and it will deny DIB out of hand, if the number of quarters does not satisfy this earnings requirement. CFR Sections 404.802, *et sequitur* define the problem and what a claimant, or claimant’s attorney can do in an attempt to resolve this issue.

Under Section 404.810, an individual (or his/her counsel) can request a statement of earnings. If you discover that your client didn’t work enough quarters, you can request this, to determine whether your worst fears are realized. Section 404.820 provides guidance to correcting the earnings record.

Bear in mind the 20/40 earnings requirement rule: if the claimant has worked even one quarter fewer than the twenty required, he/she cannot collect DIB. If the claimant worked for a nationally-known employer, even a locally-owned employer, those employers will maintain records. It is imperative that you contact these employers to determine how long your client worked for them, how much money was made over how much time, and the like.

Where problems arise are in instances where the claimant worked for an individual or corporation which no longer exists, whose employee records are long gone. If no other sources are available, seek out former bosses, supervisors, even co-employees, to resurrect how long your client worked at that employer. Affidavits from employers, old tax records (including your client’s tax returns) will be useful to support additional quarters. If your client worked for cash, for him/her to prove additional quarters may necessitate an admission that he/she didn’t file a tax return; whether filing an amended tax return for those years is possible, I cannot say.

The effect of the 20/40 rule is that if your client last worked six years ago, then he/she cannot meet the 20/40 rule, and the claim is relegated solely to SSI. If SSI is the only alternative, it too may be unavailable, because besides missing the earnings requirement (the 20/40 rule), the claimant may be married to an individual whose earnings are “deemed” to be the claimant’s. Lately, SSA has reduced SSI benefits because my successful SSI applicants are residing with persons who are not legally obligated to support them, such as “significant others” or parents of his/her adult child (who is my client)!