10 THINGS TO KNOW ABOUT...
SOCIAL SECURITY

by: Stacy Thompson

What Every Practitioner Should Know About Social Security Disability.

Even if you haven't handled and don't intend to handle cases involving social security disability, there are a number of issues that all practitioners should know about social security benefits, the application process and how it may potentially affect clients.

1. The Social Security Administration (SSA) Definition of Disability

The SSA definition differs from those utilized in Veterans Administration, Workers' Compensation or other benefits' definition of what qualifies as "disability." In terms of social security, "disability" is defined as the inability to engage in any substantial gainful activity due to a medically determinable impairment (physical or mental) or combination of impairments which can be expected to result in death or which has lasted or will be expected to last for a continuous period of at least twelve months OR "blindness."

The primary differences between the SSA definition and those utilized in other agencies:

- There are no partial or temporary awards of benefits in the SSA. Workers' Compensation and the VA systems base awards on percentages of disability, and may pay disability for short periods of time while an individual cannot work. SSA will only pay benefits to those individuals who are no longer able to work in any capacity.

- In SSA, claimants can combine impairments without regard to the cause of injury. This differs from the Workers' Compensation system that requires the injury to be within the course and scope of employment. This also differs from the VA system, which requires a nexus between the illness, injury or condition and the applicant's service.

- Durational requirements exist in SSA and require that the disability be expected to last 12 months or longer or result in death. There are no such durational requirements for WC for VA.

To qualify for disability under the SSA rules and regulations, a five-step sequential evaluation is used:

1. Is the claimant engaging in substantial gainful activity?

If the answer to this question is "YES," then there is no need for further evaluation. The claim will be denied. If the claimant is working at substantial gainful activity levels, with a few exceptions, the claimant is not disabled under the SSA rules.

2. Does the claimant have a severe impairment? A severe impairment is one that results in any reduction in a claimant's residual functional capacity, or ability to function. A severe impairment may result in exertional limitations (ability to sit, stand, walk, etc.) or non-exertional limitations (ability to concentrate and focus, complete a normal work day or work week, etc.). If the claimant does not have a severe impairment, no further evaluation is needed.

The severe impairment must be a "medically determinable impairment," or an impairment that can be proven in the medical evidence by diagnostic testing or opinion evidence.

3. Does the claimant's medical impairment meet/equal a Listing?

The Listings contain medical criteria on very specific impairments, divided by body system. To meet or equal a Listing, all parts of the criteria must be met, generally through medical testing/laboratory findings.

4. Is the claimant capable of performing past relevant work?

If the claimant is capable of performing past relevant work, the claim will be denied. Past relevant work

is work performed at substantial gainful activity levels within the last fifteen (15) years. Part-time work may be past relevant work if performed at SGA levels. Past relevant work is evaluated not just as the claimant performed the work, but how the work is generally performed.

5. Can the claimant perform other work?

If the claimant is unable to perform past relevant work, but given age, education and skills derived from past relevant work, is capable of performing other work in the general economy, the claimant is not disabled under the SSA rules. At this point, the claimant is evaluated under the Medical-Vocational Guidelines, or "Grid Rules" to determine whether the claimant is disabled.

2. Disability Insurance Benefits v. Supplemental Security Income

There are two types of benefits available for individuals deemed disabled under the Social Security rules. Both have the same medical requirement (unable to perform any substantial gainful activity), but are quite different in the eligibility requirements and payments –

Title II / Disability Insurance Benefits are payable to individuals who are insured as of the onset date of disability. To be "insured" for benefits, the worker must have paid in adequate quarters (through payment of taxes) – generally 20 of the previous 40 quarters. In addition –

- Benefits payable starting the 6th month after onset date, but never more than one year before filing date
- Benefits may potentially be paid to dependents
- 24 months after first month of benefits are paid, claimant becomes eligible for Medicare
- No limit on assets/resources/ unearned income for eligibility
- No consideration of household income/assets for eligibility

Title XVI / Supplemental Security Income benefits are paid to disabled adult claimants or disabled children with limited family assets, resources, and earnings
In addition –

- Family income is key – spouse's income may exclude claimant from SSI eligibility
- Claimant may be eligible for both SS/DI and SSI depending on family income/assets and the amount of SS/DI
- Monthly amount depends on family income/ maximum amount set by state
- If claimant is eligible for $1 of SSI, he/she is also eligible for Medicaid
- Back benefits paid only from date of application, not onset date of disability
- There are no payments to dependents

3. Workers' Compensation / VA / LTD Decision are NOT Binding on SSA

Any determination by another agency (WC, VA, SCRS, etc.) will be considered by the evaluators, but is in no way binding on the Social Security Administration. Other agencies may look at the percentage of disability a person has, or the ability of the claimant to return to past work, but SSA will base its finding on the totality of the evidence and whether the individual can return to any work.

4. James v. Anne's / Utica – Mohawk

James v. Anne held that the Commission has the authority to pro-rate a lump sum award over a claimant's life expectancy. These lump sum settlements reverse the offset provision that applies in WC cases where the claimant is receiving both WC and SS/DIB. This decision effectively reduces the amount of benefit to reduce the offset in SS benefits.

In workers' compensation, the offset applies while the claimant is receiving both WC and SS/DIB. It is calculated as the monthly SS benefit plus the monthly WC benefit = total monthly benefit. If the total monthly benefit exceeds family maximum or 80% of average current earnings, the SS benefit is reduced.

James v. Anne's Language should be in every WC settlement!

5. Vocational Expert (VE)/ Independent Medical Examination (IME) Reports

Medical and vocational opinions are treated differently in the Social Security evaluation process. For medical opinions, the significance and weight given to the treating physician's diagnoses and opinion varies depending on a variety of factors. These

factors include: the examining relationship between physician and patient, the treatment length, frequency, and extent, the supportability of the opinion, the consistency of diagnoses, and the specialization of the physician. The Commissioner ultimately reserves the right to find that claimant disabled. While medical opinions about disability status, satisfaction of listing requirements, and residual functional capacity are considered in the SSA's evaluation of the claim, these opinions in and of themselves will not direct a finding of "Disabled." All evidence, both favorable and unfavorable, must be submitted to the SSA for evaluation and the adjudicator must weigh all evidence in the determination of a claimant's residual functional capacity.

Vocational opinions are considered by the ALJ, but are not given the same weight as the medical opinions. This is because vocational experts only evaluate the claimant and their work abilities once. There are additional factors that make the vocational opinions less substantial: who commissioned the report, who paid for it, and why was the report ordered? It is also worth noting that many of the same vocational experts used in workers' compensation cases and are testifying for social security hearings.

6. Medicare v. Medicaid

Essentially, Medicare is basic health insurance for those who have reached attained age sixty-five (65) or those that are deemed disabled under the SS rules.
For the latter, Medicare triggers 24 months after the date of eligibility (DOE), or the date a claimant first receives benefits. The DOE may be retroactive, depending on the determined onset date of disability.

Medicare's medical coverage has two primary program options: Part A (no monthly premium) includes inpatient hospital care and Part B (monthly premium) includes doctor's care and outpatient hospital care. There are also optional Part D programs, or drug prescription plans.

Medicaid is a form of health insurance for elderly or disabled individuals with limited household income and resources. Eligibility for Medicaid may trigger if a claimant receives more than $1 in Supplemental Security Income benefits.

7. Medicare Set-Aside (MSA) and Special Needs Trusts (SNT)

Medicare Set-Aside Trusts apply to Workers' Compensation settlements that involve a commutation aspect (intended to cover future medicals or release WC carrier from responsibility for future medical benefits). Medicare's interest MUST always be considered, but a Medicare Set-Aside Trust is required if the settlement exceeds the "Workload Thresholds" – (1) Claimant has a reasonable expectation of Medicare within 30 months of the settlement date AND (2) the settlement is greater than $250,000.00.

Settlements under $25,000 will not be reviewed even if individual is a Medicare beneficiary. If the claimant is likely to be Medicare-eligible within 30 months of the settlement and the settlement amount is less than $250k, Medicare's interest must be considered, but a MSA is not required. For settlements greater than $250k and the recipient is not likely to be eligible for Medicare within 30 months, a MSA is not necessarily required, but would absolutely be recommended – even an anticipated filing for SS benefits may trigger "likely."

Special Needs Trusts are established to protect the SSI recipient – MUST have a SNT to avoid disqualification of benefits (including Medicaid). Assets in trust, including monetary awards / settlement proceeds are not considered countable assets for purposes of a SSI non-medical determination. The SNT must be irrevocable. Trust assets pay back Medicaid only if the assets originally belonged to the disabled individual and were transferred into the trust. Personal injury awards used to fund the trust are not required to be used to pay back Medicaid.

8. Sitting, Waiting, Wishing: Time Frames and Expediting Cases

Social security disability claims involve a lengthy process. The process can include up to five steps, each step with its own timeline and turnover.

- Initial application – decision typically within 3 to 5 months of filing
- Request for Reconsideration – if denied initial, the claimant files this appeal, which is generally decided around 4 to 7 months from the date of the filing

- Request for Hearing Before an Administrative Law Judge – depending on the hearing office involved, the wait time for a hearing varies. The case is assigned to the hearing office based on the location of claimant's residence (closest hearing office or video site). Hearings are generally scheduled between 9 and 18 months from the date the file is transferred to the hearing office.
- Decision from the Administrative Law Judge – generally issued 1 to 4 months from the date of the hearing. This time frame may be extended if there is additional evidence to be procured and/or submitted post-hearing.
- Request for Review / Appeals Council Appeal – if the decision of the ALJ is unfavorable to the claimant, an appeal may be filed with the Appeals Council. Wait times for decisions at this level vary – anywhere from 6 months to over a year. This is the final administrative review.
- Claim in Federal Court – if denied by the Appeals Council, a civil action may be brought in federal district court, a process which generally takes about 1 to 2 years to complete.

There are generally only THREE circumstances that will be considered in a request to expedite the scheduling of a hearing or the determination by the Appeals Council:

1. homeless / eviction from current residence
2. terminal illness / condition expected to result in death within 6 months
3. suicide attempt

Any request to accelerate the disability process requires valid documentation that the claimant meets one of the above. Because of the timeframe associated with the disability process, practitioners are encouraged to caution the claimant of time expectations from the beginning. Practitioners are also encouraged to inform claimants of the fact that the decision to expedite a hearing is at the sole discretion of the hearing office; the practitioner themselves, once the request has been made, have no more influence or ability to expedite the hearing. It is beneficial for the SS client to be made aware of these facts from the beginning of representation to ensure that expectations and understandings are managed and met.

Cases involving veterans with VA compensation ratings of 100% may receive expedited processing of their applications.

> *...it is important to understand that a delayed filing of the claim will only hurt the claimant.*

9. Case Analysis

There are some circumstances and situations that are considered "Case Killers" for the claimant and their claim with the Social Security Administration. These situations include:

o Failure to seek regular medical treatment or to refuse medical care
- o Habitual and continued alcohol or illicit drug use
- o Evidence of drug-seeking / malingering behavior
- o Sporadic / unexplained gaps in work history
- o Multiple ALJ denials / multiple applications

On the other hand, there are some circumstances that are considered "Case Winners":

- o Regular medical treatment, consistently following doctor's orders
- o Diagnostic testing to confirm diagnosis
- o Continuous, regular work history for a prolonged period of time
- o Evidence of work attempts / vocational rehabilitation
- o Support of the primary treating physician or specialist
- o Military service with honorable discharge

Practitioners should be aware of any and all of these circumstances when considering the claim. Each of these scenarios should be considered from a totality of circumstances perspective and the claim should be considered as a whole. However, existence of any of these factors may weigh substantially either in or against the claimant's favor for having their claim for disability benefits approved.

10. Early Bird Gets the Worm

It never pays to wait to file for social security. Practitioners are recommended NOT to advise worker's compensation clients to hold off filing until after the case is settled. Because of the lengthy process associated with SSA claims, it is important to understand that a delayed filing of the claim will only hurt the claimant. SS cases take years to decide; during that time, the claimant has no source of income and often has no access to medical treatment. Furthermore, the monthly benefit amount decreases as years pass. A more remote date last insured or alleged onset date can make the case more difficult to prove and access to treating sources less likely.

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