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ABOUT THE DISABILITY DETERMINATION PROCESS

This document is designed to help you better understand the disability determination process under the Social Security Act. It will explain what is required to establish a claim for disability under the Social Security Act and will also explain to you the process for filing and appealing a claim within the Social Security Administration. This is not meant to be an exhaustive discussion; that would take too many pages. I have written whole books on this subject (CCH: Social Security Explained; CCH: Social Security Benefits Including Medicare) and have lectured for hours to my colleagues at legal conferences about the process. Rather, the goal here is to help you to better understand the process of establishing a disability claim with the Social Security Administration. In so doing, you will not only have, hopefully, realistic expectations about your case, but will also better understand your role in establishing a claim.

ESTABLISING A DISABILITY CLAIM

Must be Insured Under the Social Security Act or SSI Eligible

In order to establish a claim for disability benefits under the Social Security Act, a worker must be insured under the Act and must be unable to engage in ANY "substantial gainful activity" by reason of any medically determinable mental or physical impairment, or by a combination of such impairments, that has lasted or is expected to last for at least 12 months. It is not the impairment that is required to last 12 months; rather, it's the inability to engage in substantial gainful activity by reason of the impairment that must last 12 months.

To be insured under the Act means that a worker has earned a sufficient number of "quarters of coverage" in employment that was subject to tax under FICA or SECA. A worker may earn up to four quarters of coverage in one year and must have earnings above a certain threshold in order to earn a quarter of coverage. In 2019 the threshold is $1,360 ($1,410 in 2020). This amount increases each year. All

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workers age 31 and above need 40 quarters of coverage in order to be insured for Social Security disability benefits, of which 20 must have been earned within the ten-year period immediately preceding the quarter in which the worker's disability began. For workers under age 31, less restrictive rules apply.

If a U.S. citizen or eligible alien is not insured under the Social Security Act but is living in the United States and has assets below $2,000 for an individual or $3,000 for a couple, and has little or no monthly *countable* income, the individual may still be able to qualify for disability benefits under Title XVI of the Social Security Act. With few exceptions, most income is countable. The individual must still meet the disability requirements of the Social Security Act in order to be eligible for these means-tested benefits. This benefit is known as Supplemental Security Income.

Inability to Engage in Substantial Gainful Activity

The requirement that a worker be unable to engage in ANY substantial gainful activity means that it is not enough to qualify for a disability benefit for a worker to be unable to engage in the work that the worker was accustomed to performing. For example, a pianist with a hand injury may not necessarily be able to continue playing the piano, however, he may be able to perform other work that does not require constant use of the hand. Administration Law Judges routinely find that individuals who cannot engage in their usual occupation, are nevertheless capable of working as a parking lot attendant, security monitor (watching video screens), or cashier, for example.

A diagnosis of a mental or physical disease or defect is not sufficient to establish a disability claim. Rather, the individual must be unable to engage in substantial gainful activity *because of* functional impairments caused by the mental or physical disease or defect. For this reason, it is important that your doctor's medical records describe not only the *type* of medical condition that is causing the impairment, but also *how* that condition functionally impairs you from engaging in substantial gainful activity. Note that in order for the Social Security Administration to find that you are *not* disabled, the agency must find that you are able to engage in activity that is both substantial AND gainful. That means you must be able to engage in employment that provides monthly earnings above the "substantial gainful activity" threshold, which, in 2019, is $1,220 ($1,260 in 2020) for non-blind individuals and $2,040 ($2,110) for blind individuals. Also note, if you are currently working at this level of earnings, you will not be able to successfully advance a claim for disability benefits.

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The Five-Step Disability Determination Process

In brief, there are five steps to determining if a claimant is disabled under the Social Security Act.

Step 1: Substantial Gainful Activity. The claimant must not be engaged in substantial gainful activity. If the claimant is working, the claim will be denied. If earnings are greater than the monthly threshold, the presumption is that the worker is not disabled. There are a few exceptions to this rule, such as where the worker is paid much more than the market value of the work that is performed with special accommodations, as in a sheltered workshop, or in a sheltered-workshop-like environment. Earnings may also be reduced by the amount of any impairment-related work expense.

Step 2: Severity of Impairment. The impairment must be severe. This is intended to weed out any frivolous claim. Any reduction in an individual's residual functional capacity to perform basic work satisfies this requirement. "Basic work" means walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, handling, seeing, hearing, speaking, use of judgment, responding to supervision and co-workers, and dealing with routine changes in work setting. Slight abnormalities do not qualify here. There has to be a medically determinable impairment. Finally, the Administration must consider a combination of all impairments, whether individually severe or not.

Step 3: Listed Impairment. A claimant may be found disabled if the claimant has an impairment that "meets" or "equals" one of the impairments listed in the Social Security regulations. (These are at 20 CFR Part 404, Subpart P, Appendix 1. "CFR" refers to "Codified Federal Regulations.") The Listing of Impairments (Appendix 1) describes for each major body system, impairments that are considered severe enough to prevent a person from engaging in any substantial gainful activity. If disability is found at this stage, there is no further inquiry as to the claimant's capacity to perform past work or any other work.

If a client has none of the findings for a listing, the claimant may still be found to have an impairment or a combination of impairments that "medically equals" a listed impairment. This occurs if, (a) the claimant has none of the findings for a listing, but has other findings that are of equal medical significance, or (b) the claimant has all of the findings, but one or more is not as severe as the listing requires, but has other findings that are of equal medical significance, or (c) the claimant has an impairment not described in the Listing of Impairments, but may

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be as severe as one that is closely analogous in to an impairment in the Listing of Impairments, or (d), the claimant has a combination of impairments, of which not one meets a listing, but together, the impairments are medically equivalent.

Step 4: Past Relevant Work (PRW). If the claimant fails to establish a disability claim at step 3, at step 4 the claimant must then prove that he or she is not capable of performing any "past relevant work." This is any work that the claimant performed in the fifteen years prior to the disability determination and must have been performed for sufficiently long periods for the claimant to have developed the ability to perform the work to the level of at least an average worker. The work qualifies even if it was part-time, so long as it was at the substantial gainful activity level, and applies, even if the work no longer exists. In the past, disabled elevator operators who were found capable of continuing in that line of work, were held to not be disabled, even after those jobs disappeared!

The test is whether or not the claimant can still perform the work as is generally performed for the position that the claimant held, and not, necessarily as actually performed by the claimant. Thus, even if the claimant's position had demands in excess of work as it is generally performed, so long as the claimant can perform the work as generally required by employers, the claimant will not be found to be disabled.

To determine if the claimant can perform his or her past relevant work, the claimant's "residual functional capacity" will be compared with the physical and mental demands of the claimant's past relevant work. A claimant's residual functional capacity (RFC) is the most that a claimant can do despite his or her limitations. RFC is measured in terms of one's capacity to perform various physical tasks and is graded from one's ability to perform heavy, medium, light, or sedentary work.

Step 5: Vocational Adjustment to Other Work. If the claimant does not have the ability to perform his or her past relevant work, the analysis moves to this last step where a determination is made if the claimant, given his or her age, education, and RFC, can perform a significant number of other jobs in the national economy. Although the RFC measures only exertional impairments, if the claimant has one or more non-exertional impairments, the agency may seek the testimony of a vocational expert to make an evaluation at this step. Some examples of a non-exertional impairment are where a claimant is unable to maintain pace, persistence, or concentration in any type of work. A worker who needs a bathroom

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break every hour would fall into this category, as would a worker who is unable to concentrate due to constant, severe headaches.

In sum, there are six ways in which a worker may be found *not* disabled:

- Working at SGA level
- Has no medically determinable impairment
- Impairment fails to significantly limit physical or mental ability to perform basic work activity
- Fails to meet 12 – month duration requirement
- Is capable of past relevant work
- Is capable of other work

A claimant may be disabled, but still not eligible for benefits. This may happen if the claimant has failed to follow prescribed treatment without good cause. However, the treatment must be "clearly expected" to restore the ability to do work. If drug addiction or alcoholism is a "contributing factor material to the determination of disability" the claimant will not be found disabled. The test here is "would the claimant still be disabled if he or she stopped using drugs or alcohol?"

THE ADMINISTRATIVE APPEALS PROCESS

Initially, a claim may be filed online, on paper, or by telephone. An initial determination usually takes 90 – 120 days, but may be shorter where the evidence is either already gathered, or not supplied after repeated attempts by the agency to secure the evidence. Any claim must be established by a "preponderance" of the evidence. That is, the evidence must be sufficiently strong to just tip the scales in favor of the claim. Based on the data for fiscal year 2018, the most recent year for which data is available, 35% of all claims are allowed at this stage.

If a claim is denied at this stage, the claimant has 65 days from the date of the decision denying the claim within which to submit an appeal. This is the "reconsideration stage." If an appeal is not filed, the determination become final and cannot later be appealed, except for "good cause," such as where newly discovered evidence, not previously available, could change the outcome. The reconsideration determination is made by another unit of the local agency that

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made the initial determination. Approximately 13% of all claims that are appealed are allowed at this stage.

If a claim is denied at the reconsideration stage, the claimant has 65 days from the date of the reconsideration determination to file an appeal for a hearing before an administrative law judge. The hearing is somewhat informal in that it is *supposed* to be non-adversarial. Testimony is given under oath and the proceedings are recorded. The ALJ will ask the claimant a series of questions and the claimant's attorney may follow up with a line of questioning as well. Direct examination of the claimant at the hearing can be used to show limitations caused by the impairments, how pain and memory loss may impair the claimant's ability to work, how the claimant spends time during the day, and so on. Corroborating testimony may also be provided by other witnesses, including friends, relatives, former employers, medical professionals, etc. The ALJ may bring in vocational and medical experts, who are paid by the Social Security Administration, to give expert testimony. This testimony is often, but not necessarily, adverse to the interests of the claimant.

Approximately 45% of the claims that reach this stage are allowed. Although the process is supposed to be non-adversarial, there is wide variation, with some judges awarding from 88 to 92% of all claims that come before them, while others, allow, as little as 11% of all claims they hear. There has been a shift in recent years in that as recently as 2010, 62% of all claims at the hearing stage were allowed. The drop in allowance rates reflects an increasingly hostile and adversarial tone by the Social Security Administration towards disability claimants in a process that is, on paper, supposed to be non-adversarial. It goes without saying that it is very important to the success of the claim that as much evidence that can be marshalled to establish the claim be presented. You should also be aware that there is a severe backlog of cases at the hearing stage. In the greater Chicago area, the wait time for a hearing is between 13 and 16 months, depending on the hearing office, as of October 2019.

If the claim is denied at the hearing level, it may be appealed to the Appeals Council of the Social Security Administration. Claimants do not appear in person before the council. Rather, arguments are submitted on paper. This appeal must also be submitted within 65 days of the date of the ALJ's decision. Approximately 1% of all claims are allowed at this stage while another 10% are remanded back to the hearing judge for another hearing. If a claim is denied at this stage, then and only then does a claimant have a right to appeal the claim to a U.S. District Court.

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At the District Court level, approximately 2% of all claims are allowed, while another 48% are remanded back to the Social Security Administration for additional proceedings.

COLLECTION OF EVIDENCE

The success of any claim is dependent on the quality of evidence that is provided. It will be necessary to collect records from all of your medical providers to the extent that the medical record relates to the impairments that form the basis of your claim. The evidence that is provided should include hospital charts, lab tests, progress notes, and evaluations by your medical professionals. This includes not only the records of physicians, but records from psychologists, social workers, physical and occupational therapists, as well. Statements from former employers, relatives, neighbors, and friends may also be helpful.

Be aware that proof of an impairment does not prove disability, except at step 3 of the disability determination process. Rather the evidence must show how your impairment limits your ability to work.

Conclusory opinions by physicians that you are “disabled” are not helpful and may actually be harmful to your claim. Whether or not you are disabled is a legal determination, not a medical determination. What is helpful, however, is an analysis as to how the medical evidence demonstrates the existence of one or more impairments and how those functional impairments prevent you from engaging in substantial gainful activity, i.e., how the impairments prevent you from holding down a job.

If you have frequent pain, I recommend that you maintain a “pain diary” and record when you have the pain, what you did to alleviate the pain, and its impact. Similarly, if you need to take frequent naps due to fatigue or pain, you should also maintain a diary that records these episodes.

As part of the intake process, I will ask you to complete a number of forms. It is very important that you answer all questions as fully as possible. This will help me to better understand the nature of your disability and who else, in your circle, including medical professionals, relatives, and friends, may be able to assist in providing evidence to substantiate your claim.

In order to help establish your claim, it is very important that you do not exaggerate or lie about the extent of your functional impairments. You need to be

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fully honest with me and with the Social Security Administration. For example, if you don't take your medication all the time, it is better for you to disclose that information to me and then explain why you don't follow prescribed treatment, rather than to have that information revealed for the first time under questioning by an Administrative Law Judge.

Be aware of inconsistencies between how you spend your day and what you are advocating in your claim. If you claim that you cannot be on your feet for more than an hour at a time, but spend hours on end at a shopping mall, that activity will not be helpful to your claim. If you claim that arthritis in your hands prevents you from working as a secretary or on a manufacturing line, but spend six hours every day on your computer, writing e-mails, searching the Internet, and engaging with social media, that could easily cause your claim to be denied. The Social Security Administration can and does investigate claims, so you should not expect that the agency would never discover this activity. These are only two examples. I am sure you could think of others.

AFTER A CLAIM IS ALLOWED

Insured claimants

If your claim is allowed, benefits under Title II (for individuals insured under the Social Security Act) will be paid beginning with the sixth month following the onset date of your disability, but no more than 12 months prior to the date of your application. That is, benefits begin after a five-month "waiting period" but you cannot be paid for more than 12 months of retroactive benefits from the date of your application. For example, if you alleged that you became disabled in January 2016, filed your claim in May 2019, and were found in September 2019 to have become disabled in January 2017, benefits will be paid retroactive to May 2018. That is, you will be paid a back benefit for the period from May 2018 through September 2019. Because your disability onset date was found in this hypothetical to be January 2017, your five-month waiting period was from January 2017 through May 2017. However, because you did not file a claim for benefits until May 2019, the earliest month for which benefits may be paid is May 2018.

On the other hand, if you file a claim for disability benefits in May 2019, alleging a disability onset date of January 2018, and the claim is awarded in September 2019, finding that you became disabled in January 2018, you would receive a back benefit beginning with the payment for June 2018, because that is the first month

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that follows the five-month waiting period, and it is within the 12-month period for which benefits may be paid retroactively.

After a claim is allowed, you will become eligible for Medicare benefits after the 29th month of disability (5-month waiting period plus 24 months of disability benefits), unless you will have reached age 65 prior to that point.

The amount of the benefit is the same as the amount that you would have received had you reached full retirement age at the time of your disability. In other words, a disability benefit is the same amount as the amount that is paid at full retirement age. For people born after January 1, 1943 and prior to January 2, 1955, this is age 66. This amount is also known as the "Primary Insurance Amount." (Note that full retirement age increases at the rate of two months per year beginning with individuals born January 2, 1955, until age 67 is reached.)

SSI Claimants

Claimants found to be disabled who are not insured under the Social Security Act, or whose earnings records are so low that any benefit under the insured provisions of the program, Title II, are less than what is known as the Federal Benefit Rate will become entitled to a disability benefit under Title XVI of the Social Security Act. Benefits under Title XVI are known as "Supplemental Security Income" or SSI. The benefit amount is what is called the "Federal Benefit Rate," which, for single individuals is $771 in 2019 ($783 in 2020). Most states also offer a state supplement, which varies from state to state, with varying criteria for eligibility. In Illinois, the amount varies, based on need, but does not exceed $70/month. Unlike benefits under Title II, retroactive benefits are not available under Title XVI. Thus, upon allowance of a claim, benefits 9re payable only from the first full month after the date of the claim.

An SSI claimant's income and assets will be subject to scrutiny before the claim is evaluated for disability. At this point, it may be necessary to sequester or spend down a claimant's assets in ways that will not jeopardize a claimant's eligibility to a Title XVI benefit. This may include setting up Special Needs Trusts and/or ABLE account. While I am able to make recommendations as to when it may be advisable to do this, I am not a trust attorney and do not prepare trusts. I can make referrals, however, to attorneys who specialize in that field of law.

If the claimant meets the income and asset limitation requirements, and is then, subsequently, found to be medically disabled, the claimant will be required to

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attend a "Pre-Effectuation Review Conference" (PERC) to confirm that the claimant still meets the income and asset tests for SSI eligibility. Although the SSA is required to notify a claimant's attorney regarding any attempt to communicate with a client, the SSA routinely and flagrantly violates this requirement with respect to the PERC interview. Additionally, the SSA will schedule the PERC interview before the attorney is notified that the claimant qualifies, medically, for a disability benefit. Therefore, if you or a loved one is notified to attend a PERC interview, you should notify me at once that a PERC interview has been scheduled.

At the PERC interview, the claimant will be asked, in detail, about living arrangements. If the claimant is living in someone else's home rent-free, or, if the claimant lives in an apartment and any portion of the claimant's room and board is paid for by someone else, the amount provided for free, or paid for by a third party is called "in-kind support and maintenance." (ISM). Any ISM that is provided will be deducted from the monthly benefit up to one third the amount of the Federal Benefit Rate (FBR). (As noted, above, the FBR for a single individual is $771 in 2019 and $783 for 2020.) However, due to a ruling by the Seventh Circuit Court of Appeals, if the claimant has a rental agreement that provides for the payment of rent that is at least ⅓ the Federal Benefit Rate plus $20, the Social Security Administration will not reduce the amount of the benefit for claimants living in Wisconsin, Illinois and Indiana. There are similar provisions for claimants residing within the jurisdiction of the Second U.S. Court of Appeals (New York, Connecticut, and Vermont), and in Texas. In order to ensure that back benefits are not reduced, it is important to enter into a rental agreement that is signed and dated as of the date of the initial claim. Additionally, because the claimant will not likely have the capacity to pay any rent at that time, due to a lack of resources and income, the claimant must *also* enter into a loan agreement that promises to pay back rent that is due and owing, once he begins to have income. Both the rental agreement and the loan agreement should be signed at the time a claim is submitted to the Social Security Administration. Note that a loan agreement that fails to explain how the loan will be repaid will not be accepted as valid by the Social Security Administration.

The above discussion relates to claimants who are adults. If the SSI claimant is a minor, the income and assets of the parents will be deemed to the minor.

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Returning to Work

After you have been awarded disability benefits, you may, at some point, begin to feel like you could go back to work. If this is the case, the Social Security Administration has a program, the Ticket to Work program, which allows insured workers to experiment with returning to work, while continuing to receive a benefit. There are other programs for those receiving means-tested disability benefits known as Supplemental Security Income. A discussion of these programs is beyond the scope of this paper. However, if you should reach that point, you are welcome to contact me at that time for a consultation to explore your options.

Finally, if you have any questions about the information provided in this people or about any other matter related to your claim, please don't hesitate to contact me.

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