WHITMAN-WALKER CLINIC

LEGAL SERVICES PROGRAM

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

This document sets forth the process and timeline for handling a Request for Reconsideration for a client whose initial application for Social Security disability benefits has 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 Reconsideration case. However, this document is only a general overview of the major issues. For more information, consult the WWC-LSP Social Security Appeals Manual.

CLIENT CONTACT

Usually, a volunteer will set up two meetings with a client to obtain information. At the first meeting, the client 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 Reconsideration (Form SSA-561)
- Disability Report – Appeal (Form SSA-3441)

[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.

- Signed Authorization to Release Information (Form SSA-821)
- Appointment of Representative (Form SSA-1696)

At the second meeting: The volunteer should:

- 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 <u>60 days</u> from the date of the denial letter to file a Request for Reconsideration. 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 and a letter brief.

- **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.

<u>OBTAINING THE CLIENT'S MEDICAL RECORDS</u>

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 naming 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 date-stamped. Then, when writing the letter brief, the volunteer should cite to each appendix by page when documenting the existence of symptoms.

To write the letter brief, the volunteer should study the intake form and client notes. 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 letter brief.

ESTABLISHING CONTACT WITH THE SOCIAL SECURITY ADMINISTRATION

Once the volunteer receives the return receipt confirming that SSA has received the Request for Reconsideration and other initial documents, he or she should follow up with the relevant 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 disability case, SSA will forward the case to the Disability Determination Service (DDS) for medical review. By calling the local SSA office, the volunteer can confirm whether the case has been forwarded to the DDS for the relevant jurisdiction. (There are separate DDS offices for Maryland, Virginia, and the District.) If the case has been forwarded to DDS, the volunteer should call DDS and obtain the name of the examiner assigned to the case. It is important for the volunteer to introduce himself or herself to the examiner and explain that the volunteer is in the process of gathering medical records and will file them and a letter brief as soon as possible. The volunteer should offer to assist the examiner by providing any information necessary for the processing of the case.

- **Practitioner's Tip:** The volunteer should make clear to the DDS examiner that s/he will try to locate and provide any information that the examiner needs. Throughout the reconsideration process, the volunteer should keep in contact with the DDS examiner and attempt to resolve any issues or provide any information that will help the client obtain a favorable decision from DDS.

- **Practitioner's Tip:** It is important to be solicitous and polite in all conversations with the DDS examiner. When checking on the status of a client's case, the volunteer should always offer to assist the DDS examiner and request whether any additional information would be helpful. Because a favorable decision at this stage is extremely beneficial to the client, the volunteer should not pressure the DDS examiner to make a hasty decision.

WRITING THE LETTER BRIEF

The letter 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 letter 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]

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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.

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 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 letter 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.

FOLLOWING-UP WITH THE DISABILITY DETERMINATION SERVICE (DDS)

File the letter brief and medical records with the appropriate SSA office, either in person or by certified mail, return receipt requested. Follow-up by phone to make sure that the materials have been received and logged into SSA's system. Also contact the DDS examiner to make sure that he or she receives them.

It is important to keep in regular touch with the DDS examiner. After the initial phone call, the volunteer should contact the examiner regularly to learn the status of the case. The volunteer should also inquire whether the examiner needs additional information about an issue or condition; if so, the volunteer should offer to obtain it. It is important for the volunteer to present himself or herself as a resource for the DDS examiner. Discuss with the examiner the strengths and weaknesses of the case and offer to provide additional information.

Timeframe. The letter brief and medical records should be filed within two months of filing the Request for Reconsideration, at the latest. Volunteers who wait longer risk the possibility that the DDS examiner will make a decision in the case before receiving the additional medical records and the letter brief.

- **Practitioner's Tip:** There is a tension inherent in the Request for Reconsideration process between urging SSA to make a decision in the case as soon as possible, and asking them to refrain from deciding until all relevant medical evidence has been collected and submitted. This is why volunteers must be diligent about collecting and analyzing the medical records as soon as possible, and staying in touch with DDS to know where the disability examiner is in the decision-making process.

Once the letter brief is filed, it is appropriate to check in with the DDS examiner every few weeks to learn the status of the case and check if any other information is required. The volunteer should expect a decision within four months of filing the letter brief. If the client has not received a determination within this time, the volunteer should call WWC-LSP to discuss the case.

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.