

AN ADVOCATE'S IN-DEPTH GUIDE

TO

SOCIAL SECURITY DISABILITY

AND

MEDICAL LETTER WRITING GUIDE

(Spinal Cord Injury)

Peter H.D. McKee
DOUGLAS, DRACHLER & McKEE, LLP
1030 Securities Building
1904 Third Ave.
Seattle, Washington 98101
TELEPHONE: (206) 623-0900
FAX: (206) 623-1432
E - Mail: PHDM@QWEST.NET

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INTRODUCTION

The following materials are presented in conjunction with a live seminar I present on the topic of Social Security disability law. My hope is that this seminar will give all those attending a more in-depth understanding of the one federal programs that most frequently is asked to address the needs of the disabled - Social Security and Supplemental Security disability benefits, administered by the Social Security Administration. I also hope that these materials will help those of you who have been or may be asked to provide information to the Social Security Administration regarding your clients who have applied for Social Security or Supplemental Security Income Disability benefits. When this material is reviewed in conjunction with Social Security regulations regarding specific disabling conditions (including the "Listing of Impairments"), it can be of help in focusing the letter writer's attention on the specific medical information which must be presented for an accurate determination by the Social Security Administration of disability or non-disability.

NOTE:

In the Fall of 2003, the Commissioner of the Social Security Administration announced a comprehensive plan for major revisions of the way Social Security processes disability claims. These plans intend to alter many aspects of the adjudicative and bureaucratic process at all levels. The specifics of the proposed changes were announced by the Commissioner of Social Security on July 27, 2005 with a public comment period which closed October 25, 2005. However the final word on changes and when and how they will be implemented, remains in flux. Thus, much of what is described in the following materials may change in the next few years.

If anyone has specific questions he or she faces about Social Security that you or your clients have encountered, please feel free to give me a call.

Peter H.D. McKee
(206) 623-0900

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BASIC FACTS AND OVERVIEW OF SSA & SSI

I. Social Security and SSI Disability Programs - (ADULTS).

A. Social Security Disability Insurance Benefits

1. Also known as:
 - a. SSA, SSDI, Title II, "Disability".
2. Like an insurance policy:
 - a. Must be "disabled" as defined by SSA, and,
 - b. Must have paid into the Social Security system by working in the recent past.
 - (1) Must show that from the date claimant first became disabled, claimant had paid into the Social Security system by working and earning at least \$500.00 per quarter in five out of the last ten years (20 out of the last 40 "work quarters"). (Currently they must earn \$1000 in a quarter to get a quarter's credit.)
 - (a) The date the claimant asserts s/he first became disabled is a critical determination which may have an important impact on whether the client is found eligible for Title II benefits, regardless of whether the client can now show s/he is disabled.
 - c. Income and resources are not relevant to eligibility - millionaires can

receive Social Security Disability benefits if they meet the other conditions of eligibility.

3. Medicare insurance is payable only after two years from the date the claimant is found eligible for Title II benefits. Premiums of \$93.50 per month are currently taken out of claimant's Title II check. Medicare does not pay for medications, although it will pay for certain types of mental health services or psychiatric treatments.
4. Benefit amounts are based on level of past earnings and contributions into the Social Security system. Depending on earnings record and age, a claimant can receive nothing or up to a current maximum of approximately \$2,116.00 per month as an individual.
5. Retroactive benefits can be awarded up to one year prior to the date of application if client can show disability at that time.

B. Supplemental Security Income Disability Benefits.

1. Also known as:
 - a. SSI, Title XVI, "supplemental income".
2. Similar to a public assistance disability program.
 - a. Must be "disabled" as defined by SSA, and
 - b. Must not have significant non-exempted resources or income.
 - (1) Non-exempt resources may not exceed \$2,000.00 for an individual, and \$3,000.00 for a married couple.
 - (2) Income must be relatively low, as income will affect the amount

of the SSI benefits paid on a monthly basis. If non-exempt income is too high, it can prevent payment of SSI, even though claimant is found "disabled". (It is usually safe to assume that recipients of GAU will likely meet the income and resources limitations of SSI).

- (3) SSI frequently "supplements" a Title II award which is low due to claimant's minimal work history and/or earnings in the past.
 - (a) Maximum combined benefits a single claimant can receive currently is \$643.00 in all of Washington State. Since June, 2002, Washington State cut most state supplements to SSI
 - (b) Maximum benefits payable on SSI alone is \$623.00 in all of Washington State.
 - (c) Clients may have claims for both SSI and Title II benefits. The information that is provided to Social Security will be considered in both claims.
- (4) Medicaid eligibility is part of the benefits awarded to a successful SSI claimant, even if only \$1.00 per month is ultimately paid due to award of Title II, or other income.
 - (a) Medicaid pays for some mental health services such as group counseling, while GAU will not. Community

Mental Health Centers can retroactively bill for services provided to a GAU recipient who gets on SSI back to the date of application or onset, whichever is later.

3. If found eligible, benefits can be awarded retroactively only to the date of application.
4. In every case where a client has applied for either SSI or Title II in the past, the client may have the right to request a "Reopening" of the prior determination denying the prior claim. Rarely, if ever, would such a requested Reopening be granted at any stage in the appeals process prior to the administrative hearing. However, Reopening can produce a financial windfall to both the client and the State if handled properly.
 - a. Client can request a Reopening of the prior denial determination for any reason within one year and within two years for "good cause" in SSI cases. "Good cause" Reopenings can be requested within four years of the most recent denial in Title II disability cases.
 - (1) "Good cause" can include the presentation of 'new and material evidence' not previously made available at the prior application.
 - (2) Medical documentation or supported professional opinions regarding the onset date of a client's condition is frequently critical to a proper evaluation of a case by Social Security.
 - b. Whether the Social Security Administration will grant the request to

Reopen and award benefits based on a prior application which had been denied and not appealed is completely discretionary, and not subject to clear rights of appeal.

II. Other Basic Facts You Need To Know

A. Definition of "Disability" (Adult Standard):

1. **"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 which has lasted or can be expected to last for a continuous period of not less than twelve months."**

a. **"Substantial"** - relates to whether the work is "make-work" or "real" work that people are paid to do in a significant number in the national economy.

(1) Simply because the work is performed in a "sheltered work shop" setting does not mean that it is not "substantial". However, the more "sheltered" the setting is, and the more the "sheltered" aspects of the work setting are described, the more likely it will not be considered "substantial"

b. **"Gainful"** - relates to considerations of whether the work is the type of work that pays a person more than \$900 per month. The fact that the claimant did not get paid this amount does not settle the question of whether others are paid a greater amount for the same work.

- (1) Remember, the threshold dollar figure for "gainful" activity is a "presumption" only, and there are many facts that can demonstrate that the fair market value of the claimant's actual work performed falls below the dollar figure, and is therefore not to be considered "gainful" activity.
 2. The determination of whether a person is disabled for purposes of Social Security or SSI is a legal determination based on many factors, including medical evidence, age, education, and vocational factors.
 3. The fact that a claimant has been found disabled for another program, such as GAU or Labor and Industries, does not prove that the claimant is "disabled" as defined by Social Security. It may, however, be an important fact which should be brought out.
- B. Please remember that, as a person with special expertise in the medical/psychiatry field, you may be the person best able to provide the clinical observations and professional opinions about your patient's medical/psychological conditions. However, you are not qualified to make the ultimate determination that a person is "disabled" as defined by Social Security Administration. That decision must be left to others.

III. **Minor** Childrens' Social Security and SSI Disability Benefits.

- A. Because children under age 18 usually have no work record, and certain medical considerations as to the likely severity of a condition differ between adults and children, Social Security evaluates the disabilities of children differently than those of an adult.

B. Minor Childrens' Social Security Disability benefits.

1. A disabled minor child may receive Social Security benefits (Title II), but only on his/her parent's earnings record, and only if one parent is **either deceased, retired, or disabled.**
 - a. The child will be entitled to monthly benefits equal to one-half of their parent's benefits while the parent is alive, and three-quarters of such benefits of the parent has died.
 - b. In fact, a dependent child of a deceased or disabled worker is entitled to such benefits regardless of the child's disability. These are called Dependent Childrens benefits.
 - c. Entitlement to children's benefits terminates with the occurrence of any of the following : (1) the death of the child; (2) the child turning 18 if the child is not him/herself disabled; or (3) if the child is receiving benefits because of a parent's disability, with the end of the benefits for the parent.
2. **Thus, a disabled minor child of two healthy, non-retired parents** WILL NOT be eligible for any Title II disability benefits. However, if the family meets the income and resources limitations of the SSI program, the disabled child will be eligible for SSI benefits.

IV. **Adult** Childrens' Disability benefits.

- A. An adult disabled child may be entitled to receive Social Security disability benefits on his/her parent's earnings record if the child's parent is either deceased, retired, or disabled, and the child can show that the child became disabled before s/he turned 22.

1. The adult standard of disability applies.

V. Drug Addiction and Alcoholism - Post March 29, 1996

A. On March 29, 1996, Congress passed legislation which bars a person from eligibility for either SSI or Social Security disability benefits if drug addiction or alcoholism is determined to be, ..." a contributing factor material to the finding of disability".

1. No longer can substance abuse be the basis of an award of disability.
2. Proving that a claimant's underlying disabling conditions are not materially affected by current or even recent substance abuse can be quite difficult.
3. Total, documented and sustained sobriety is the only effective way to ensure that substance abuse will not be used as an excuse to deny benefits to a person is , in fact, disabled independent of that substance abuse.

VI. Non-Citizen Ineligibility for SSI

A. On August 22, 1996, President Clinton signed the "Welfare Reform Act" of 1996. This legislation virtually eliminated SSI (and other federally funded needs based programs such as food stamps) eligibility for many noncitizens.

B. Because of the severe, draconian effects of the 1996 legislation, one year later, on August 5, 1997, the "Balanced Budget Act of 1997" was enacted, with several remedial measures to soften somewhat the effects of "Welfare Reform" on legal resident aliens. As it now stands:

1. "Lawfully residing" non-citizens in the U.S. by August 22, 1996, who were either receiving SSI by August 22, or who are later found to be blind or disabled will be able to keep and/or receive SSI disability benefits.

- a. Thus, no longer will non-US citizens, age 65 and over, be eligible for SSI just based on age. All such claimant's will have to prove disability.
2. Newly arriving lawfully residing non-citizens who were not in the U.S. by August 22, 1996 and who file a claim for SSI disability benefits will not be eligible for SSI unless they fall within the following groups of people:
 - a. Immigrants granted refugee status and aliens granted asylum will be eligible, but only for the first 7 years after entry to the United States.
 - b. Veterans - "Qualified" aliens who are active duty service members or veterans with an honorable discharge, as well as their spouses and unmarried dependent children under 21.
 - c. 40 Quarters - Lawful permanent residents who have worked at least 40 "qualifying quarters" for social security purposes, or who can be credited with the quarters earned by spouse or parents.
 - C. Again, the technical aspects of these new laws are quite complex and will likely require legal interpretation in many individual cases.
 - D. Because of these new laws, all non-citizens who seek SSI benefits should be encouraged to begin preparation for taking their citizenship test after they have been in the US for 5 years as a legal resident alien. Complex legal questions regarding immigration law can best be answered by an experience immigration lawyer.

SOCIAL SECURITY APPLICATIONS / ADMINISTRATIVE PROCESS

I. Initial Application

A. Local District Office of Social Security

1. Applications are made through any local district office (D.O.) of Social Security. It should usually be a joint application for SSI and SSA disability benefits. Depending on income, a claimant can receive both SSA and SSI.
 - a. Many offices are taking the initial application over the telephone. While at times this may be advantageous to the client, there are times when applying in person would be better for the client. The client has the right to insist on making an application in person.
2. Claimant should list every source of medical treatment, counseling, etc. he/she has had. Names, addresses, and telephone numbers of sources of any medical information would ideally be provided on the initial application forms.
3. Especially for the claimant who is physically or mentally unable to give an accurate portrayal of the severity of his/her impairment, or accurately portray his/her past job history, any GAU recipient who is applying for SSI benefits should be in touch with their local DSHS SSI Facilitator.
 - a. At present, there are DSHS employees around the state who are designated as SSI Facilitators. Their job is to assist GAU recipients in

working through the Application and Reconsideration stages of the Social Security claims process. You should get to know the SSI Facilitators in your area, who can be of great assistance to your client in helping them through the bureaucratic maze.

4. Special problems arise in the case of a mentally ill claimant who denies the importance or severity of his/her mental problems, or who denies that his/her impairments played any role in the loss of past jobs. Of particular importance is the accuracy of the claimant's description of the limitations of daily activities. The applications process **is not** the time for the claimant to paint an inaccurate "rosy" picture of what claimant used to be able to do, or what claimant hopes to be able to do in the future. Alcoholic claimants may be especially prone to denial of functional limitations.

II. Disability Determination Service (D.D.S.), (a.k.a O.D.I.)

1. In most states, Social Security contracts with a division of the state's welfare department, usually called the Disability Determination Service, (known in State parlance as the Office of Disability Insurance, O.D.I.), to make the initial eligibility evaluation of each claim for disability benefits filed.
2. D.D.S. has the obligation to develop the medical and vocational record and then to apply the appropriate federal standards of disability under the Social Security Act to determine whether the claimant is "disabled" as defined by Social Security regulations.
 - a. DDS relies extensively upon the Program Operations Manual System,

POMS, which is an internal interpretation of the federal laws and regulations which define the standards of disability which apply in Social Security and SSI cases. At times, the POMS conflicts with controlling federal law.

3. D.D.S. should attempt to gather information from all the medical sources mentioned in the application forms. If a source of information is not included in the application forms, D.D.S. might not attempt to gather this information.
4. Rigid time pressures and large caseloads may result in a failure to develop fully all medical information. Failure of medical sources in promptly providing medical information is also another reason for the lack of full development. If requested information is not provided, the case will be processed without it.
5. Initial "determination" is made by D.D.S., and Social Security then sends out a document captioned, "Social Security Notice" and/or a "Supplemental Security Income Notice" advising the claimant that benefits are approved or denied.
 - a. The attached "Disability Determination Rational", which purports to explain the reasons for denial, is rarely relied on by lawyers who represent denied claimants as being an accurate or complete portrayal of the true magnitude of the claimant's disabilities. It should not be relied on as the sole source of information to understand why benefits have been denied and whether the claimant should appeal the denial.
6. A claimant has 60 days after he/she receives the initial denial notice to request a Reconsideration. Only in unusual circumstances should claimant start the

whole process over by reapplying. Requesting a Reconsideration is proper way to appeal an initial denial. Requests for Reconsideration can be filed with any local Social Security office.

III. Reconsideration

- A. Within 60 days, a denied claimant must request Reconsideration. This may be done by phone, but clients should assume the worst and make sure that a written request is actually received by the local Social Security office.
 - 1. GAU recipients should be in contact with the local SSI Facilitators who will be helping the client fill out several forms at this stage.
 - 2. If the client has seen new medical providers, or any significant changes in the course of treatment has occurred, these should be indicated in the forms completed at the time the Request for Reconsideration is filed. If medical providers that were mentioned at the time of application are not mentioned in the Disability Determination Rationale, the client should mention them again to insure that the appropriate medical records are obtained.
- B. D.D.S. does the Reconsideration evaluation.
 - 1. National statistics show that if claimant's benefits are denied initially, then, upon review at Reconsideration, benefits will again be denied in at least 86% of the cases. (FY 2002). Claimants should be encouraged to go through this necessary step, if only so that they can get to a hearing at the third step of the applications process where chances are much better that benefits will be awarded. The client should not let the system itself deny benefits that might well be awarded at the

hearing level. From the claimant's standpoint, the guiding principle is "Keep on appealing!"

- C. D.D.S. will make a second determination and Social Security will then send out a second set of documents captioned "Social Security Notice of Reconsideration" and/or "Supplemental Security Income Notice of Reconsideration" advising the claimant if benefits are approved or denied. A second "Disability Determination Rational" will also accompany the Reconsideration denial notice.
- D. To appeal, the claimant must again protest within 60 days. Claimant should complete a written Request for Hearing and take it to any local Social Security office.
- E. At this stage, if the client has not contacted an experienced Social Security lawyer and/or paralegal to represent him/her, this should be done immediately after receiving the denial notice upon Reconsideration. GAU recipients who have been assisted by an SSI Facilitator to this point will be referred to a lawyer on a special referral panel of lawyers who will meet with the client to assess his/her case and determine if the lawyer will represent the client.

IV. Administrative Hearing

- A. Hearings are held by the Social Security Administration's Office of Hearings and Appeals. Administrative Law Judges hear the testimony and review the evidence of each appealed case. For claimants who have already been denied twice by the time they request a hearing, the following statistics are encouraging: **Nationally, benefits are awarded to claimants who have attorney representing them at hearings in 68% of the cases!** (Unrepresented claimants have benefits awarded at the hearing stage in 43.5%

of the cases.) **Nationwide, the overall reversal rate at the hearings level is 63.5%.**
(FY 2002)

- B. Administrative law judges are employees of the Social Security Administration but are to be independent in their evaluation of the claim. Most, if not all, A.L.J.s are attorneys and their job is to hear disability cases, as well as other types of Social Security and Medicaid/Medicare cases. The A.L.J.s are not federal court judges.
- C. The hearing is the most critical stage of the entire process:
1. Most likely it is the first time a person who is deciding the case has seen the claimant face-to-face.
 2. Claimant can have an advocate or lawyer at the hearing who should know the applicable regulations that the A.L.J. will be applying to decide the case.
 3. The hearing is informal, and rules of evidence, including hearsay rules, are not strictly applicable. Thus, written reports may be submitted without having to have the author attend and testify. Medical reports can frequently make the difference between winning and losing at this stage. While informal, the A.L.J. will be looking for specific relevant information which will be critical to the judge's legal determination as to the claimant's eligibility for benefits.
 4. Therapists, counselors, doctors and informed friends can all play critical roles at a hearing in fully describing and documenting the disabling nature of the claimant's conditions.
 5. The A.L.J. may call a medical advisor (a doctor) and a vocational expert to attend the hearing and examine the evidence. The A.L.J. will then ask these experts

hypothetical questions about the nature and severity of the claimant's disabilities. While it is the judge who must make a final determination on such questions, the opinions of these experts frequently determines the outcome of a case. If the testimony of these experts is not supportive of the claim for disability, cross-examination by an experienced lawyer or paralegal is essential.

- a. At hearings, trained lawyers might be called upon to file motions to exclude specific evidence which might be in the file, to submit legal briefs citing controlling federal case law and federal regulations which support the client's claim for disability benefits, to cross examine doctors, psychiatrists and other medical providers regarding their medical opinions and understanding of the controlling federal disability regulations regarding particular medical conditions, to cross examine vocational experts regarding the basis of their professional opinions regarding work available in the national economy and the "residual functional capacity" of the client, to prepare and present the live or written testimony of both professional and lay witnesses which supports their client's claim for disability benefits.
6. Whatever is presented at the hearing, either by way of written evidence or live testimony forms the basis of the hearing record upon which the decision is to be based. If the client loses at the hearing, the client will be stuck with the record that s/he makes at the hearing. Usually it is very difficult to augment the record of the hearing once the judge issues a decision in the case. If the client has been

denied benefits at the initial level and at Reconsideration, then the Hearing stage is the place where the client has the best chance to win his/her benefits. No one should assume that a later appeal, after losing at the hearing, will correct the errors which may have occurred at the hearing.

7. Usually the judge will not announce his/her decision at the hearing, but will review the case after the hearing and issue a written decision within a month or two of the hearing.
 - a. If the claimant is found disabled and the decision is favorable, SSI claims must then be reviewed by the local Social Security office to determine the "non-disability" factors of eligibility (usually questions of income and resources). This process can take a few weeks or several months. Only after this review is completed will dollars be sent to the client.
 - (1) In cases of mental impairments arising from substance abuse, SSA will routinely require that a "Representative Payee" be appointed to receive and supervise the spending of the claimant's monthly benefits.
 - (2) Claimants who live in the house of a relative and pay reduced rent may be subject to a reduction of their monthly SSI check due to the "deeming" of income through the provision of reduced rent by the relative. The specific facts of the living arrangement are critical in determining whether such a reduction is proper. Do not assume it is.

- b. Favorable Title II, Social Security disability decisions are processed in Baltimore, Maryland by Social Security and can take two or more months before either present or retroactive benefits are sent to the claimant.

V. Appeals Council

- A. If the A.L.J. denies benefits, or if the claimant disputes such things as the date set by the A.L.J.'s decision as to the onset of the clients, disability, the claimant has 60 days to appeal and Request a Review of a Hearing Decision. The appeal is decided by the Appeals Council in Baltimore, Maryland through a paper review of the evidence presented at the administrative hearing. New evidence might be includible at this stage, but the claimant should not count on it.
 - 1. Critical legal issues arise as to how one limits the focus of the scope of appeal if the claimant is not appealing the entire decision.
 - a. Great care must be taken in what is said in the Request for Review of Hearing Decision as to what is being appealed and the reasons for it. A poorly drafted appeal of an otherwise favorable decision which erroneously established the onset date of a claimant's disability could result in the Appeals Council completely reversing the entire decision.

VI. Federal Court

- A. If benefits are denied by the Appeals Council, claimant has 60 days to file an appeal in federal court.
 - 1. No testimony is taken in the federal court action, as it is just a review of whether the A.L.J. had "substantial evidence" to justify his/her decision, and not whether

that decision could have been decided differently.

- a. Only in rare cases is evidence which was not part of the original record allowed to be made part of the record on appeal to the federal court.
2. No client should be allowed to face the problem of finding a lawyer to represent him/her for the first time at the Federal Court appeals level.
 - a. Most lawyers are hesitant to take a case that has gone so far as to get into Federal Court without lawyer representation.

THE "SECRET" WORLD OF THE SOCIAL SECURITY LAWYER

I. Who are they, anyway?!

A. Private practice lawyers.

1. Social Security Disability law is not a topic of general familiarity to most private lawyers.
2. Many private practitioners first learned the law of Social Security Disability as staff attorneys for legal services offices around the country. Others began to represent these clients in conjunction with Workers Compensation claims.

B. Legal Services Attorneys

1. Overview

- a. In the past, Legal Services offices and their staff attorneys played a major role in representing SSA/SSI disability claimants in their application and appeals from denials.
- b. With the significant defunding of Legal Services by the Republican-controlled federal Congress in 1995, massive lay-offs and office closings in Washington state have crippled the legal "safety net" that once served the poor and disabled claimants for Social Security and SSI benefits. Private lawyers are now being called upon more and more to fill the legal voids which remain.

C. SSI/GAU Facilitation and Referral Program.

1. Back in 1987, as part of the established state-wide effort by DSHS to assist GAU recipients in their claims for SSI benefits, the State developed a lawyer referral system. Any GAU recipient who has been denied SSI benefits at the Reconsideration level should be referred by an SSI Facilitator to an attorney in their area who on a referral panel of experienced Social Security lawyers.

II. How Do The Lawyers Get Paid? (They aren't doing it for their health, I bet.)

- A. Payment of lawyers in SSA disability cases is tightly regulated by federal law. The Social Security Administration will allow a fee of 25% of the retroactive benefit, not to exceed \$5,300.00, to be automatically approved without a need for a formalized Fee Petition being filed. However, if the client, or the attorney, or the ALJ in very limited situations, objects to such a fee, or if a fee higher than \$5,300.00 is being sought, the Fee Petition must be filed by the lawyer.

1. The Social Security Administration has the duty to withhold 25% of the claimant's past-due benefits and to pay from that withheld sum the authorized fee directly to the attorney of record. Because of these two features, most attorneys have retainer agreements with their clients to limit their fee to 25% of the past due benefits. However, the law does permit a fee to be approved in excess of 25% of the past due benefits.
2. Note - In the past, SSA did not withhold attorney fees from past SSI benefits. For the lawyers, this can cause much financial worry, especially in the case of clients who were on AFDC and not GAU in the past. Legislation signed into law on February 11, 2004 now authorizes withholding of approved attorney fees from

successful SSI claims.

B. Attorneys Fees and the GAU client.

1. Under RCW 74.04.620, since 1983, clients on GAU who were successfully represented by a lawyer in their SSI case and whose attorney has a fee approved by SSA will have 25% of what DSHS recoups and retains paid to the attorney on the approved fee.

a. Problems for attorneys in obtaining the full approved fee:

(1) When client was on TANF.

(2) When client was on GAU for short time and is awarded a substantial back SSI award.

2. Virtually all lawyers take the cases on a contingency basis - if benefits are not awarded, no fee is collected.

3. Costs

a. Social Security does not regulate or approve the payment of costs incurred in the successful or unsuccessful claim.

(1) Many lawyers will ask that client be responsible, win or lose, for out of pocket expenses.

(a) Long distance telephone, photocopying, medical records, charges billed by doctors for medical report writing, etc..

(2) How individual lawyers handle the issue of costs varies.

b. Availability of DSHS funds for payment of medical reports under the SSI Referral Program will reduce the costs that client may face in a case.

D. From the time a favorable decision is reached in a client's claim for SSI or Title II benefits, it can be as long as six months or more before the lawyer receives whatever funds that has been withheld by either SSA or DSHS for payment of an approved fee. In the past, if an SSI claimant was not on GAU or little GAU had been paid, lawyer may actually receive nothing on a completely successful SSI case if the client has disappeared or spent his/her retroactive award.

MEDICAL PROVIDERS'
QUESTIONS REGARDING MEDICAL LETTER WRITING
FOR SOCIAL SECURITY CLIENTS

1. WILL I BE REQUIRED TO TESTIFY, BE SUBJECT TO CROSS EXAMINATION, OR BE REQUIRED TO ATTEND A DEPOSITION?

No. -- Social Security hearings are fairly informal compared to other legal proceedings. You need only submit a letter. There is no opposing lawyer, and you will not be subpoenaed or cross examined. However, if you are concerned about a patient or client and wish to testify, this can be arranged. Obviously, testifying in person can be much more effective.

2. WILL A LETTER MAKE ANY DIFFERENCE?

Absolutely! -- Of those Social Security cases which are appealed, over 60% of the denials are reversed and the benefits are awarded. Properly framed letters from treating physicians, psychiatrists, and therapists are given great weight and are often the crucial evidence which proves that a claimant is disabled.

3. WHY ARE LETTERS MISCONSTRUED?

In writing a letter regarding your client's medical or psychiatric conditions, you should assume that the reader of your letter knows nothing about physical or mental illness. You should assume that the job of the person employed by the Social Security Administration or the Department of Social and Health Services who has requested medical information is to deny benefits. Of course,

neither of these statements is true, but assuming this perspective when writing a letter for a client or patient will help you write a precise and direct letter that will not easily be misconstrued. Remember, any positive comments you make, without clarifying the exact nature of these comments, might well be emphasized by the Social Security Administration to mean that there is no disability.

4. WHY DOESN'T SOCIAL SECURITY BELIEVE ME WHEN I TELL THEM THAT MY CLIENT IS GRAVELY DISABLED?

The determination that a client is "disabled" is a legal conclusion which is ultimately to be decided by Social Security. Such conclusions by a treating physician, without providing the medical evidence upon which the physician bases his or her opinion are virtually useless. Be sure to document your medical conclusions and professional opinions regarding the severity of your patient's disabling conditions with the medical facts contained in your patient's medical file.

SOCIAL SECURITY MEDICAL LETTER WRITING GUIDE

1) Review "Listing of Impairments"

- A. Review the area(s) of the "Listing of Impairments" for all mental problems from which your patient is suffering.
 - 1. Note **each** of the clinical findings and symptoms which the "Listing of Impairments" discusses under the relevant subsection.

2) Compare "Listing of Impairments" to Patient

- A. Compare each relevant listed impairment and the specific clinical findings with those findings that you or any other medical provider has made in the medical record of your patient.

3) Write Specific Letter

- A. Using the order and structure found in the relevant "Listing of Impairments," write a letter which does the following:
 - 1. Gives your general past history of treatment and dealings with the patient.
 - 2. Taking each disorder one at a time, as defined by the "Listing of Impairments," compare the exact findings or symptoms of the relevant listed impairment with the specific findings or symptoms of your patient.

4) Use Medical Terminology

- A. Do not simplify medical terminology, but use the recognized medical terms or measurements which may be mentioned in the relevant "Listing of Impairments."

5) Describe Limitations of Daily Activities

- A. Where relevant, include observations of how the medical symptoms or findings of your patient actually limit the normal functions of your patient.

1. In the case of mental impairments, pay special attention in addressing your professional opinions to an evaluation of the degree of functional limitations imposed on your patient by their mental impairments in the following four specific areas:

a.) "Restriction of Activities of Daily Living";

- (1.) Are patient's activities of daily living "**markedly**" restricted as compared to the normal daily activities of the average, unimpaired individual?

b.) "Difficulties in Maintaining Social Functioning";

- (1.) As compared with the wide range of social functioning experienced by the average unimpaired person, would you say that your patient's social functioning is "**markedly**" limited?

c.) "Deficiencies of Concentration, Persistence or Pace, Resulting in Failure to Complete Tasks in a Timely Manner (in a work setting or elsewhere)";

- (1.) Has your patient or client had "**frequent**" episodes of deficiencies of concentration, persistence or pace which have

resulted in a failure to complete tasks in a timely manner?

d.) "Episodes of Deterioration or Decompensation in Work or Work-like settings which Cause the Individual to Withdraw from that Situation or to Experience Exacerbation of Signs and Symptoms (which may Include Deterioration of Adaptive Behaviors)";

(1.) Has your client experienced such episodes of deterioration or decompensation "**repeatedly (three or more times)**"?

2. Provide the "raw data" or clinical information gained from your own observations or from the patient's medical history which support each of your conclusions regarding the severity of the above-described limitations you have noted. Remember that undocumented conclusions which simply recite that a patient has "marked restrictions of activities of daily living" will be disregarded as inadequately documented.

6) As a summary of your detailed narrative report, **if you believe that your patient "meets or equals" a Listed Impairment**, attach a completed Psychiatric Review Technique Form now required by the Social Security Administration in all mental impairment cases. Submitting the P.R.T.F. without a thorough narrative report which documents the ultimate conclusions found in the P.R.T.F. is of little use.

7) Consider Equivalency/Combination of Impairments

A. If a patient's clinical findings as to each separate impairment do not exactly match all of those findings mentioned in a relevant "Listing of Impairments," comment on whether

the conditions of your patient, individually or in combination, can be considered "medically equivalent" to the severity of conditions and resulting limitations of functions experienced by an average person who suffers from the relevant combination of listed impairments most analogous to the impairments of your patient.

- 8) Remember, even if the client's conditions do not meet or equal the "Listing of Impairments", many claimants are still disabled under Social Security standards as they cannot perform any "substantial gainful activity" on a regular, full-time basis.
- 9) Attach all available medical records regarding any condition of your patient with any letter you send.

Excerpts from
The Listing of Impairments (Adults)
20 CFR, Part 404, Subpart P, Appendix 1, Part A

(Relating to Spinal Cord Injuries)

Section 11.00 Neurological - Adult

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C. Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, **spinal cord**, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

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11.04 Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

Section 1.00 Musculoskeletal System - Adult

A. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. Impairments may result from infectious, inflammatory, or degenerative processes, **traumatic** or developmental events, or neoplastic, vascular, or toxic/metabolic diseases.

B. Loss of function.

1. General. Under this section, loss of function may be due to bone or joint deformity or destruction from any cause; miscellaneous disorders of the spine with or without radiculopathy or other neurological deficits; amputation; or fractures or soft tissue injuries, including burns,

requiring prolonged periods of immobility or convalescence. For inflammatory arthritides that may result in loss of function because of inflammatory peripheral joint or axial arthritis or sequelae, or because of extra-articular features, see 14.00B6. **Impairments with neurological causes are to be evaluated under 11.00ff.**

2. How we define loss of function in these listings.

a. General. Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the **inability to ambulate effectively on a sustained basis for any reason**, including pain associated with the underlying musculoskeletal impairment, or the **inability to perform fine and gross movements effectively on a sustained basis for any reason**, including pain associated with the underlying musculoskeletal impairment. The inability to ambulate effectively or the inability to perform fine and gross movements effectively must have lasted, or be expected to last, for at least 12 months. For the purposes of these criteria, consideration of the ability to perform these activities must be from a physical standpoint alone. When there is an inability to perform these activities due to a mental impairment, the criteria in 12.00ff are to be used. We will determine whether an individual can ambulate effectively or can perform fine and gross movements effectively based on the medical and other evidence in the case record, generally without developing additional evidence about the individual's ability to perform the specific activities listed as examples in 1.00B2b(2) and 1.00B2c.

b. **What we mean by inability to ambulate effectively.**

(1) **Definition.** Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.)

(2) To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail. The ability to walk independently about one's home without the use of assistive devices does not, in and of itself, constitute effective ambulation.

c. **What we mean by inability to perform fine and gross movements effectively.** Inability to

perform fine and gross movements effectively means an extreme loss of function of both upper extremities; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. To use their upper extremities effectively, individuals must be capable of sustaining such functions as reaching, pushing, pulling, grasping, and fingering to be able to carry out activities of daily living. Therefore, examples of inability to perform fine and gross movements effectively include, but are not limited to, the inability to prepare a simple meal and feed oneself, the inability to take care of personal hygiene, the inability to sort and handle papers or files, and the inability to place files in a file cabinet at or above waist level.

d. Pain or other symptoms. Pain or other symptoms may be an important factor contributing to functional loss. In order for pain or other symptoms to be found to affect an individual's ability to perform basic work activities, medical signs or laboratory findings must show the existence of a medically determinable impairment(s) that could reasonably be expected to produce the pain or other symptoms. The musculoskeletal listings that include pain or other symptoms among their criteria also include criteria for limitations in functioning as a result of the listed impairment, including limitations caused by pain. It is, therefore, important to evaluate the intensity and persistence of such pain or other symptoms carefully in order to determine their impact on the individual's functioning under these listings. See also §§ 404.1525(f) and 404.1529 of this part, and §§ 416.925(f) and 416.929 of part 416 of this chapter.

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E. Examination of the spine.

1. General. Examination of the spine should include a detailed description of gait, range of motion of the spine given quantitatively in degrees from the vertical position (zero degrees) or, for straight-leg raising from the sitting and supine position (zero degrees), any other appropriate tension signs, motor and sensory abnormalities, muscle spasm, when present, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examination table. Inability to walk on the heels or toes, to squat, or to arise from a squatting position, when appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs, or both upper and lower arms, as appropriate, at a stated point above and below the knee or elbow given in inches or centimeters. Additionally, a report of atrophy should be accompanied by measurement of the strength of the muscle(s) in question generally based on a grading system of 0 to 5, with 0 being complete loss of strength and 5 being maximum strength. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip and pinch strength.

2. When neurological abnormalities persist. Neurological abnormalities may not completely subside after treatment or with the passage of time. Therefore, residual neurological abnormalities that persist after it has been determined clinically or by direct surgical or other

observation that the ongoing or progressive condition is no longer present will not satisfy the required findings in 1.04. **More serious neurological deficits (paraparesis, paraplegia) are to be evaluated under the criteria in 11.00ff.**

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