

II. Initial Considerations in Social Security Disability Claims

A. Types of Disability Cases

There are two basic types of disability claims processed by the Social Security Administration: Title II, known as Old Age, Survivors, and Disability Insurance program (“SSDI”) and Title XVI, known as Supplemental Security Income (“SSI”). 42 USCA §§ 401 & 1381. The disability standard for Title II and Title XVI is the same. The difference between the two is financial.

1. Title II is based on Quarter of Coverage (“QC”)

A claimant must have earned 40 QCs in his lifetime, 20 QCs of which must have been earned within the past 10 years.

Since 1977 an individual is credited with a Quarter of Coverage based on the wages or self-employment income earned in that year that equals an amount necessary that year to qualify for a Quarter of Coverage. The maximum number of Quarters of Coverage that can be earned per year is four. 20 CFR § 404.143.

2. Title XVI

SSI developed almost 40 years after Title II. SSI is a need based public assistance program. A claimant will qualify for SSI benefits if 1) he is Blind or Disabled and a resident of the United States; and 2) a citizen or a national of the United States, an alien lawfully admitted for permanent residence in the United States or an alien permanently residing

in the United States under color of law; 3) he did not have more income than is permitted; 4) he did not have more resources than are permitted; and 5) he filed an application for SSI benefits. 20 C.F.R. 416.202.

3. Child's Insurance Benefits

The Social Security Act provides that disabled children of an insured wage earner who has died or who is eligible for disability or old age benefits under the Act may be entitled to Child's Insurance Benefits, if the child became disabled before age 22. 20 C.F.R. § 404.350.

4. Disability

The non-financial criteria are the same for Title II and Title XVI claims.

a. Disability

The Social Security Act defines Disability as:

“(A) 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 which has lasted or can be expected to last for a continuous period of not less than 12 months; or
“(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 416(i)(1) of this title), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

“(2) For purposes of paragraph (1)(A)--

“(A) An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work

which exists in significant numbers either in the region where such individual lives or in several regions of the country.” 42 USCA § 423.

b. Blindness

The blindness under the Social Security Act is defined as: "central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less." 20 CFR § 404.1581.

c. Duration

The Social Security Act requires that the medical impairment be expected to result in death; or it must have lasted or must be expected to last for at least 12 continuous months. 20 CFR § 404.1509.

B. Case Evaluation

1. Type of Claim

The first issue to consider when evaluating a case is the type of claim. It is important to determine if the case is Title II or Title XVI.

2. Type of Disability

The second issue to consider when evaluating a case is the type of disability.

3. Level of Appeal

The third issue to consider is at what stage in the process is the claimant's claim. The Social Security Administration has the following

levels: Initial Application, Request for Reconsideration, Request for Hearing, Request for Review of Hearing Decision, Federal Court lawsuit.

a. Initial Application

The initial determination of disability in both Disability Insurance Benefits and Supplemental Security Income cases--the decision whether a claimant is disabled under the appropriate disability standard contained in the Social Security Act--is made by a separate state agency, known as the Disability Determination Section. 42 U.S.C.A. § 421(a); 20 CFR §§404.1603-1618, 416.1003-416.1018. In Texas this state agency is the Texas Rehabilitation Commission.

b. Request for Reconsideration

The second decision level is the Reconsideration. The reconsideration determination is also made by the Texas Rehabilitation Commission.

c. Request for Hearing

The third decision level is the Request for Hearing. It is at this level that most claimants seek the assistance of an attorney. It is at this level that a representative can be the most helpful. The claimant will appear before an Administrative Law Judge ("ALJ"). It will be the only time in the process that the claimant will be able to present his claim to the person who is makes the decision. The claimant can call witnesses,

present evidence, review the Administration's evidence and cross-examine the Administration's witnesses.

d. Request for Review of Hearing Decision

The fourth and final Administration decision level is the Request for Review of Hearing Decision. The Appeals Council in Falls Church, Virginia conducts this review.

e. Federal Court lawsuit

The Appeals Council decision is the final decision of the Administration and results in the exhaustion of administrative remedies. The exhaustion of administrative remedies is necessary before a claimant can file a lawsuit against SSA.

C. Making the Decision to Accept or Decline Representation

In making the decision to represent a claimant it is important that the representative have a thorough understanding of the types of claims, the definition of disability and the process the SSA decision maker uses to decide claims.

1. Types of Claims

See above for types of disability claims.

2. Disability

For above for discussion of definition of disability.

3. The Sequential Evaluation Process

The SSA decision maker must follow a sequential process outlined in 20 C.F.R. § 404.1520:

- Is the Claimant currently working (and if so, is the work substantial gainful activity)?
- Is the impairment severe?
- Does the impairment meet or equal an impairment listed in Appendix 1?
- Does the impairment prevent the Claimant from performing past relevant work?
- Does the impairment prevent the Claimant from doing other work?

When the representative has a thorough understanding of the sequential evaluation process he understands that it is important to determine if the claimant's impairment is severe, if it meets or equals a Listing, and if it does not equal or meet a Listing can the claimant perform his past work or any other work. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. A severe impairment is an impairment or combination of impairments that significantly limits the claimant's physical or mental ability to do basic work activities. 20 C.F.R. § 404.1520. When reviewing a potential claim the representative must obtain information regarding the

severity of a claimant's medical impairment, its duration and how it impairs the claimant's ability to work.

D. Getting the Information You Need

It is the claimant's responsibility to provide medical evidence showing the existence of a physical and/or mental impairment, or a combination thereof, and the level of severity of such impairment(s) during the period that disability. 20 C.F.R. § 404.1512(c). As the claimant's representative it is your duty then to obtain the relevant evidence and make sure it is in the claim file or presented at the hearing. The typical types of evidence include medical records, medical opinions, vocational evidence and witness testimony.

1. Medical Records

The most useful evidence a representative can obtain is medical records. The 42 USCA § 423 provides that a

physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.”

...

(5)(A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require. An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to

produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability. Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Commissioner of Social Security under this paragraph shall be entitled to payment from the Commissioner of Social Security for the reasonable cost of providing such evidence. 42 USCA § 423(3) & (5)(A).

The representative should obtain medical records for all treating physicians. The records can be obtained through a written request to the medical provider along with a signed authorization. Attached as Exhibits A and B is a sample form letter and a sample Medical Authorization.

Texas Statute provides that medical providers cannot charge for copies of their records if the records are to be used in the patient's claim for disability benefits. Texas Health & Safety Code §§. 161.201 – 161.204.

2. Medical Opinion

In addition to medical records the representative should obtain the opinion of the claimant's treating physician(s) regarding the severity of claimant's impairments and his residual functioning capacity. The opinion of the claimant's treating physician(s) can be obtained through testimony

at the hearing or by completion of a questionnaire. Generally, the claimant's treating physician(s) are not called to testify because of the physician's busy schedule and the cost to the claimant. The ALJ will accept a questionnaire completed by the physician. If you have the physician complete a questionnaire you should submit it along with the physician's resume at least 10 days before the hearing. This will allow the medical expert who will testify at the hearing an opportunity to review the questionnaire before the hearing.

3. Vocational Evidence

Occasionally, it is necessary to obtain evidence for the claimant's employer regarding the type of work the claimant was performing prior to the disability. This is necessary when the claimant is not performing the job as typically performed (i.e., the employer was providing the claimant with an accommodation).

4. Witness Testimony

Occasionally, it is necessary to obtain the testimony of a lay witness. The most helpful lay witnesses are the claimant's spouse, clergy, or a social worker. The lay witness can testify regarding the claimant's daily activities. This type of testimony is useful in developing the record in claims of pain, epilepsy and mental impairments.

E. Pre-Hearing Preparation

1. Prepare the claimant for the hearing

You should meet with your client a few days before the hearing to prepare him for it. You should discuss with him the issues, his testimony, and review his medical conditions. Attached as Exhibit C is a copy of a form to use to prepare clients for the hearing.

2. Review the claim file and be familiar with its contents

You should have obtained a copy of the claim file several weeks before the date of the hearing. The claimant has a due process right to examine the claim file prior to the hearing. HALLEX I-2-135. You should review the file and make notes regarding the relevant medical records. Attached as Exhibit D a copy of the form to use for this purpose.

3. Make sure all of the proper documentation is in the file

It is important to review the claim file prior to the hearing to make sure the following documents are in the claim file: Fee Agreement, Appointment of Representative form (SSA-1696-U4), Claimants Recent Medical Treatment form (SSA form HA-4631), Claimant's Medications (SSA form HA-4632), Claimant's Work Background (SSA form HA-4633).

F. Computing Offset of Workers' Compensation Benefits

It is important for a representative to understand the amount of reduction to a claimant's Social Security disability benefit that will result for the claimant's receipt of worker's compensation benefits. The

If a claimant receives a lump sum worker's compensation benefit payment then the amount of the lump sum payment is prorated to reflect the monthly rate that would have been paid had the settlement not been paid in a lump sum. 20 C.F.R. § 404.408(g). The month benefit will be reduced if:

- The individual first became entitled to disability insurance benefits after August 1981 based on a disability that began after February 1981, and
- The individual entitled to the disability insurance benefit is also, for that month, concurrently entitled to a periodic benefit (including workers' compensation or any other payments based on a work relationship) on account of a total or partial disability (whether or not permanent) under a law or plan of the United States, a State, a political subdivision, or an instrumentality of two or more of these entities, and
- The individual has not attained age 65.

20 C.F.R. § 404.408(a)(2). The Social Security disability benefit payable is reduced by the amount by which the sum of the monthly disability insurance benefits payable on the disabled individual's earnings record and the other public disability benefits payable for that month exceeds the higher of:

- Eighty percent of his "average current earnings," or
- The total of the claimant's disability insurance benefit plus all benefits payable to his family based on the claimant's earnings record.

20 C.F.R. § 404.408(c). The number that is eighty percent of the average current earnings can be found on the Earnings Record-PIA Determination sheet in the claim file.

In making the offset calculation the following benefits are not counted:

- nondisability benefits,
- VA benefits,
- Needs-based benefits,
- Private pension benefits,
- Private disability insurance benefits,
- Public disability benefit based on employment covered under Social Security, and
- The state's worker's compensation plan provides for a reduction in the worker's compensation benefits if the person receives Title II benefits.

20 C.F.R. § 404.408(b)

IV. Effective Strategies for the Social Security Disability Hearing

A. Tips for Working With the Local Hearing Office

After the claim file arrives from the local Social Security office the Office of Hearings and Appeals (“OHA”) will mail a letter to claimant and his representative informing them that the claim file is now at the OHA. At this point the representative should contact the OHA periodically to check on the status of the claim file. The claim file works its way through several stages while at the OHA. First, the file is unassigned and waiting to be assigned to an ALJ. Next it is assigned to an ALJ but is unworked. When it is in this stage the medical records are updated. When the medical records have been updated the records are given exhibit number and the file is made available for review. After the file has been exhibited it is ready for scheduling. When the claim file is exhibited it is then ready for review by the representative. At this point you can contact the OHA and schedule a time to review and copy the claim file. It is important that you obtain a copy of the file at this time. The Social Security Administration provides the copy free of charge; however, you must do the copying yourself. After you have a copy of the claim file you should immediately contact your client to determine if the claim file contains all relevant medical records. It usually does not. Due to the delay in obtaining medical records the file is usually out of date by about six months. Also, the claim file might be missing records from prior medical providers.

The representative can assist in the processing of the claim at the OHA by determining what medical records are not in the file, obtaining them and submitting them as soon as possible. If your client's claim meets one of the following criteria then he has a good chance of receiving an on the record decision:

- 55 years of age or older,
- IQ of 60 to 70,
- Claimant has a terminal illness, or
- Claimant's primary impairment is cancer.

If your client meets one of the above criteria the representative should write a letter to the ALJ explaining the claimant's situation and document how the claimant meets one of these criteria by citing the Exhibits are submitting additional medical records.

B. Rules for Submitting Evidence

The basic rule of thumb for a representative is to obtain all relevant medical records not in the claim file as soon as possible and submit them to the ALJ for inclusion in the claim file. The representative should make sure not to submit duplicative medical records.

The ALJs in the Houston area require that all medical records be submitted at least 10 days prior to the hearing. If there are only a few records most ALJs will accept then less than 10 days prior to the hearing.

Regardless of how close it is to the hearing you should submit the medical records as soon as possible.

If all the relevant medical records are not in the claim file at the time of the hearing the ALJ has two options. First, the ALJ can continue the hearing to a later date. This is not a preferable option for your client because the file will have to go back into scheduling with the other claim files. This will result in a delay of two to three months. Second, the ALJ could leave the record open for a period of time following the hearing to allow the representative time to submit the missing records. For example, the administrative record might be left open for an additional 10 days. This allows the representative to obtain the records and submit them. It also allows the representative an opportunity to briefly summarize the claim and why how the claimant meets the criteria for disability. If the ALJ requests post hearing evidence and the claimant seeks to question the source of the evidence at a supplemental hearing then the ALJ must grant the request unless the ALJ is going to issue a fully favorable decision.

C. Documenting and Presenting Medical and Vocational Evidence

The Rules of evidence are relaxed at the hearing. The ALJ can subpoena records or witnesses; however, it is not necessary. The ALJ will accept copies of medical records of medical providers. It is not necessary to prove a business record exception to the hearsay rules.

It is permissible to submit a questionnaire completed by the claimant's treating physician regarding the claimant's medical impairments. The questionnaire should be worded so the medical provider summarizes the objective findings that support any subjective claims. The questionnaire should also have the treating physician provide his opinion of whether the claimant's medical impairment meets or equals a Listing. The questionnaire should also have the treating physician provide his opinion of the claimant's residual functioning capacity.

D. Effective Cross-Examination of Expert Witness

The ALJ will usually have a medical expert and/or a vocational expert to testify at the hearing. When an ALJ uses an expert witness at the hearing he must notify the claimant in the Notice of Hearing mailed at least 20 days before the hearing. If there will be an expert witness at the hearing then the representative should be prepared to cross-examine the medical expert and/or the vocational expert.

1. Medical Expert

The medical expert is present to testify regarding the medical records in the claim file. There are three elements to the medical expert's testimony. First, he summarizes the medical records in the claim file. Second, he offers an opinion as to whether the medical records support a finding that the claimant meets or equals a Listing. Third, if his opinion is that the claimant does not meet or equal a Listing then he provides his

opinion as to the claimant's residual functioning capacity. The representative should be prepared to cross-examine the medical expert on each of the above types of testimony.

The representative should be prepared to cross-examine the medical expert on his summary of the medical records. The witness usually starts by mentioning the different objective test results and findings in the claim file. The representative should be prepared to cite the exhibit and page numbers of relevant medical records in the claim file that the witness did not mention. The representative should have the witness explain why he omitted them.

The representative should be prepared to cross-examine the medical expert on his opinion as to whether the medical records meet or equal a Listing. Even if the medical expert testifies that the medical records meet or equal a Listing the representative should be prepared to cross-examine the witness regarding the onset date. Cross-examine the witness to point out that he did not consider the claimant's testimony when offering his opinion. Get him to confirm that his testimony is based only on the medical records in the claim file and not the claimant's hearing testimony.

The representative should be prepared to cross-examine the medical expert on his opinion of the claimant's residual functioning capacity. Again, cross-examine the witness to point out that he did not

consider the claimant's testimony when offering his opinion. Get him to confirm that his testimony is based only on the medical records in the claim file.

2. Vocational Expert

The representative should be prepared to pose a hypothetical question to the vocational expert that includes a residual functioning capacity that is supported by the medical records and the claimant's testimony. This hypothetical should include sufficient limitations on the residual functioning capacity that results in the vocational expert testifying that the claimant cannot perform any gainful activity.

The representative should be prepared to cross-examine the vocational expert on the exertional and skill levels of the claimant's past relevant work. The representative should have the vocational expert testify regarding the transferability of any skills the claimant might have from his past relevant work. The Social Security Administration classifies work on the basis of exertional level and skill level. The exertional levels are: sedentary, light, medium, heavy and very heavy. 20 C.F.R. § 404.1567 and 416.967. These terms have the same meaning as the Dictionary of Occupational Titles. The skill levels are: unskilled, semi-skilled and skilled. C.F.R. §§ 404.1568 and 416.968. The Dictionary of Occupational Titles lists specific vocational preparation ("SVP") for each occupation. These SVPs correspond to the SSA definitions.

E. Trial Tactics for Securing a Favorable Ruling

1. Be prepared

It is important to be prepared. The representative should develop a theory of his case that has a basis in the Regulations, Rulings and case law. He should be aware of claimant's impairments and make sure the evidence is fully developed regarding the impairments. In preparation for the hearing the representative should do the following:

- Confer with the claimant well before the hearing to be aware of treating sources.
- Submit evidence as early as possible.
- Submit questionnaires before the hearing.
- Inform the ALJ if the claimant is currently working or when the claimant last worked.
- Send the ALJ a brief pre-hearing memorandum or letter.
- Make sure your client will show up at the hearing. Determine in advance whether the claimant has transportation to the hearing and that he knows where to go.

2. Make an Opening Statement

Most Administrative Law Judges allow you to make a brief statement of the case. Opening statements should be brief and to the point. State the theory of the claim; identify the issues, such as onset

date, recent work, etc.; and cite the Listing and/or Medical-Vocational Grid numbers that are applicable to the claim. Do not tell the ALJ what the testimony will be.

3. Side Effects of Medications

The Social Security Administration regulations require the decision maker to consider the side effects of the claimant's medications. 20 C.F.R. 404.1529 and SSR 96-7p. Consideration the side effects of the claimant's medications in a close case can make the difference. The Fifth Circuit has remanded cases where the ALJ failed to consider the side effects of medications. *Crowley v. Apfel*, 197 F.3d 194 (5th Cir. 1999). In regards to medications a representative should do the following:

- When you meet with your client ask him about the medications he takes and their side effects.
- Review the medical records for mention of medications and any adverse side effects.
- Make sure the claimant tells his doctor and any consultative doctors about the side effects, if any, from his medications.
- If you contact the doctor for a medical report be sure to ask about any adverse side effects.
- Consult the Physicians Desk Reference to determine the side effects and submit a copy of the relevant page(s) as an exhibit at the hearing.

- At the hearing, be sure to question your client about the side effects of his medications.
- At the hearing, be sure to question the medical expert about the side effects of the claimant's medications.
- At the hearing, be sure to include the side effects in the hypothetical question to the vocational expert.

4. Documenting Subjective Complaints of Pain

A large portion of the claims involve an allegation of pain. Pain can be a disabling impairment in and of itself or it can be used to reduce the claimant's residual functioning capacity to less than a sedentary level. To accomplish this it is important that the evidence be properly developed to support the claimant's allegation of pain. The representative should do the following:

- Have the claimant's treating physician complete a questionnaire regarding the claimant's pain;
- Have the claimant keep a diary or journal documenting the pain;
- Question the claimant at the hearing regarding the pain, specifically, its severity, what triggers it, and what relieves it;
- Use a lay witness to document the claimant's pain;
- Ask the medical expert if the medical records support the claimant's allegations of pain.

F. The Appeals Process

Recent Social Security Administration statistics show that sixty percent of the Initial Claims are denied. Twenty-five percent of the denied claims file a Request for Reconsideration. Eight-four percent of the Reconsideration Decisions are denials. Ninety percent of the Reconsideration Denials file a Request for a Hearing. Thirty-six percent of the Hearing Decisions are denials. Seventy-one percent of the Hearing denials file a Request for Review of Hearing Decision. Eighty percent of the Appeals Council decisions are denials.

1. Request for Reconsideration

If the claimant receives an unfavorable initial decision then he can request a Request for Reconsideration. The SSA will reconsider its previous decision.

2. Request for Hearing

If the claimant receives an unfavorable reconsideration decision then he can file a Request for a Hearing. The claim is then transferred to the appropriate Office of Hearings and Appeals where a hearing before an Administrative Law Judge is held.

The representative should be aware that the Federal Courts have held that a claimant waives an issue if he does not raise it at the hearing level. In 2000 the U.S. Supreme Court ruled that issue exhaustion did not apply to proceedings before the Appeals Council. *Sims v. Apfel*, 120 S.Ct. 2080 (2000). The Court ruled that claimants did not have to present an

issue to the Appeals Council as a prerequisite to judicial review of that issue. The *Sims* decision left open the possibility of issue exhaustion at the ALJ level. The Fifth Circuit has considered that issue and held that an allegation of an impairment is waived if not raised at the ALJ level. *Jackson v. Apfel*, 234 F.3d 246 (5th Cir. 2000). **Subsequent history** The U.S. Supreme Court denied a Petition for Certiorari in *Mills v. Massanari*, a case involving issue exhaustion at the ALJ level from the First Circuit. In *Mills* the First Circuit held that an issue not raised at the ALJ level or the Appeals Council will not be considered by the district court. *Mills v. Apfel*, 224 F.3d 1 (1st Cir. 2001).

3. Request for Review of Hearing Decision

If the claimant receives an unfavorable decision from the ALJ then he can file a Request for Review of Hearing Decision. The claim is then transferred to the Office of Hearings and Appeals in Falls Church, Virginia. The current processing time of a claim at the Appeals Council is 24 to 36 months; therefore, to decrease the delay the representative should remember the following when filing a Request for Review of Hearing Decision:

- Provide a cover letter with request for review that identifies case as having chance of reversal or remand. These arguments may allow the case to be decided quickly.

- Request tapes only when required. Ask the ALJ if you can tape the hearing yourself.
- Only request exhibits you do not have.

4. Federal Court lawsuit

If the Appeals Council decision is unfavorable then the claimant can file a lawsuit in Federal Court. The Appeals Council's unfavorable decision is the final decision of the Social Security Administration and at this point the claimant has exhausted his administrative remedies.

The lawsuit must be filed in the local Federal District Court where the claimant lives. The Summons and Complaint must be served on the U.S. Attorney and copies mailed to the _____ and _____. After service Administration has 60 days to file its Answer and a copy of the transcript of the administrative proceedings.

The following pointers are applicable with any lawsuit.

- Know your Judge.
- You should be familiar with the local rules before writing the brief and what your Judge requires.
- Keep the brief as short as possible. Get to the point as soon as possible.

Successful representation of a claimant in Federal Court can result in attorney's fees under the Equal Access to Justice Act ("EAJA"). A request for EAJA fees must be filed within 30 days after the Judgment

becomes final. Contact the OGC attorney handling the case to see if it is possible to stipulate to the amount of attorney's fees.

NOSSCR 4/03

Be aware of claimant's impairments and make sure the evidence is fully developed.

Inform the ALJ if claimant is currently working or when the claimant last worked

Confer with the claimant well before the hearing to be aware of treating sources

Submit evidence as early as possible

Submit questionnaires before the hearing

Send the ALJ a brief pre-hearing memorandum or letter

Determine in advance whether the claimant has transportation to the hearing and where to go.

Appeals Council

Provide a cover letter with request for review that identifies case as having chance of reversal or remand. These arguments may allow the case to be decided quickly.

Request tapes only when required. Ask the ALJ if you can tape the hearing yourself.

Only request exhibits you do not have.

NOSSCR 11/00

Side Effects of Medications

The Social Security Administration regulations require the decision maker to consider the side effects of the claimant's medications. 20 C.F.R. 404.1529 and SSR 96-7p.

Consider the side effects of the claimant's medications. In a close case this can make the difference. The Fifth Circuit has remanded cases where the ALJ failed to consider the side effects of medications. *Crowley v. Apfel*, 197 F.3d 194 (5th Cir. 1999).

When you meet with your client ask him about the medications he takes and their side effects.

Review the medical records for mention of medications and any adverse side effects.

Make sure the claimant tells his doctor and any consultative doctors about the side effects, if any, from his medications.

If you contact the doctor for a medical report be sure to ask about any adverse side effects.

Consult the Physicians Desk Reference to determine the side effects and submit a copy of the relevant page(s) as an exhibit at the hearing.

At the hearing be sure to question your client about the side effects of his medications.

At the hearing be sure to question the medical expert about the side effects of the claimant's medications.

At the hearing, be sure to include the side effects in the hypothetical question to the vocational expert.

NOSSCR 11/00

There are 44 million people receiving Social Security benefits. 30 million are retirees, 6 million are disabled workers and 7 million are survivors of disabled workers.

NOSSCR 12/00

Representing claimants in Federal Court

When you file the lawsuit you serve the Summons and Complaint on the U.S. Attorney, and mail a copy to the _____ and _____. After service the Summons and Complaint are sent to OHA in Falls Church, Virginia where the transcript is compiled.

Know your Judge.

Writing the Brief

You should be familiar with the local rules before writing the brief and what your Judge requires.

Remember to keep the brief as short as possible. Get to the point as soon as possible.

Attorney's Fees

Equal Access to Justice Act ("EAJA") fees must be filed within 30 days after the Judgment becomes final. Contact the OGC attorney handling the case to see if it is possible to stipulate to the amount of attorney's fees.

NOSSCR 1/01

If the ALJ requests post hearing evidence and the claimant seeks to question the source of the evidence at a supplemental hearing then the ALJ must grant the request unless the ALJ is going to issue a fully favorable decision.

POMS are online at <http://policy.ssa.gov/poms.nsf/poms?OpenView>. The POMS are searchable.

NOSSCR 9/02

In 1999 Social Security Administration changed its policy to allow the processing of subsequent disability claims when a request for review on a prior claim is pending at the Appeals Council. Under this policy a hearing on the subsequent claim will be delayed until after the Appeals Council rules on the prior claim.

NOSSCR 9/01

The Social Security Administration has established “The Glossary of Social Security Terms” online at <http://www.ssa.gov/glossary.htm>.

NOSSCR 2/02

In 2000 the Social Security Administration revised its policy to annually adjust for inflation the earnings guidelines that we use to determine whether a non-blind employee is engaged in Substantial Gainful Activity. The amount adjusts annually based on national wage growth. 20 C.F. R. 404.1574 and 416.974. The amount is currently \$800.00 per month.

NOSSCR 2/02

Social Security Administration classifies work on the basis of exertional level and skill level. The exertional levels are: sedentary, light, medium, heavy and very heavy. 20 C.F.R. § 404.1567 and 416.967. These terms have the same meaning as the Dictionary of

Occupational Titles. The skill levels are: unskilled, semi-skilled and skilled. C.F.R. §. 404.1568 and 416.968. The Dictionary of Occupational Titles lists specific vocational preparation (“SVP”) for each occupation. These SVPs correspond to the SSA definitions.

NOSSCR 3/02

A claimant can apply for disability benefits online at www.ssa.gov/applyforbenefits.

NOSSCR 3/02

Documenting Subjective Complaints of Pain

Have the claimant keep a diary or journal documenting the pain.

NOSSCR 7/02

2001 allowance rates for the State of Texas

Initial Decision: Allow 37.3 %; Deny: 63.7 %

Reconsideration: Allow 17.7 %; Deny: 82.3 %

NOSSCR 6/02

If your client's claim meets one of the following criteria then he has a good chance of receiving an on the record decision:

55 years of age or older,

IQ of 60 to 70

Claimant has a terminal illness, or

Claimant's primary impairment is cancer.

Waiver of Issues

In 2000 the U.S. Supreme Court ruled that issue exhaustion did not apply to proceedings before the Appeals Council. *Sims v. Apfel*, 120 S.Ct. 2080 (2000). The Court ruled that claimants did not have to present an issue to the Appeals Council as a prerequisite to judicial review of that issue. The *Sims* decision left open the possibility of issue exhaustion at the ALJ level. The Fifth Circuit has considered that issue and held that an allegation of an impairment is waived if not raised at the ALJ level. *Jackson v. Apfel*, 234 F.3d 246 (5th Cir. 2000). **Subsequent history** The U.S. Supreme Court denied a Petition for Certiorari in *Mills v. Massanari*, a case involving issue exhaustion at the ALJ level from the First Circuit. In *Mills* the First Circuit held that an issue not raised at the ALJ level or the Appeals Council will not be considered by the district court. *Mills v. Apfel*, 224 F.3d 1 (1st Cir. 2001).