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WHITMAN-WALKER CLINIC

LEGAL SERVICES PROGRAM

PROCEDURES FOR HANDLING SOCIAL SECURITY DISABILITY APPEALS AT THE ALJ HEARING LEVEL[1]

This document sets forth the process and timeline for handling an ALJ hearing for a client whose initial application and Request for Reconsideration (the first level of appeal) for Social Security disability benefits have both been denied. The Whitman-Walker Clinic Legal Services Program (WWC-LSP) wants to provide as much guidance and support as possible to help volunteers accepting these cases. The following document sets forth important information and timelines to remain aware of, as well as useful tips for working on a ALJ Hearing case. However, this document is only a general overview of the major issues. For more information, we encourage you to seek mentoring and to consult the Social Security law, regulations, and rulings.

CLIENT CONTACT

Usually, a volunteer will set up two initial meetings with a client to obtain information. At the first meeting, the volunteer should obtain basic information and get the client's permission to obtain medical records. The first meeting should be more of an introduction meeting, so that the client does not get overwhelmed and feel burdened with providing answers or documents.

Upon receipt of case: *Within one week* of receiving a case from WWC-LSP, the volunteer should have the first meeting with and interview the client using the intake checklist. At this meeting the volunteer should:

- Obtain the names and addresses of all the client's medical providers
- Get the client's signature on the forms listed below, including the Medical Release Forms
- Get the client's signature on forms being sent to the Social Security Administration (SSA) office immediately
- Establish a regular time for meeting with or contacting the client, preferably once a week, but no less than once every two weeks

Within one day after the initial client meeting: The volunteer should file the following documents with SSA:

- Cover letter
- Request for Hearing (Form HA-501)

[1] The guide was written primarily by Erin Loubier, Senior Managing Attorney, Whitman-Walker Clinic, with substantial assistance from Elizabeth Harrison Hadley, Senior Volunteer Attorney.

- Disability Report – Appeal (Form SSA-3441)
  (available online at https://s044a90.ssa.gov/apps6z/i3441/)
- Signed Authorization to Release Information (Form SSA-827)
- Appointment of Representative (Form SSA-1696)

➢ **Practitioner's Tip:** The Disability Report – Appeal asks whether there is new evidence and, if so, directs that it be submitted within 10 days. In most if not all cases, it will not be feasible to develop and submit new evidence to the SSA within ten days after a person files for a hearing. The attorney should state in the cover letter that accompanies the Request for Hearing and Disability Report – Appeal that any new evidence will be submitted in advance of the hearing. This is a common practice, and we are not aware of any cases where a client has been penalized because evidence was submitted in advance of the hearing but not within 10 days of the filing of the Disability Report – Appeal. The report should include, at a minimum, the current HIV physician, as well as any other current treating physician if there is another alleged disabling condition. Note that a list of medications will be provided with medical records, and indicate that you will supplement the claimant's work background with your brief. We recommend that advocates explain functional limitations using the questions provided on the Whitman-Walker functional limitations form in the form of an affidavit.

At the second meeting: The volunteer should:

- Discuss medical conditions, symptoms, limitations, activities of daily living and ability/inability to perform them
- Ask the client if s/he is aware of anyone who would be willing to write an affidavit to support his medical claims (family/friends/co-workers)
- Work with the client to write his/her own affidavit

➢ **Practitioner's Tip:** The volunteer should be aware that additional meetings with the client may be necessary. Time may be a limiting factor to getting the necessary information in one meeting, as well as the stamina and motivation of the client. Additionally, the client may have information useful for updating the appeals, so s/he may wish to meet with the volunteer again.

The client has 60 days from the date of the denial letter to file a Request for Hearing. However, the volunteer should file the documents named above as soon as possible. Indicate in the cover letter that these documents will be supplemented in the near future with the client's medical records, supporting documents, and a brief arguing how the client meets the SSA's disability criteria.

➢ **Practitioner's Tip: Always file at the SSA office where the client initially applied for benefits.** A volunteer who files documents elsewhere for short-term convenience risks many complications, including the loss of the client's file and/or delays.

➢ **Practitioner's Tip: Always file by certified mail, return receipt requested, or file in person and obtain a date-stamped receipt for the filed documents.** It is not unusual

for SSA to lose files and documents. Proof of receipt is well worth the effort and may prove critical for preserving a client's appeal rights.

- **Practitioner's Tip: Always follow up with the local office and the Office of Disability Adjudication (ODAR), which is the hearing office, to ensure that the appeal has been entered and the file has been sent to ODAR.**

OBTAINING THE CLIENT'S MEDICAL RECORDS

After meeting with the client and filing the preliminary documents listed above, the volunteer should begin **immediately** to gather the client's medical records. A brief cover letter and a signed copy of the client's consent to release medical records should be sent to each provider. **All requests for medical records should be mailed within one week of the initial meeting with the client.**

After mailing or faxing the requests for medical records, the volunteer should follow-up with each provider within two weeks. Obtaining the medical records can be a lengthy and time-consuming process, and volunteers need to be very proactive in pursuing them. Medical records are often voluminous and may take time to copy. Also, some providers will require the client to sign the provider's own consent form before they will release any information. With the new Health Insurance Portability and Accountability Act (HIPAA) requirements, most providers will be especially careful about releasing information. These additional requirements imposed by providers will cause delay, so volunteers need to be prepared to spend extra time and energy tracking down medical records.

- **Practitioner's Tip:** Many lawyers fail to pursue the medical records aggressively. Do not assume that providers will respond in a timely fashion. Be proactive about gathering the records.

- **Practitioner's Tip:** Keep in touch with your client so that you know of any new medical appointments and can continue to update the records as the process progresses.

ANALYZING THE MEDICAL RECORDS

Each set of medical records should be treated as a distinct appendix. The volunteer should prepare a coversheet for each set of medical records separated by provider. The client's name and Social Security number should be at the top and the middle of the page should have the name of the physician, hospital, or other provider who treated the client and the dates of treatment covered by the records. Each page of the record should be bate-stamped/labeled by number in the bottom right corner or the bottom middle of the page. Then, when writing the brief, the volunteer should cite to each appendix by page when documenting the existence of symptoms.

To write the brief, the volunteer should study the intake form and notes from the client meetings. For each symptom mentioned by the client, the volunteer needs to examine the medical records and note places where that symptom or condition is documented.

- **Practitioner's Tip:** Examining the medical records can be time-consuming. Often the records are barely legible and out of order. The time devoted to organizing them and taking notes on their contents, however, will greatly expedite writing the brief.

- **Practitioner's Tip:** Create a chart with all of the medical conditions, diagnoses, symptoms listed on the left column of the chart. Create a short hand code for each medical provider's records, i.e., WWC for Whitman-Walker Clinic. As conditions, diagnoses, and symptoms are mentioned in the medical records, list the code and page number of the symptom mentioned, i.e., left column has diarrhea and you find diarrhea in the Whitman-Walker Clinic records at pages 1, 4, 10, 15 and the Washington Hospital Center records at 15, 16, 20, 21, 22. The entry on your chart would be WWC 1,4,10, 15 and WHC 15-16, 20-22. When writing the brief, the citations for your allegations goes very quickly. The chart also helps indicate where your records are light and may need some communication with a treating physician.

ESTABLISHING CONTACT WITH THE SOCIAL SECURITY ADMINISTRATION (SSA) AND THE OFFICE OF DISABILITY ADJUDICATION AND REVIEW (ODAR)

Once the volunteer receives the return receipt confirming that SSA has received the Request for Hearing and other initial filing documents, he or she should follow up with that local SSA office by phone. It is important to confirm that the case has been entered into SSA's computer and that the file has not been lost.

After receiving a Request for Hearing, SSA will forward the case to the Office of Disability Adjudication and Review (ODAR) for assignment to an ALJ and scheduling of the hearing. By calling the local SSA office, the volunteer can confirm whether the case has been forwarded to ODAR. (Most DC, suburban Maryland, and Northern Virginia cases are sent to the DC hearing office/ODAR). The volunteer should also follow up with ODAR to confirm that it has received the file and find out if the case has been assigned.

- **Practitioner's Tip: ODAR Contact Information**

  Office of Disability Adjudication and Review (ODAR)
  820 First Street NE
  Union Center Plaza II
  Eighth Floor
  Washington, DC 20002
  Phone: (202) 523-0412
  Fax: (202) 408-8995

- **Practitioner's Tip: Copying the File – Make an Appointment at ODAR.** Once the case is at ODAR, the volunteer should arrange a "copy appointment." The copy appointment is made through the main number. There are copy machines and paper available at ODAR. You show up for your appointment and then are given the file and can make a complete copy. It can be helpful to wait until the case is "pulled". Pulling is

the method to organize the file into exhibits. Some advocates want a copy of the file immediately to gather evidence. Others wait until the case has been "pulled". ODAR has recently begun to offer claimants a complete copy of their case file on disk. The attorney should request this disk as soon as the case has been sent to ODAR.

WRITING THE BRIEF

The brief should be structured as follows:

1. Overview of Case: Brief statement naming the client and stating that this is a Request for Reconsideration of SSA's denial of medical benefits under SSI, SSDI, or both.

2. Procedural history of case: State the dates of initial application, denial, reason for denial (medical), and date of application of Request for Reconsideration. Explain that the purpose of the letter is to summarize the client's medical records and explain why the denial was in error. State that, because the client suffers from a terminal illness, SSA's regulations for expediting such cases, known as the TERI regulations, apply. At the top of the first page of the brief, above the date and the inside address, insert in bold: **"This is a TERI claim; Mr. XXXX has AIDS. Please process pursuant to POMS sections DI E11010.001 and DI E23020.001."**[2]

3. Description of client and inclusive list of medical conditions: A summary of the client's age, medical condition, HIV-related conditions, symptoms, and hospitalizations, and any other medical conditions or hospitalizations. Include dates. ***List the symptoms and conditions in order of importance, not chronologically.***

4. Analysis of Medical Conditions and Medical Evidence: For each symptom, cite to the relevant SSA "Listing of Impairments." See POMS section D1 34001.010A.14.08 A – L. Then cite the client's medical record (by appendix and page) to show that he or she meets the requirements of the Listing or regulation. These are known as "stand alone" conditions, and if the client suffers from the condition at the required level of severity, and also has evidence of HIV infection, he or she will most likely be found disabled.

If the client does not meet a Listing, but has had three or more hospitalizations within one year, or required three or more intravenous treatments in one year, for one of the HIV-related conditions specified in POMS section D1 34001.010A.14.08 M, show where the hospitalizations are documented in the medical record and argue that the client is disabled under this standard. The requirement of three hospitalizations for the same condition in one year is strict.[3]

If the client does not meet a Listing and has not had three or more hospitalizations within one year, cite POMS section D1 34001.010A.1408N and explain how the combined effect of the

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[2] **POMS is the Program Operations Manual System and can be found on the SSA website: https://secure.ssa.gov/apps10/poms.nsf/aboutpoms.**

[3] If a client has had two long hospitalizations, i.e., hospital stays of several days to a week or more, the volunteer should argue that these are the equivalent of three short hospitalizations because a single hospitalization need not be an overnight stay. The point is to show that the same AIDS-related infection or condition is serious enough to require hospitalization and repeatedly interrupts a client's life. The SSA has accepted this reasoning in certain cases.

client's conditions and symptoms prevent him or her from working and affect his or her activities of daily living. Under this regulation, "repeated manifestations of HIV infection" which result in restrictions on the client's activities of daily living, or difficulties in maintaining social functioning, or difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace, will result in a finding of disability. For this argument, cite all relevant conditions documented in the client's medical record, both HIV-related and non-HIV-related health issues. Also cite the client's affidavit regarding his or her activities of daily living and the functional limitations report. Cite any other affidavits submitted by friends or others to substantiate the client's difficulties with working and carrying out daily activities.

- **Practitioner's Tip:** Each affidavit should be made a separate appendix and date-stamped. Cite to the specific appendix and page to document assertions about the client's residual functional capacity and ability to perform activities of daily living.

In working with the client to obtain an affidavit, the volunteer should make sure that the client describes all his or her physical and mental symptoms and documents thoroughly the ways in which his or her life has changed with the onset of severe illness. Sometimes clients become so accustomed to living with debilitating conditions, such as frequent diarrhea or extreme fatigue, that they do not even mention them to the doctor. For this and other reasons, medical records may not adequately document the state of the client's health. Also, because a client's affidavit is by necessity a subjective document, in which the client's symptoms are self-reported, it is helpful to obtain the testimony of others to document their observations about the client's health and limitations.

Summary of Analysis of Medical Conditions: Briefly summarize the medical evidence cited and assert that the client meets either a Listing or the requirements of another regulation and should therefore be found medically disabled. The paragraph should then state that, even if SSA disagrees with the conclusion that the client is medically disabled, a vocational assessment will show that the client cannot perform his previous job or any full-time job in the national economy, given the client's age, education, and prior work experience.

5. Vocational Assessment: If SSA determines that a client's medical evidence does not, in and of itself, establish disability because the claimant's condition does not meet or equal a Listing, SSA will perform a "vocational assessment" to determine the claimant's ability to work despite the impairment. SSA looks first at a client's past relevant work, which generally means a job that the client has performed in the past. However, even if SSA determines that the claimant cannot return to his or her past work due to the alleged impairment or impairments, SSA will then evaluate whether the claimant is able to do any job that exists in significant numbers in the national economy. To make this analysis, SSA relies heavily on the Medical Vocational Guidelines, also known as the GRIDS. (See 20 CFR 404, Subpart P, Appendix 2, for the GRIDS).

Using the GRIDS, the volunteer should do a vocational analysis for the client. Briefly summarize the client's age and job experience. Compare them to the appropriate GRID. Attempt to show that the GRIDS for light or sedentary work are the ones relevant to the client; there is a greater likelihood of a finding of disability if these GRIDS apply. Argue that the

client's residual functional capacity, i.e., remaining ability to do work, prevents him or her from doing even light or sedentary work.

Assessment of Non-Exertional Factors: The GRIDS apply only to the aspects of work requiring physical exertion (e.g., standing, lifting, walking, etc). They do not apply to non-exertional aspects of working, such as memory, concentration, and other mental skills. If a vocational analysis of the client's condition using the GRIDS does not clearly produce a finding that the client is disabled, the volunteer should argue that the GRIDS do not apply because the client's disability stems from non-exertional issues.

- **Practitioner's Tip:** For a fuller explanation of the SSA listings and the GRIDS, see www.ssa.gov.

6. Summary and Conclusion: Conclude the brief with a statement indicating that the client meets or equals a Listing or the requirements of a regulation because of specific medical conditions and symptoms as noted. Offer the alternative argument that, even if SSA disagrees with this conclusion, a vocational assessment indicates that the client cannot perform his or her previous job, or any job available in the national economy. Finally, if appropriate, argue that the GRIDS do not apply because the client's limitations arise from non-exertional factors. Ask for a finding of disability. Note that because the client is HIV-positive, the TERI regulations apply and the case should receive expedited processing.

PREPARATION FOR THE HEARING

Vocational Assessment of Claimant

SSA looks first at a claimant's past relevant work, which generally means a job that the claimant has performed in the past. However, there are three exceptions. First, any work that is not substantial gainful activity (SGA), i.e., work that pays less than the annual SGA amount set by the SSA (available at ssa.gov), is not considered past relevant work. Second, the SSA excludes any work that the claimant did not perform long enough to learn how to do it. Third, work performed over 15 years before either the date the claimant applied for disability benefits or the date of onset of disability is not considered past relevant work.

An important concept in SSA's determination of the severity of a disability and its impact on a claimant's ability to work is the "Residual Functional Capacity," or "RFC." A claimant's RFC refers to the claimant's capacity to perform activities and function, despite the physical and mental limitations caused by the claimant's medical condition or combination of conditions. In determining a claimant's RFC, SSA must consider the total combined limiting effects of all the claimant's medical conditions, even those medical conditions that by themselves are not considered severe.[4] At Step 4 (and at Step 5 if the analysis proceeds to that step), SSA analyzes a claimant's RFC in detail. (See explanation below.)

RFC is divided into physical RFC and mental RFC. Physical RFC refers to the claimant's ability to perform the physical demands of a job, including sitting, standing, walking,

[4] *See* 20 C.F.R. § 404.1545 (a) (2).

lifting, carrying, pushing, pulling, or performing other functions requiring manipulation or certain body postures. [5] To measure these physical demands, SSA assigns each job to one of five levels measuring its exertional requirements:

- Sedentary: Jobs that require only occasional walking or standing (for no more than a total of two hours per day), lifting no more than 10 pounds, and occasionally lifting or carrying light articles such as files, ledgers, or small tools.

- Light: Jobs that require lifting no more than 20 pounds, with frequent lifting or carrying of no more than 10 pounds (for one third to two thirds of the day); or very little lifting or carrying but a frequent walking or standing; or primarily sitting but requiring some moving of arm or leg controls. To perform light work, a claimant must be able to do all these activities.

- Medium: Jobs that require lifting no more than 50 pounds, but with frequent lifting or carrying of objects weighing up to 25 pounds, and the ability to use hands and arms to grasp and hold objects, but not for precision work.

- Heavy: Jobs that require lifting no more than 100 pounds, but the frequent lifting or carrying of up to 50 pounds.

- Very heavy: Jobs that require lifting objects weighing more than 100 pounds, and the frequent lifting or carrying of objects weighing 50 pounds, or more.

Physical RFC also measures non-exertional requirements such as a claimant's sight, hearing, ability to manipulate objects, tolerance of dust and fumes, and similar attributes that are dependent on a claimant's physical health.

A claimant's mental RFC measures his or her ability to perform certain mental activities, such as understanding, remembering, and carrying out instructions. It also measures the claimant's ability to handle supervision, interact with co-workers, and cope with the demands and pressures generated by working.[6]

The claimant has the burden of proving both that he/she does not have the capacity to return to past relevant work, and that this inability results from the claimant's impairments, not from other problems. SSA compares the claimant's RFC to the requirements of the claimant's relevant previous jobs. A claimant who is deemed able to return to past work will not be found disabled.

If the claimant proves that he or she cannot return to Past Relevant Work due to the alleged impairment or impairments, SSA then asks whether the claimant is capable of performing any job that exists in significant numbers in the national economy. At this step, the burden of proof shifts to SSA to demonstrate that there are other jobs that a claimant could

[5] *See* 20 C.F.R. § 404.1545 (b).
[6] *See* 20 C.F.R. § 404.1545 (c).

perform. The claimant's ability to do other work is determined by evaluating the claimant's physical and mental RFC, including both the exertional and non-exertional abilities inherent to the claimant's RFC, as well as an evaluation of the claimant's age, education, and prior work experience.

To perform this analysis, SSA relies heavily on the Medical Vocational Guidelines, also known as the GRIDS.[7] The GRIDS consist of tables based on the RFC required for sedentary, light, and medium work. Each table contains rules evaluating a claimant's age, education, and work experience. Each rule dictates a finding of disability or non-disability in a specific case, but only if the claimant precisely meets the criteria of a given rule.[8]

In using the GRIDS, SSA is evaluating the claimant's ability to apply the work skills used in previous jobs to other employment. To assess the transferability of a claimant's skills, SSA also evaluates a claimant's age, level of education, and literacy in English. In general, the GRIDS presume that older claimants are less able to adapt their skills to a new job than younger claimants, and that claimants with little education are also less adaptable to new work situations than better-educated claimants. In addition, the GRIDS assume that unskilled work is never transferable.

To implement these assumptions, the GRIDS divide age, education, and types of work into different levels. A claimant is categorized as:

- Younger (ages 18 to 49);
- Closely approaching advanced age (age 50 to 54);
- Advanced age (age 55+); or
- Closely approaching retirement age (ages 60 to 64).[9]

Levels of education are divided into:

- Illiterate, marginal (6^{th} grade education or less);
- Limited (7^{th} through 11^{th} grade education); and
- High school graduate and above.

Work is divided into levels depending on the level of training, judgment, and precision required:

- Unskilled,
- Semi-skilled, and
- Skilled.

[7] SSA's GRIDS are included in Appendix D of this chapter; *see also* 20 C.F.R. § 404 Subpart P, App. 2.
[8] See 20 CFR 404, Subpart P, Appendix 2, for the GRIDS, which are also reproduced in the Appendix of this Chapter.
[9] *See* 20 C.F.R. § 404 Subpart P, App. 2 at § 201.00 (h).

Cross Examining the Vocational Expert (VE)

The key to preparation for the vocational expert follows preparation for the case generally. Collecting medical evidence from the treating physician/medical sources is critical. The ALJ is required by law and regulation to defer to the treating physician – this is known as the "treating physician rule." Therefore gathering evidence that explores the limitations that the claimant has is necessary to establish the limitations in activities of daily living and work related tasks. During the direct examination of the claimant, it is crucial to have the claimant testify to how the symptoms and conditions that he or she experiences limit his or her ability to perform activities of daily living, prior work, and any kind of work in the national economy. Getting this testimony out during direct is critical to then use during cross examination of the VE. Preparing a list of all of the claimant's symptoms and major citations in the medical evidence can be helpful to have during the direct examination and cross examination as a means to ensure that they are all in the record.

The ALJ will pose hypotheticals to the VE as a means to ask the VE whether the claimant is able to perform jobs in the national economy. The volunteer should carefully take notes on the hypotheticals posed and determine what facts about the claimant were not reflected in the ALJ's hypothetical to the VE. If the ALJ accurately depicts the claimant in the hypothetical, are there any additional facts or nuances that need clarification for the VE to get an accurate picture of the limitations that the claimant experiences. If there are, then you need to add those facts to the hypothetical by posing questions to the VE.

AFTER THE DECISION IS RECEIVED

Favorable decision: If the client receives a favorable decision from SSA, the volunteer should make sure that the client actually receives his or her benefits, and that the benefits have been correctly calculated.

Denial: If the client receives a denial, he or she has **60 days to file an appeal.**

Within one week of the denial, the volunteer should counsel the client regarding the likelihood of success in an appeal. The volunteer should evaluate whether the client was denied disability benefits because the case is deficient in some way, or whether the SSA simply did not receive or did not evaluate all relevant evidence.

Appeals have a strict time limit, so within two days of counseling the client about whether to appeal, the volunteer should notify WWC-LSP about whether he or she will represent the client on appeal by sending a closing form on the Reconsideration request and indicating whether he or she will keep the case for an appeal.

If the volunteer chooses not to continue handling the case, he or she should return two complete copies of the file to WWC-LSP immediately. The volunteer should also include a brief cover memorandum assessing the strengths and weaknesses of the case. This needs to be done promptly so that WWC-LSP can evaluate whether to re-assign the case and ensure that the

appeal is timely filed. If the client wishes to pursue an appeal, the volunteer should counsel the client to call WWC-LSP as soon as possible.