SSDI Claims Guide for Paralegals

I. Basic Information

a. Social Security offers disability through two main programs: Disability Insurance Benefits (DIB) and Supplemental Security Income (SSI).
   i. DIB is a benefit paid to individual's who have achieved insured status with SSA through their payment of federal taxes generally for 5 out of the last 10 years. Essentially, a disabled worker is asking SSA to pay his/her retirement pension early as a disability pension.
      1. Disability benefits are roughly equal to full retirement benefits.
         a. Clients can find this information through a "my Social Security" account obtained at ssa.gov.
   ii. SSI is a benefit paid to disabled or retired people who have not obtained insured status because they never worked, never worked and had taxes withheld, or worked, but not enough, to obtain insured status.
      1. SSI is means tested. It is based on medical eligibility and income/resource limits.
   iii. Some people who are insured but have a low earnings record are eligible for both benefits—DIB and SSI.

b. Benefits are obtained by filing an application for benefits with SSA.
   i. DIB benefits can be applied for online.
   ii. SSI benefits generally can be applied for directly with Social Security over the phone or in person. SSA is working on a protective filing date application that starts the process online.

c. The application process begins by filing an application. If the application is denied, a Request for Reconsideration is filed. If it is denied, a Request for Hearing before an Administrative Law Judge (ALJ) is filed. If it is denied, a Request for Review of Hearing Decision is filed with the Appeals Council. If the Appeals Council appeal is denied, the claimant has the right to file a lawsuit against Social Security in federal district court.
   i. Most cases are won after the Request for Hearing is filed.
      1. The rate of approval varies by year, by office and by case type. The rate is as low as 40% and as high as 80%.
   ii. National approval rates are obtainable at https://www.ssa.gov/policy/docs/statcomps/di_asr/2020/sect04.html.
      1. The rate of approval on initial applications is usually is between 20 and 30 percent.
      2. The rate of approval at the reconsideration appeal is between 7 to 13 percent.

d. Representatives before SSA are required to follow the "Rules of Conduct and Standards of Responsibility." *See:* 20 CFR § 404.1740.

e. A claimant is disabled if, because of severe and non-severe medically determinable impairments, he/she cannot perform past relevant work (PRW) and, based on age, education and work history, cannot perform significant numbers of less exertional work.
    i. Past relevant work is work performed at the substantial gainful activity (SGA) level within the 15 years prior to the onset of disability.
    ii. Substantial gainful activity is work activity that is substantial, gainful and, in general, exceeds an annual rate. For 2022, SGA is $1,350 per month in gross wages for non-blind individuals.
f. Sources of law. Social Security is governed by regulations, found in 20 CFR Parts 400 – 499. Disability rules are contained mostly in Part 404. SSI rules are found in Parts 416.
    i. Social Security issues Rulings which contain an explanation of Social Security's policy on certain issues.
    ii. Social Security has internal rules found within the Program Operations Manual System (POMS) that explain how SSA makes determinations and decisions in cases.
        1. POMS are used at the local field offices by the case workers.
    iii. The Hearing Office uses HALLEX as guidance/policy/procedure.

II. Obtaining Representation with SSA

a. Attorneys and non-attorney representatives can represent claimant's before SSA.
    i. Attorneys qualify for direct payment of an attorney's fee if they use an SSA approved fee agreement.
    ii. Non-attorneys qualify for direct payment of fees if they hold a bachelor's degree or have equivalent training/work in the field of disability and pass an examination given by SSA.
b. SSA maintains almost every disability file electronically. If you have submitted appropriate representation documents, SSA will provide access to parts of the electronic file at the initial and reconsideration phases. At the hearing phase, the entire electronic record is disclosed to the claimant.
c. SSA generally refers to an attorney/non-attorney as a representative
d. Any representative must file a SSA Form 1696 "Claimant's Appointment of Representative" with SSA to represent the claimant before SSA. *See*: https://www.ssa.gov/forms/ssa-1696.pdf.
e. **Practice Tip**: Always submit a signed, authorized fee agreement with the 1696. Otherwise, SSA assumes you are going to file a fee petition to receive an attorney's fee.
    i. Fee petition process is much more time consuming and can extend the time in which payment is received.
f. Since Covid, SSA has implemented an electronic e1696 allowing the representation forms to be filed without any physical contact between the claimant and representative. See: https://secure.ssa.gov/ssa1696/front-end/

i. **Practice Tip:** Your client needs an email address to submit this form which can be an issue. Many Social Security disability claimants are not computer savvy.

g. Having a form 1696 on file with SSA will allow SSA to discuss the claimant's case with you over the phone or in person.
   i. Section 2 "Disclosure" of the form allows the claimant to select a check box giving SSA permission to speak with not only the representative but also the representative's associates and staff members.

h. **Practice Tip:** SSA will almost always ask for several pieces of information to identify you as someone they can speak with even with a properly executed 1696 on file including: claimant's mother's maiden name, place of birth, DOB and mailing address.

III. **Medical Records, Opinion Evidence and Reporting Referrals**

a. Medical records are the most important type of evidence in a disability case.
   i. Almost all the decision-making at the initial and reconsideration levels of application/appeal come from evaluation of medical records. Very little consideration is given to the claimant's allegations.
      1. This leads to the vast majority of cases being denied initially and upon reconsideration.

b. At the initial and reconsideration phases, SSA delegates its decision-making authority to a state agency (in Kentucky we have the "Disability Determination Services") to make the disability decisions.
   i. The state agency will obtain copies of claimant's medical records based on the information given to it by the claimant and the claimant's representative.
      1. **Practice Tip:** It is important at the initial and reconsideration phases to stay in regular contact (every 6-8 weeks) to obtain updates about medical treatment from the client and provide that information to the state agency.
         a. We use a form document to provide that information to the state agency. You can mail, fax or electronically upload that information into the claimant's electronic claims folder.
   ii. At the Request for Hearing phase, SSA does not update medical records. That responsibility is passed to the claimant and/or the representative.

c. At the initial and reconsideration phases, SSA employs physicians/psychologists to review the claimant's medical records and provide opinions about the claimant's residual functional capacity (RFC), which is the most the claimant can do exertionally/non-exertionally despite his/her impairments.
   i. The claimant is never seen or talked to by these medical providers.
   ii. Many are not specialists in the field of impairment claimed by the claimant.

d. Opinions from the claimant's treating physician are often over-looked or rejected by the state agency.
    i. **Practice Tip:** From a strategy standpoint, it may not be a good idea to solicit an opinion from a treating physician at the initial and reconsideration phases because the state agency might offer a good reason for rejecting it, which can make things harder before an ALJ.
e. In March of 2017 SSA changed its rules about the weight an opinion from a treating physician is entitled. Prior to 3/17 well-supported opinions from treating sources (a physician who has treated the claimant on a regular and ongoing basis) were entitled to controlling weight if they were not inconsistent with the other substantial evidence of record. Controlling weight meant SSA was bound by that opinion.
    i. Even if the treating physician's opinion was not entitled to controlling weight, SSA regulations and federal case law gave considerable deference to the opinions of treating physicians.
f. Since March of 2017, SSA is no longer required to give deference to the opinions of treating physicians. Their opinions are entitled to no more weight than the opinion of a one-time examiner. Instead, SSA says medical opinions must be weighed based on their consistency and supportability with the rest of the medial evidence. The more consistent and supported the opinion is, the more weight it is supposed to be given.
g. Under SSA's rules of conduct and standards of responsibility for representatives, the representative is required to promptly provide SSA with all known evidence or disclose the existence of the evidence at least 5 business days before the hearing.
    i. The representative has an affirmative duty to disclose/submit all evidence.
h. The representative also has a duty to advise SSA if he/she drafted any forms/letters, etc. that were provided to any witness in an effort to solicit an opinion and the representative must disclose if he/she referred the claimant to any medical or vocational provider for a report/opinion.

IV. **Claim Evaluations: Disability Timelines, Identifying Weaknesses and Forming Strategies**.

a. Determine the claimant's alleged onset date (AOD) as soon as possible. It is the day the claimant became disabled under Social Security's rules.
    i. Usually, it is the last day the claimant worked, but not always.
    ii. Look at work activity before the AOD to see if it was an unsuccessful work attempt (UWA) to establish an earlier onset date.
        1. An UWA is defined in the regulations at 20 CFR § 404.1574. Generally, it is a short period of time worked by the claimant that ended because of the claimant's disability. If work is an UWA, it does not count against the claimant. A claimant can be disabled prior to an UWA.

iii. **Practice Tip:** Be on the lookout for claimant's who cannot identify the AOD. It happens more than you think and can be a red flag. Claimants who don't know when they became disabled can be problematic.

b. A clear, concise timeline is the best timeline. For example, the claimant worked at the same job for 25 years, sustained an injury, was taken off work and was never able to return because of the limitations caused by the injury. This is the ideal case.
    i. Frequently, cases do not follow that timeline. Many times, a claimant will attempt to return to work, but be unable to persist. Sometimes, they will switch occupations. Sometimes they leave the work force for other reasons.
    ii. Always obtain an explanation from the claimant if he/she alleges an onset date that is different from the last day worked.
        1. This is especially true if the claimant worked after the AOD or received unemployment benefits after the AOD.
    iii. Remember the disability must last for 12 continuous months to qualify for Social Security benefits. No matter how severe/limiting a medical condition is, it cannot qualify as a disability unless it lasts for 12 continuous months.
        1. **Practice Tip:** Be on the lookout for conditions like heart attacks, strokes, cancers that were treated in less than 12 months. Many times, the condition will not meet the duration requirement.
c. Does the medical evidence support the AOD? Sometimes, a claimant will stop working and later medical evidence supports disability. Be prepared to amend the onset date. ALJ's are generally more persuaded by the medical evidence than they are other evidence.
    i. When you think about your theory of disability, have specific reference(s) to the medical evidence. Be able to explain how the objective findings support the inability to sustain substantial gainful activity (SGA).
    ii. SSA prefers objective medical evidence over diagnosis. Objective medical evidence includes findings from diagnostic testing like an MRI or blood work. It also includes abnormal findings from physical examination like reduced range of motion, positive straight leg raising, impaired motor or strength functioning.
        1. Objective findings are always the most persuasive evidence. For instance, the claimant alleges severe, debilitating back pain but has only mild changes on x-ray, CT scan or MRI. No matter how legitimate the claimant's pain may be, that case will likely be denied because there is not substantial medical evidence of an impairment that could reasonably be expected to produce the pain the claimant is alleging.
d. Weaknesses:

i. AGE: claimants under the age of 50 have to prove they cannot perform their past work and <u>any other work</u> that exists in the national economy including sedentary work.
    1. It does not matter if the claimant has no sedentary work experience. SSA has taken judicial notice of the existence of thousands of unskilled sedentary positions existing in the national economy.
    2. It does not matter if there is no sedentary work available in the regional or state economy. It only has to exist somewhere in the national economy. Social Security assumes they can move.
    3. It does not matter if the work pays substantially less than the claimant's former work.
    4. **Practice Tip:** You have to make the claimant understand he/she has to prove the inability to perform just about any job, not only the past work. Many clients are very focused on the inability to perform past work and have a hard time understanding SSA may find they cannot perform past work but are still not disabled.
        a. This makes cases hard for younger individuals who have worked only medium and heavy manual labor.

ii. Work Skills: The more skilled the claimant's work history, the more transferable work skills SSA can find to allow for other work.
    1. In theory, the 40-year-old secretary is the worst client to have because you have to prove she cannot sustain work activity on a regular and ongoing basis (8 hours a day, 5 days a week).

iii. Spotty work history: SSA may assume the client is not inclined to work.

iv. Lack of medical treatment. Unless the claimant truly cannot afford to seek treatment, i.e., no health insurance SSA assumes there will be reasonable, necessary and ongoing medical treatment.
    1. The inability to seek necessary medical treatment and/or follow prescribed treatment can be used against your client unless there is a reasonable justification. Social Security has a ruling (SSR) explaining how the inability to seek treatment can be used to deny a disability case. *See:* SSR 18-3p.
    2. If you practice in a state that adopted the Obamacare Medicaid mandate (like Kentucky) your client may have access to Medicaid. It is important to talk to your client about what efforts he/she has made towards applying for Medicaid coverage.
        a. Also consider other practical things like what (bad) habits your client may have and if that interferes with medical treatment. For example, cigarette smoking is an expensive habit and many judges will not believe someone is impoverished if he/she smokes daily.

v. Inconsistent medical treatment or findings. Clients who do not follow the advice of medical providers, do not follow up on referrals, quit treatment or abruptly stop medication can be problematic. If the condition is so severe it keeps a person from working, SSA assumes the claimant is going to be in regular and ongoing treatment.
    1. Beware of claimants who quit physical therapy, stop taking medications after a short period of time, will not see a specialist, rely on antidotal information (the guy down the street) to make medical decisions, do not routinely follow up, ignore medical advice or just don't want to do what the medical provider says.
        a. These claimants may not be in true violation of a Social Security rule or regulation, but judges frequently do not believe claimants who have inconsistencies in their medical treatment.
    2. Similarly, beware of claimants who disagree with everything the medical providers recommend. Claimants who know more than the providers are a red flag.
    3. A more difficult issue is a claimant who refuses treatment, typically surgery, because of a fear of a bad outcome (or their uncle had the procedure and didn't get better). SSR 18-3p has good guidance on how to deal with this situation because it's not always black and white.

vi. Drug and Alcohol use. Social Security has a regulation that states a disabled person is not entitled to benefits if drug or alcohol use is material to the finding of disability. There is a Ruling—SSR 13-2p that discusses the Agency's policy regarding DAA (drug and alcohol addiction) in great detail.
    1. The ruling states occasional use does not make use material.
    2. Materiality looks at whether the claimant would be disabled without the influence of DAA. This is not so hard in cases involving physical impairments, but makes things terribly difficult when the impairments are mental.
        a. The Ruling does not require the claimant to prove a specific time of sobriety so a measure of functioning can be made without consideration of DAA, but practically, you almost have to have a sustained period of sobriety to show how the person functions without DAA.
            i. This makes it hard for the occasional user. They are never truly sober. SSA defines occasional has occurring one-third of the time or less. So a person using methamphetamine once a week is arguably an occasional user. But you would find very few medical providers who would say the "occasional"

meth use is not interfering with psychological functioning.

ii. Since drugs are illegal in most states, any drug use is generally going to be considered abuse.

e. Forming Strategies

i. Have a good intake process. Screen cases as much as possible on the front end.

1. Because you cannot access the Social Security file until after a 1696 is filed, you have to go on faith with some things your client tells you.

ii. Start reviewing the electronic record as soon as possible.

1. If it turns out the claimant has exaggerated health problems to you and the medical evidence does not support him/her, the earlier you know this the sooner you can either withdraw from the case or advise the client to get more medical treatment.

iii. Know your client.

1. Having a thorough interview with the client early on to learn about their work history, education and medical treatment will identify weaknesses (and strengths) early on.

iv. Stay up to date on medical treatment. Notify SSA at the initial and reconsideration phases of medical treatment.

1. At the initial and reconsideration phases you may want to request the records yourself.
2. If the client has access to medical portals, check those for records.

V. Initial Application, E-folder and Supporting Documentation

a. The initial disability application can be filed online.

i. Tailor a questionnaire to have the client complete before the first appointment.

ii. If the case is concurrent, meaning it is DIB and SSI, you can inform SSA the claimant wants to file for SSI through the disability application. Social Security will contact the client directly to get the income/resource information to determine eligibility.

1. We ask a few basic questions in our initial questionnaire to determine SSI eligibility. If we think they may be eligible, we will let SSA make the determination.

iii. Social Security is in the process of creating an online method of seeking a protective filing date for SSI only applications. The claimant will be able to file and preserve a filing date with SSA contacting them in the interim to determine financial eligibility.

b. When filing an initial application, you may not know whether the client is eligible for either DIB or SSI. You can look at the work history and make an educated guess, but if you are in doubt, you can direct your client to call the local SSA

office and ask what the date last insured (DLI) is. If they are not insured and do not have a DLI, they are not going to be eligible for DIB.

i. Some people have a remote DLI. You will have to prove disability began before that date or they will not be eligible.

1. For example, we represented a gentleman who applied for benefits in 2020 but had not worked since 2014. His DLI was 9/15 so we had to prove his disability started before 9/15. Even though his current age and medical conditions qualified him, those pieces of evidence were not relevant to his disability because of the remote DLI. We had to go back to his treatment notes from 2015 and earlier to prove his disability.

c. If the claimant is SSI only, you will have to defer to SSA to complete the application.

d. All the claimant's evidence will be stored electronically by SSA. SSA creates an E-folder through Electronic Records Express (ERE) on its website. It will contain your client's medical and other evidence. Once you have a valid 1696 in the file, SSA will provide you with electronic access to the file if you are a registered ERE user.

i. Use of the ERE system is mandatory for withholding and direct payment of attorneys' fees.

ii. You can submit evidence electronically into your client's electronic folder.

e. Supporting documentation

i. SSA, through the state agency, will request medical and other evidence based on the information they are given.

ii. It is not common for you to have to provide medical records directly to SSA.

1. As stated earlier, sometimes it is a good idea to request and submit evidence SSA is missing.

a. For example, the claimant recently underwent an MRI that revealed a ruptured disc. You would want SSA to have that info and it is worth your time to request it.

b. I would not make a habit of requesting evidence because SSA will expect you to do it more and more. You do not want to have the burden of accumulating evidence shifted to you by the state agency.

i. **Practice Tip:** obtaining medical evidence is the most time consuming and resource draining part of disability cases. In a perfect world, you could obtain all the records yourself, but it is not practical. Let Social Security through the state agency do its job.

iii. SSA will send multiple, lengthy forms for your client to complete (that they then will ignore.)

1. While it is tempting to do the forms for the client, I find it is worthwhile to at least let the client make an attempt at completing the forms. This is the best chance you will have to get their side of the story without any coaxing from you. It will identify possible issues or problems (like the client only focuses on inability to perform past work) in the case and allow you to address them early on.
2. At reconsideration, if you tell SSA there has been a change in the claimant's condition, the state agency will send most of the same forms to the client to complete again.
    a. **Practice Tip:** If there is no meaningful change in the claimant's abilities since the first set of forms was completed, do not complete the forms again. We have the client write something short and simple like "I'm still just as bad as before" on the forms and return the to the state agency.
        i. Some judges will look for inconsistencies in the initial and reconsideration forms and use it against your client**.**

f. You should have access to the "E" and "F" sections of the electronic claims folder shortly after the initial application is filed. The E section includes Disability Related Development documents. The F section contains Medical Records received while the state agency is reviewing the disability claim.
    i. To access the electronic record you are required to be a registered user of SSA's Business Service Online. You will receive a username and password to access SSA's Appointed Representative services. You must also register a cell phone number with SSA. A unique passcode will be texted to you each time you seek to enter a claimant's file online.
    ii. The file ultimately will contain Parts A, B, D, E and F. Parts A, B and D are not generally released to the claimant until a Request for Hearing is filed.
    iii. **Practice Tip:** Periodically review the electronic file, especially for the medical evidence. You can view it directly on Social Security's website if you are a registered user through the Electronic Records Express (ERE). Or you can download a copy from ERE or through third party providers (like Prevail or Assure Disability). The original file format on ERE is a .tiff document and/or a PDF. Third party providers usually provide a title page with hyperlinks to each document. SSA does not offer this service.
g. You can provide evidence directly to SSA, usually

VI. Requests for Reconsideration

a. The first appeal of an initial denial.

b. It must be filed no later than 60 days after the claimant receives the decision. SSA assumes the claimant received the decision within 5 days from the date of the decision.
    i. If you can show you received the decision more than 5 days from the date of the decision, you have 60 days from the date actually received.
        1. **Practice Tip:** Establish a habit of always date stamping mail the day it is received to establish the actual day you receive the initial denial.
c. SSA uses Form 561 "Request for Reconsideration" to initiate the appeal. It is filed along with a Form 3441 "Disability Report Appeal" and Form 827 "Authorization to Disclose Information…." *See:* https://www.ssa.gov/forms/ssa-561.html.
    i. The Request for Reconsideration should be filed online if you expect direct payment from Social Security. Using the electronic filing is a condition to receiving direct payment of the attorney's fee.
        1. Even if you file online, you still have to provide SSA with signed Forms 561 and 827 by the client. You can file it with the electronic appeal, fax it or mail it.
d. You are asking the same group of people to "reconsider" their first decision. The vast majority of the time, around 90%, SSA upholds the initial denial and denies the reconsideration.
e. The state agency updates medical treatment looking for anything that might change their first decision.

VII. Requests for Hearings and Briefs: What to Include and How to Frame the Case

a. A Request for Hearing before an Administrative Law Judge, SSA Form 501 is filed to initiate the second appeal. Forms 3441 and 827 are filed with the Request for Hearing.
    i. The same 60 days deadline applies.
    ii. It too is filed electronically.
b. A Request for Hearing moves the file from the state agency to the Social Security hearing office with jurisdiction over the case. The hearing office is known as the "Office of Hearing Operations" or OHO.
c. When the file reaches the hearing office, it will go through different phases as it is being prepared for a hearing, such as: master docket, pending folder assembly, pending ALJ assignment, ready to schedule, hearing scheduled, post hearing, pending decision writing, decision writing, closed.
d. Through the ERE access you can obtain a status sheet of all cases pending at the hearing level and it will tell you at which phase each case is.
e. Once the Request for Hearing is filed, SSA will no longer update medical or other evidence. It is important to review the file to establish what evidence is missing from the file or upcoming.
    i. At this phase, a lot of time and effort goes into requesting medical records from various medical providers and submitting those records directly to OHO via ERE.

ii. This is also a great time to attempt to obtain a medical opinion from claimant's treating physician.
    1. Medical opinions can be on a variety of issues:
        a. Does the claimant's impairment meet a Listing (a medical condition with specific criteria that automatically disables the client regardless of age, education or work experience)?
        b. Are there exertional limitations in the claimant's ability to: sit, stand, walk, lift, carry, push, pull?
        c. Are there non-exertional limitations in the claimant's postural abilities (balancing, kneeling, crouching, crawling, or climbing).
        d. Are there environmental limitations (avoiding dangerous machinery, heat, dust, fumes, noise)
        e. Are there other non-exertional limitations like difficulty functioning because of being nervous, anxiety, depressed; difficulty maintaining concentration or attention; difficulty understanding or remembering instructions; difficulty seeing or hearing.

f. Getting ready for a hearing:
    i. It is time to be absolutely certain about the claimant's age, education, past work history (15 years prior to disability onset or adjudication) and skills acquired while working, if any.
        1. SSA treats all adults from the ages of 18-49 as younger individuals. Younger individuals have to prove they cannot perform past work or any other work existing in the national economy, including sedentary work.
        2. From the age of 50-54, SSA will find the claimant is disabled if he/she cannot perform past relevant work and is capable of performing only sedentary work.
        3. From the age of 55 to retirement age, SSA will find the claimant is disabled if he/she cannot perform past relevant work and is limited to performing sedentary and light work. In other words, if the claimant cannot perform past relevant work and capable of performing light and sedentary work, he/she is still disabled.
    ii. Over time, SSA has diminished the importance of a limited education and literacy skills. *See:* SSR 20-1p.
    iii. Past relevant work includes the work performed at the substantial and gainful activity level and lasted long enough for the claimant to perform it and was not an unsuccessful work attempt. Generally it is the 15 year period before adjudication of the claim (the time of the hearing) or before the date last insured, whichever occurred earliest.
        1. Past work should be evaluated to determine the exertional level—sedentary, light, medium, heavy or very heavy.

2. And the skill level—unskilled, semi-skilled or skilled. If the work is semi-skilled or skilled, are there transferable skills? Transferability of skills is defined in 20 CFR § 404.1568 and § 416.968.
3. Jobs are usually defined under the Dictionary of Occupational Titles (DOT) and SSA relies on the DOT description of jobs.

iv. You must have a very strong understanding of the medical evidence, especially the objective evidence supporting impairments and limitations.
    1. Objective evidence includes medical signs that are measurable through diagnostic testing or physical examination.
        a. X-rays, CT scans, MRIs are very common pieces of diagnostic evidence.
            i. Not only do these reports define the impairment(s), but should also give you an idea of the severity of the condition—mild, moderate, severe.
        b. The abnormal signs obtained on a physical examination like reduced range of motion, muscle spasm, decreased strength, reflexes, etc. are also important pieces of evidence to substantiate (or diminish) the claimant's complaints.

v. The point of the hearing is to determine the claimant's residual functional capacity (RFC). RFC is the most the claimant can do despite his/her impairments.
    1. RFC is based on the limitations and symptoms from the claimant's medically determinable severe (and non-severe) impairments. It includes exertional and non-exertional limitations.
        a. Symptoms include pain. The claimant does not have to have evidence of the pain itself but SSA looks at whether there is a medical impairment which could reasonably be expected to produce the alleged symptom/limitation.

vi. Prepare your claimant to testify at the hearing.
    1. The hearing lasts about one hour. Identify the most important issues. Everything will not be covered. Some cases turn on whether the client can return to past work, some on whether the impairments have lasted 12 continuous months, some on whether the objective evidence supports the level of severity the claimant alleges. Find the most pressing issue.
    2. Practice questions with your client. Help them to answer with short, specific answers.
        a. The client should be able to identify each disabling impairment, describe the medical treatment for it and how it makes him/her feel.
    3. Walk them through their day-to-day limitations. For example, how long can they sit/stand/walk? Is that consistent with what they

actually do each day? Compare their daily activities to their limitations. Are those consistent?

4. Look for problematic statements in the medical evidence. Prepare the client to explain as necessary.
    a. Is there evidence of non-compliance on the part of the claimant? SSR 18-3p covers whether non-compliance can be used to deny a disability claim.
5. If the medical evidence is not overwhelmingly in favor of your client, is there a logical explanation? Maybe the client cannot afford treatment. Maybe he/she has exhausted all treatment options. *See:* SSR 16-3p for the Agency's explanation for how it evaluates symptoms.

g. The ALJ issues an unfavorable decision. How to appeal.
    i. An appeal of an unfavorable or partially favorable decision is taken by filing a Form 520 Request for Review of Hearing Decision with the Appeals Council. *See:* https://www.ssa.gov/forms/ha-520.html.
        1. The Form 520 can be filed online, it can be faxed to the Appeals Council or it can be filed with a local field office.
        2. A legal brief can be filed with the Form 520 or the claimant can ask for an extension of time to file a legal brief.
            a. The legal brief should highlight the factual and legal errors made by the ALJ.
            b. Grounds for reversal:
                i. Did not consider all the evidence of record.
                ii. Similarly, focused only on some of the evidence without explaining away contradictory evidence.
                iii. Did not properly weigh the medical opinions of record.
                iv. Did not adequately evaluate the claimant's pain or other symptoms.
    ii. The issue before the Appeals Council is whether the ALJ's decision is supported by substantial evidence or whether the ALJ violated one of Social Security's regulations.
        1. Substantial evidence is a *de minimis* standard. It is less than a preponderance of the evidence and more than a mere scintilla.
    iii. Winning with the Appeals Council is hard—nationally its rate of remand is generally never over 20% and is often closer to 10%.
    iv. That does not mean it is not worth filing an appeal. In order to exhaust administrative remedies, you must file the Request for Review.

VIII. **Federal District Court Appeals**

a. Federal district courts have jurisdiction over the final decision of the Social Security Administration under section 405(g) of the Social Security Act.

b. Suit is taken by filing a Complaint, naming the Defendant as the Commissioner of SSA.
c. The Defendant is served via the Attorney General, Office of General Counsel for SSA and the local US Attorney.
d. Once the Defendant is served, the Commissioner files an Answer and a copy of the administrative transcript.
e. The district court will typically issue a scheduling order, directing the parties to file a Motion for Summary Judgment to brief the case. The Plaintiff generally has 60 days from the filing of the Answer to file a Motion for Summary Judgment.
f. The Commissioner usually has 30 days to file its own MSJ.
g. After the Motions are submitted, the case will be decided in a written decision by the district court.
    i. In many courts, a Magistrate is assigned to review the briefs and make a recommendation.
        1. Consent to the Magistrate is not mandatory.
    ii. A party disagreeing with the Magistrate's recommendation generally has 10-14 days to file Objections to the Magistrate's report. After any objections are filed, the district court will rule and issue a judgment on the Motions for Summary Judgment.
    iii. The federal district court can reverse the denial of benefits and either remand the case back to the Agency for another hearing or enter an award of benefits.
h. The district court's final judgment is appealable to the US Court of Appeals.