CHAPTER 46

Obtaining Disability Benefits

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One of the most difficult issues faced by practitioners in the field of rheumatic diseases today is determining the degree to which their patients are disabled related to their capacity to perform work in the competitive labor market. Requests for such information come not only from patients, but from the programs that deal with determining disability and provide financial assistance for those who qualify.

The issue is surrounded by numerous and often very perplexing questions, e.g., "Can my patient perform work on a regular or part-time basis?" "Could he or she perform work if it were modified to accommodate existing physical restrictions and limitations?" "Is there any work situation in which my patient would not be placed at risk?"

If the answer to all these questions is "No," and if it is obvious that the patient will require some type of financial assistance to get on with his or her life, the next difficult and perplexing question is, "How can I help my patient obtain that assistance?"

This chapter is written with the hope that it will provide answers to those, as well as other, questions related to obtaining disability benefits for your patient. The author is with the Disability Assessment Research Clinic, University of Arizona College of Medicine, and has >50 years' experience in Social Security Disability and is a Diplomat of the American College of Forensic Examiners. The Clinic sees ~500 patients and clients annually in Tucson, Phoenix, and several other cities in southern Arizona. The staff, which has >150 years combined experience, is comprised of physicians, psychologists, and vocational evaluators who conduct comprehensive, integrated medical, psychological, neuropsychological, cognitive, and functional capacity assessments.

The Clinic's primary goal is to return individuals to productive employment in the competitive labor market. However, when evidence indicates that individuals cannot return to work, the Clinic's goal then becomes assisting them to obtain disability benefits. At that point in the process, the Clinic becomes the individual's advocate. In the 10 years the Clinic has been in operation, it has been successful in obtaining disability benefits for 90% of its patients it determined were disabled. That success is based primarily on the Clinic's advocacy role in which it coordinates all patient, practitioner, and attorney input combined with its very close adherence to the steps outlined in this Chapter for obtaining disability benefits.

DETERMINING YOUR PATIENT'S DISABILITY

There are 3 very important factors for the practitioner to consider in the overall process of assisting patients in obtaining disability benefits: 1) determine, for yourself, that your patient is disabled; 2) determine that the disability is based on valid, objective evidence; and 3) determine that the evidence can be defended without question.

The importance of valid, objective information cannot be overemphasized. It is the basis for determining disability in the programs designed to provide financial assistance for their disabled clients. These programs include 1) Social Security Disability Insurance (SSDI), 2) Federal Supplementary Security Insurance (SSI), 3 and 4) Short and Long Term Disability Insurance (STDI; LTDI), and 5) Workers' Compensation Insurance (WCI). Although each program differs in its operation, each has its specific disability criteria, consultants (physicians, psychiatrists, psychologists, physical therapists, etc.), and review process. More importantly, all programs determine disability based primarily on the validity and objectivity of the evidence provided to its disability determination unit.

Consequently, the evidence you use to determine for yourself that your patient is disabled is the same as what you need to provide the program(s) from which he or she is seeking assistance. The general nature and type of evidence needed in determining disability in these programs is presented below.

Evidence of Disability

First and foremost, the evidence needs to include all available, objective data substantiating the patient's medical condition. That data should include the results of x-rays, laboratory work, magnetic resonance imaging, as well as results from any specific evaluations requested (e.g., neurological, psychological, vocational, functional capacities, etc.). No objective data that helps substantiate the practitioner's conclusions should be omitted.

Second, but as important, the evidence needs to substantiate the practitioner's interpretation of the impact of that medical condition upon the patient's functional capacities. For example, if the practitioner states that the patient's medical condition is such that it creates a substantial loss of hand function, the evidence needs to substantiate any resulting diminished functional capacity as well as how that diminished capacity affects the patient's ability to perform the physical tasks required in his or her job (current, last, future). In addition, evidence needs to substantiate the degree of risk the practitioner states can be created for the patient if he or she continues performing those required tasks.

Because the loss or diminishment of functional capacity of any body part is so critical in the ultimate decision of disability, it is extremely important for the practitioner to be aware that adjudicators in most disability programs look specifically for its impact related to 3 areas: 1) the performance of the physical demand factors required for performing jobs in the competitive labor market, 2) the performance of any number of additional physical activities related to the patient's daily living, and 3) the affect of pain or other symptoms on the performance of physical activities.

Physical demand factors can include the following: lifting and carrying, walking (ambulating), climbing, balancing, stooping, kneeling, crouching, crawling, pushing, and pulling. Specific attention is given to the ability to perform upper-extremity fine and gross movements effectively as they relate to reaching, grasping, and fingering.

Additional physical activities can include performing activities of daily living, such as the ability to prepare a simple meal, feed oneself, take care of personal hygiene, drive a car, ride a bus, and use a cane, walker, or wheelchair. Consequently, whatever statement the practitioner makes related to these and other physical functions, the evidence needs to support it.

If, in the practitioner's opinion, pain or other symptoms are affecting the patient's ability to perform specific tasks, objective medical evidence must show the existence of a medically determined impairment that could reasonably be expected to produce pain or other symptoms being experienced by the patient.

Evidence and Malingering

Another important, although disconcerting, reason for providing valid objective data is the role it plays in the area of malingering. Related to that area, it's important for the practitioner to be aware of the fact that adjudicators are not advocates for the patient applying for benefits from their programs. In fact, experience dictates that in numerous cases, the opposite is often true. For example, an SSDI residual functional capacity form asks the practitioner whether or not the patient is a malingerer. Given that situation, the evidence provided to disability programs must not only support the practitioner's statements, it must also be strong enough to eliminate or neutralize the possibility of malingering. If questions remain, referral to a psychologist for an evaluation can be useful to assess potential malingering.

DISABILITY PROGRAMS

When the practitioner has gathered and reviewed all available data, and has made the decision that his or her patient is disabled, he or she is ready to assist the patient in obtaining disability benefits.

As stated above, there are 5 primary disability programs designed to provide financial assistance to qualified applicants: Social Security Disability Insurance, Federal Supplemental Security Insurance, Short and Long Term Disability Insurance, and Worker's Compensation Insurance.

Only the SSDI program will be reviewed in this Chapter. The reason for doing so is pragmatic in nature. The SSDI disability determination process is generally the most structured and demanding of all disability programs. If the evidence provided to SSDI determines disability for your patient, it will almost certainly suffice for determining disability in the remaining 4 programs including SSI, a federal program for welfare recipients who may be disabled. SSI patients are treated under Medicaid in most states and under the state's welfare health care program in others. For example, in Arizona, the program is the Arizona Health Care Cost Containment System. The disability criteria for SSI are the same as for SSDI.

Social Security Disability Insurance

SSDI is the most common, and most extensive of all disability programs. It is paid for by payroll taxes and is provided for all workers who have contributed enough to the system to qualify. Once the patient qualifies for SSDI, he or she receives monthly benefits, which may include payments for children under the age of 18. Actual benefits are determined by the amount of the patient's contributions to the Social Security system. The more the patient has paid into the system, the higher his or her benefit amount.

However, prior to qualifying for benefits, the patient must step through the disability determination process; the first step is to make an application. When a patient initiates an application for SSDI benefits, it is usually handled by a field office of the Social Security Administration (SSA). When that office has verified personal information, it sends the case to a State Disability Determination Services unit (DDS). DDS, which is usually funded by the federal government, is a state agency responsible for developing and reviewing medical evidence and making an initial disability determination.

If, upon review, it is determined that additional data are required, or that there are inconsistencies in the existing data, DDS refers claimants (your patients) to its consulting physicians and other specialists for additional evaluation.

When DDS has gathered all existing data, and all inconsistencies have been resolved, it determines disability based on the sequential process presented below:

- Step 1: Is the claimant currently engaging in substantial gainful activity?
- Step 2: Does the claimant possess a severe impairment?
- Step 3: Does the claimant possess one or more impairments that meet or exceed the listing of impairments?
- Step 4: Can the claimant perform past relevant work?
- Step 5: Can the claimant do any other work?

The steps in the determination process are sequential. For example, if the answer to the Step 1 question "no," the process proceeds to Step 2, and so forth. DDS answers question 3 based on Listings of Impairments found in *Disability Evaluation Under Social Security*, also known as the "Blue Book." It is a must-have resource for every practitioner attempting to assist patients in obtaining disability benefits. It is essentially a cookbook for determining disability and it is easily available in hard copy or on the Internet.

It's important for the practitioner to know that if the severity of the patient's condition meets or equals the level of severity described in the Listings, the patient will be determined to be disabled. If not, the process will continue and there must be an evaluation of whether or not the patient retains the residual functional capacity to do other work. Given that information, it makes some sense not only to know and understand the Listings, but also to present your evidence as it relates to their content.

Of some importance in providing evidence for SSDI is the practitioner knowing that the SSA reserves for itself the ultimate role of determining whether or not a patient is disabled. In that respect, the adjudicators look only for evidence to support disability, and dismiss any general statement by the practitioner indicating that the patient is disabled. Practitioners would be well advised to not make such a statement but to just present the evidence that confirms it.

If the patient is denied benefits based on the initial application, he or she can appeal by requesting the decision be reconsidered and can provide additional evidence at that time.

If the patient is denied again, he or she can request a hearing before an Administrative Law Judge (ALJ) in the SSA's Office of Hearings and Appeals. At each level of appeal, new evidence needs to be provided. In that respect, it becomes increasingly important that new evidence is as valid, objective, and directly related to the Listings as already provided (if not more so).

It is also important to know that at the initial level of review, 63% of cases are denied. Of much interest related to that rate is the fact that it almost matches the approval rate at the ALJ level. It's also important to know that with appropriate evidence, experienced disability attorneys are, more often than not, successful in obtaining benefits for patients at the ALJ level. Knowing that, it makes some sense for the practitioner to suggest that the patient obtain the services of a disability attorney, especially when the claim has been denied at the initial and reconsideration levels.

All the above information points to the fact that the practitioner needs to continue to provide valid, objective evidence for the patient as he or she moves through the disability determination process.

SSDI and Early Retirement Benefits

There is yet another important reason for providing evidence that assists your patient in obtaining SSDI benefits. That is the relationship between those benefits and early retirement benefits. Because of the severity of specific rheumatic diseases and their debilitating impact on functional

capacities, many patients are forced to retire early from the work force. At that point in time, it is important for the practitioner to be aware of the possibility that the patient, regardless of his or her age, can combine early retirement benefits with SSDI benefits. For example, if, based on the evidence, you feel your patient's medical impairment is such that he or she could qualify for SSDI benefits, he or she should be encouraged to apply. If approved, the benefit would be the same as would have been awarded if the patient had continued to work until the graded age, which is based on date of birth.

ADDITIONAL STRATEGIES

As has been presented to this point, the number 1 strategy for obtaining disability benefits for your patient is providing valid, objective evidence in a manner that meets the criteria established by your patient's disability program. To do that, you need to know how that program works. For example, you need to 1) understand the SSDI, SSI, STDI, LTDI, and WCI programs, how their disability determination units function, and what evidence they look for; and 2) get that evidence and provide it the way the unit wants it.

The time has long past when a letter from the practitioner stating that the patient is disabled and cannot work will obtain disability benefits for that patient.

A second important strategy is to identify established, aggressive patient advocacy programs of which the practitioner can become an integral part. The reasons for this are twofold and not all that complicated. 1) Almost without exception, patients are not successful in getting on disability by themselves. The process is too complex, confusing, and demanding and it usually requires more knowledge and expertise than they possess. 2) Almost without exception, practitioners have neither the time nor resources required to establish or operate such a program.

The advocate can be a person, an agency, a program, or any resource that has an excellent working knowledge of the disability programs presented above and can do the following: 1) take the patient through all the steps (starting with the application) required to get on disability, 2) coordinate the efforts of the professionals involved with the patient's application (practitioner, specialists, attorney), and 3) protect the patient's rights in the disability process. Possible advocacy resources are presented in the next section.

Another important strategy is to establish a direct relationship with your patient's disability program. For example, in addition to having the "Blue Book" in house, request a meeting with, or talk with, the director of your state DDS or the manager of the DDS office handling your patient's claims to be certain you're providing the evidence the service needs in the format it can use. It takes time and resources to put the evidence package together. If it's not obtaining disability benefits for your patient, you need to know why.

ADVOCACY RESOURCES

Advocacy resources differ from city to city; however, most major population centers have voluntary agencies capable of assisting patients through the disability process, especially the application process. In Arizona, for example, an excellent program in the greater-Phoenix area is Arizona Bridge to Independent Living. Similar independent living programs, centers, and agencies are available in most cities. Additional resources include the Lupus Foundation and the United Way. Both organizations can either assist your patient directly or help you identify appropriate volunteer services.

If your patient has been denied benefits, and you feel that he or she is truly disabled, perhaps the most important advocate your patient can have at that point in the process is an experienced, knowledgeable disability attorney. It has been my experience, confirmed by the 63% denial rate of initial applications, that patients do not have the expertise required to deal successfully with the disability system. Using the objective evidence you provide them, disability attorneys can, more often than not, obtain the benefits you feel your patient deserves.

PROPOSED CHANGES IN THE SSDI PROGRAM

It's important for the practitioner to know that there are proposed changes in the SSDI system that could have a positive affect on your patient obtaining disability benefits. Currently, if an initial denial is appealed, DDS is responsible for reviewing the case at the reconsideration level. The proposed change would have those cases reviewed by a panel of experts, the makeup of which has not yet been determined but would certainly include physicians, psychiatrists, psychologists, etc. The primary reasons for the changes are to limit the number of cases that rise to the ALJ level and, in so doing, reduce the current 18-month waiting period. It is the general consensus among many prominent experts in the field that such a panel could work to the advantage of the patient, given the panel is provided with the evidence as has been discussed in this chapter.

SUMMARY

Helping your patient receive disability insurance is not an easy task. The system is difficult, demanding, and oftentimes adversarial. Getting through it requires a combination of tenacity, knowledge of the disability programs involved, and a commitment to the patient. However, if you are convinced your patient is, indeed, disabled, it's not an impossible task to overcome and is certainly more than worth the effort.

Special thanks to Mr. John Ellis for his review of the chapter's content related to the SSDI program.

Recommended Reading

Code of Federal Regulations, Title 20, Appendix 1 to Subpart P of Part 404–Listings of Impairments.

Disability Evaluation under Social Security, Social Security Administration, Office of Disability Programs, SSH Pub. No. 64-039, ICN 468600, January, 2005.

Federal Register, (Definition of Disability, 404.1505/1506/1508/1509/1510/1511) (Evaluation of Disability, 404.1520/1520a/1521/1522/1523) (Medical Considerations, 404.1525/1526/1527/1528/1529) (Residual Functional Capacity, 404.1545/1546)

Field J, Field T. The transitional classification of jobs. 6th ed. Athens (GA): Elliott & Fitzpatrick, Inc; 2004.

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