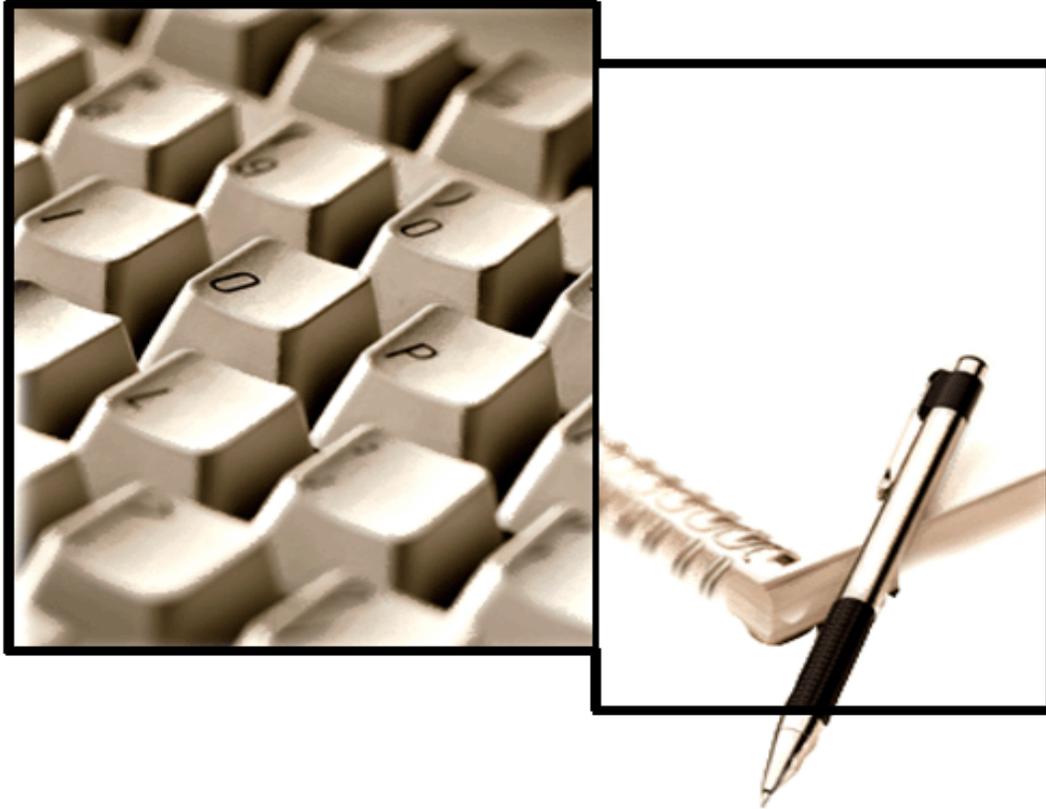


Title XVI Claims Specialist Basic Training Curriculum



Unit 8

Module 08

Disability Issues and Appeals

SOCIAL SECURITY ADMINISTRATION,
Office of Human Resources, Office of Learning
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LESSON PLAN

Module Objectives

At the conclusion of this module, the trainees will be able to:

1. Define Substantial Gainful Activity (SGA) as it relates to work and earnings and explain its effect on Social Security Administration's (SSA's) definition of disability.
2. Identify situations where wages represent SGA.
3. Identify situations where self-employment represents SGA.
4. Complete an SSA-821-BK, SSA-820-BK and SSA-823.
5. Correctly prepare an SSA-831-C3/U3 and the appropriate notices, and make the systems input, for an SGA denial.

Length of Module

6 hours

Forms

SSA-820-BK

SSA-821-BK

SSA-823

SSA-831-C3/U3

SSA-4268-U4

SSA-L-8030

SSA-3033

BACKGROUND AND RATIONALE

We normally think of being disabled as meaning unable to work. However, in many instances, people with severe impairments are involved in some type of remunerative work activity. SSA's guidelines do not totally prohibit an individual from working and earning limited income when (s)he is entitled to disability benefits. A goal of the SSA disability program is to encourage rehabilitation whenever and to whatever degree possible.

At the same time, the ability to do significant work is a primary factor in deciding if an individual is disabled under our programs. Regardless of the severity of an individual's impairment, the demonstrated ability to do substantial gainful work will prevent him/her from meeting SSA's definition of disability.

Generally, to be eligible under SSA's disability program, a claimant must be unable to perform Substantial Gainful Activity (SGA). In most cases, we evaluate a person's ability to do SGA by considering medical and vocational evidence. However, when a person is working, the work activity and earnings themselves may demonstrate his/her ability to perform SGA. Evaluation of work and earnings comes under field office (FO) jurisdiction. This module is designed to familiarize you with these determinations.

OBJECTIVE 1:

Define SGA as it relates to work and earnings and explain its effect on SSA's definition of disability.

SGA in the Disability Program

[DI 10501.001](#)

Definition of Disability

SSA defines a disabled individual as someone who is unable to engage in substantial gainful activity (SGA) due to a physical or mental impairment that has lasted or is expected to last 12 continuous months or to end in death.

Disability Determination Services (DDS) Medical Issues

DDS determines all medical and vocational issues related to SGA: i.e., it determines whether or not an individual has the ability to engage in SGA in spite of the severity of his/her condition.

(FO) SGA Issues

The FO determines when wages or self-employment income constitutes SGA.

SGA Defined

SGA is work activity that involves doing significant physical or mental activities.

Substantial: Work can be found to be substantial even if it is performed on a part-time basis, or even if the individual does less, is paid less, or has less responsibility than in previous work.

Gainful: Work activity is considered gainful if it is the kind of work usually done for pay, whether in cash or in kind, or for profit, whether or not a profit is realized.

Earnings provide an objective and feasible measurement of work.

Averaging Earnings

Earnings that fluctuate from above to below the SGA threshold are averaged except in determining the trial work period (TWP) service months or during the extended period of eligibility (EPE). When an individual has periods of non-work with periods of work, whether to average over the entire period or to average each period separately depends on the type of work performed before and after the interruption. If the work is relatively the same, the total earnings are averaged over the period of months worked. If the work is significantly different, the earnings are averaged over separate periods of work. The examples in [DI 10505.015](#) illustrate the application of the averaging concept.

Determining Countable Earnings

If you cannot determine a monthly breakdown of earnings, make a reasonable determination of earnings for a month, based upon the available information and evidence. For instance, obtain as much information as possible on the employment (hourly or weekly wage rate, average hours of work per day or week, start and stop work dates, etc.) If you can determine the weekly wage rate, multiply the weekly rate by 13/3 (4.333) to determine a monthly rate ([DI 10505.005](#) and [DI 10505.010A.4, Example A](#)).

SGA Amounts for the Disabled

[DI 10501.015](#)

“Countable earnings” of employees indicate SGA and “countable income” of the self-employed is “substantial” if the amount averages more per month than the current year SGA amount. The amounts are listed in [DI 10501.015](#).

Blind Individuals

SSI does not consider SGA for the blind.

Title II blind individuals have only one SGA guideline.

The monthly SGA amount for persons receiving Social Security disability benefits based on blindness is countable monthly earnings averaging more than the current year blind individuals limit. The yearly amount is located in [DI 10501.015](#). The computation of the SGA amount for people who are blind will be adjusted annually based on the national average wage index.

Sheltered Workshop Wages

[DI 10505.025D](#)

Sheltered employment is employment provided for individuals with disabilities in a protected environment under an institutional program. An employee working in a sheltered workshop or comparable facility for severely impaired persons will ordinarily be considered not engaged in SGA if the employee's "countable earnings" do not average more than the amount shown in the Earnings Guidelines ([DI 10501.015](#)).

Developing and Documenting Work that is Clearly Not SGA

[DI 10505.003](#)

If alleged earnings are below the TWP threshold, and there is no conflict with earnings data in our records (i.e., queries such as the Office of Child Support and Enforcement (OSCE) query), stop development and follow these guidelines:

- Document the monthly earnings allegations and write "clearly not SGA" on the Remarks section of the Disability Report – Field Office (SSA-3367) in the Electronic Disability Claim System (EDCS).
- In Title XVI-only cases, document your findings in EDCS and also on the Work Expenses (IBIE) page in the SSI Claims System.

- If you have transferred the case to the DDS, alert the examiner to your “clearly not SGA” determination in EDCS via the update after transfer (UAT) function, following instructions in [DI 81010.095](#).
- If an exclusion prevents you from documenting your determination in EDCS, write your determination on a SSA-5002 and fax it into the non-disability repository for evidentiary documents (NDRed), following the instructions in [GN 00301.322](#).

Using N33 vs. N01

If a claimant is engaging in SGA and earnings are above the income break-even point per [SI 00810.350](#), completion of the SSA-831 is not necessary. Deny the claim for excess income per the Abbreviated Application Process in [SI 00602.001](#).

SSI Only

SGA rules only apply to SSI in initial claims situations. The rules concerning SGA for SSI are: An individual must qualify for one month of regular SSI payments using regular SGA rules. In other words, if the individual has earned income at the SGA level in the effective month of application, then SSI payments are prohibited until the earned income drops below SGA levels. The requirement that an individual have this month of entitlement where earned income is below SGA levels is known as the prerequisite month.

Once the prerequisite month is established, then the issue of SGA as a condition of continuing eligibility as a disabled individual does not apply to the SSI recipient. The earnings from work (less any work incentives) count under the income and resource rules.

In SSI only cases, the use of the Abbreviated Application process should not be used when SGA is involved. The Title 16 Claims Specialist should take the claim using a Deferred or Full application and document the work by completing the SSA-820-F4 or SSA-821-BK. Post the wages to the Wages page in the SSI Claims System. On the Substantial Gainful Activity section, be sure to answer the SGA question. Finally, post the SGA denial code, N33, to the SSR after completing the SSA-831 C3/U3. See [DI 10501.025](#) and [SI 00602.001](#).

EXAMPLE:

June Jackson filed an application for SSI in February, alleging that she was disabled. Since she had no means of support, she had to continue to work part time until her SSI benefits started. She works at a local hotel as a night clerk and earns \$1,500 per month.

The FO determined that her work constituted SGA and denied her claim for engaging in SGA.

Effect on the Disability Decision

[DI 81010.140](#), [DI 10505.035](#)

Processing Title XVI and Concurrent Cases

When the claimant is working at the time the application is filed, the FO will undertake SGA development. You will complete form SSA-820-BK (self-employed) or SSA-821-BK (employee) to make the determination. Always process SGA denials electronically unless an EDCS exclusion applies.

If the Certified Electronic Folder (CEF) is the official folder and SGA is found:

- Complete the SSA-820/821 through EDCS using signature proxy, save to the Certified Electronic File (CEF). If a paper SSA-820/821 or the SSA-820/821 from inForm must be used, create a bar code cover sheet in eView and fax the paper SSA-820/821 into the Certified Electronic File (CEF), keeping in mind that a wet signature is not required.
- Document your determination on the SSA-823 and save to the CEF.
- Create a notice in DPS with proper attachments containing the required personalized explanation. If the notice is not stored in the Online Retrieval System (ORS) then fax a copy into the Certified Electronic File (CEF). If the claimant has submitted documentation that cannot otherwise be annotated or stored electronically, create barcodes for those documents and fax them into the certified

electronic folder (CEF). Verify the image is legible in eView before shredding or returning the documents to the claimant.

After completing the “Field Office Determination – Denial” page:

- EDCS closes the claim as a SGA denial;
- The Claims Action screen displays the Determination/Disposition of the claim along with the date of the last action taken of the claim; and
- The SSA-831 created by EDCS saves to the CEF.

Input the denial (N33) to the Supplemental Security Record (SSR).

If the Modular Disability Folder (MDF) is the official folder and SGA is found:

- Complete a paper SSA-820/821 from inForm and put in the MDF.
- Document your determination on the SSA-823 and put it in the MDF.
- Complete Form SSA-831 (Disability Determination and Transmittal using inForm. File the form in the MDF. In concurrent cases, the Title XVI file is documented with a copy of the Title II SSA-831 determination.
- Create a notice in DPS with proper attachments containing the required personalized explanation. If the notice is not stored in the Online Retrieval System (ORS) then place a copy in the MDF.

Input the denial (N33) to the Supplemental Security Record (SSR).

If the Certified Electronic Folder (CEF) is the official folder and SGA is not found:

- Complete a SSA-820/821 from UniForms in EDCS and save into the CEF.
- Document your determination on the SSA-823 and save it in the CEF.
- Transfer EDCS to DDS. DDS will use the information from the SSA-820/821 in making the medical decision.

If the Modular Disability Folder (MDF) is the official folder and SGA is not found:

- Complete a paper SSA-820/821 from inForm and put in the MDF.
- Document your determination on the SSA-823 and put it in the MDF.
- Transfer the folder to DDS. DDS will use the information from the SSA-820/821 in making the medical decision.

Return to Work Within a Year of Onset

[DI 13010.110](#)

Title XVI Only

When an individual returns to work less than 12 months after onset and the information is received prior to the date of final determination, determine if the work is SGA.

Work is SGA

- If the case has not been transferred to DDS, prepare an SSA-831 denial determination in EDCS and process the claim to an N33 denial ([DI 11055.035](#)).
- If this is an electronic case and DDS has “closed” the case as an allowance, print the SSA-831 from eView, write in remarks “Do not process” and fax the SSA-831 back into the CEF along with a copy of the notice to the claimant to document the electronic folder. It is also recommended to fax the SSA-820/821 SGA development documentation into the EF.
- If this is a paper folder and DDS has returned the claim to the FO as an allowance, write in remarks of the SSA-831 “Do not process”. Include in the MDF a copy of the notice to the claimant to document the folder with the SGA findings. It is also recommended to place the SSA-820/821 SGA development documentation into the MDF.

- If the claimant returned to work earning SGA less than 12 months after onset, but his work activity later stopped, send the case to the DDS to consider a later onset date.

NOTE: If a later date of onset cannot be established or the 12-month duration is not met:

- Issue an SGA denial.
- Process a previously prepared, uneffectuated, SSA-831 allowance determination.
- Use the SSI Claims System to code the denial.
- Show Y for “Close Event” on the Build SSR (DSSR) screen.
- Enter Y for Close Initial Claim, 2 for initial Claim Decision, and N33 for Denial Code on the Adjudicative Decision (DADJ) screen.

Work Is Not SGA

If the work is not SGA and the individual is continuing to work after the date of final determination, handle the work activity as earned income.

When an individual returns to work less than 12 months after onset and the information is received after the date of final determination, determine if the work is SGA.

SGA Began Before Date of Final Determination

When SGA began before final determination but the information was received after this date, reopen and revise the determination to a denial.

When SGA began before the date of the final determination but stopped, and the UWA criteria are not met, forward the case to the DDS to consider later onset dates.

SGA Began After Date of Final Determination

When SGA began after final determination, the issue of SGA cannot be reopened. The recipient’s wages will be determined under “work incentive”

provisions (1619(a) and 1619(b)) and normal rules covering income and resources.

Work Is Not SGA

The recipient's wages will be determined under the 1619 (a) provision and normal rules covering income and resources.

OBJECTIVE 2:

Identify situations where wages represent SGA.

The Earnings Guidelines

[DI 10505.001](#)

Determining SGA

When we decide whether an employee's wages represent SGA, we base our SGA determination on his/her countable monthly earnings.

Countable monthly earnings are the gross earnings minus any applicable exclusion. Impairment related work expenses (IRWE) and subsidies are deducted from countable monthly earnings in making SGA determinations.

NOTE: When an individual has both IRWEs and subsidies, it will be necessary to first determine the value of services being rendered and then deduct the IRWE ([DI 10520.030A.3](#)).

Impairment Related Work Expenses (IRWE)

[DI 10520.010](#); [DI 24001.035](#); [DI 10520.025](#)

IRWEs are expenses that a disabled SSI recipient incurs only because he/she works. To be deductible, this expense must be paid for by the impaired person.

IRWE Development

IRWE development is different for Title II and Title XVI. In Title II only cases, the FO must first determine if IRWE is material to an SGA decision.

If the alleged IRWE will not reduce earnings below the SGA level, no verification is necessary.

In Title II only cases (when initial development establishes that IRWE is material), all Title XVI cases, and all concurrent cases (Title II and Title XVI), the following issues must be covered:

- Need for item or service must be verified if the FO cannot make a reasonable judgment about the relationship between the item or service and the disabling condition(s).
- Payment for service or item by the disabled person must be documented.
- Payment must be within reasonable limits.

For more information on how to document IRWEs, refer to [DI 10520.025](#).

IRWE is also used in computing Federal Countable Income (FCI) when determining SSI payment amounts.

Computational Steps in SSI

When computing SGA, follow these steps:

Gross wages	\$1100.00
Less IRWE	<u>- 200.00</u>
	\$ 900.00

(Countable monthly earnings for SGA determination = \$900.00)

Subsidies Reduce SGA Countable Income

[DI 10505.010A](#)

Subsidy

A subsidy is payment in excess of the reasonable value of the work performed and is used to reduce monthly countable earnings for SGA purposes. A subsidy can be specific or nonspecific.

Specific Subsidy

A specific subsidy occurs when an employer can provide the specific subsidy amount after determining the reasonable worth of the service and explaining how the subsidy was calculated.

EXAMPLE:

Mr. Davis reports that Will Evans, a severely impaired employee, receives a subsidy of 25 percent. Mr. Davis based this estimate on the fact that although he pays all his employees \$1,300 per month for doing the same kind of work for the same amount of hours, Will typically packs about 30 boxes per day while the other employees pack about 40. Will's countable monthly earnings for SGA determination would be \$975 per month.

Nonspecific Subsidy

With a nonspecific subsidy, the employer cannot readily determine a specific amount. When there appears to be a nonspecific subsidy, we must establish a reasonable dollar amount to be deducted from gross wages.

Subsidy Determination Questions

Obtain the following information to provide a basis for a subsidy determination:

- Why was the individual hired?

- What are the individual's job duties?
- How much time does the individual spend on those duties?
- Who did the job before the individual was hired and how much time did that person spend on the duties of the job?
- If the individual were separated from the job, would (s)he be replaced? If so, how much time would the replacement spend on the individual's duties?
- How often is the individual absent from work?
- Does someone else do the individual's work when (s)he is absent? How much time does the temporary replacement take to do the individual's job?

Relationship of Pay to Services

- How are the individual's total earnings computed?
- Is the individual's pay reduced proportionately when (s)he is absent from work? (Compare the employer's practice concerning the impaired individual to the practice applied to an unimpaired worker, explaining any difference).
- Does the individual receive any unusual assistance or supervision?
- If the individual's pay is not set according to normal business practices, what consideration is given to the size of the individual's family, number of years of past service with the employer, previous earnings, friendship or relationship to the employer, or other factors related to the performance of the work?

NOTE: See [DI 10505.010](#) for a specific example when trying to determine a subsidy.

Unsuccessful Work Attempt (UWA)

[DI 10501.055](#); [DI 11010.145](#)

Definition

An UWA is when an employee returns to work after an illness or injury, but the work was involuntarily discontinued or reduced below the level of SGA after a short time for reasons relating to the individual's impairment.

Key Parts

The key elements of an UWA are:

- Attempt to do SGA;
- Work stopped or was reduced;
- Short duration of work; and
- Work changed due to disability.

Significant Break

There must be a significant break in the continuity of the claimant's regular employment. A break in continuity would occur when the impairment or the removal of conditions essential to further performance causes the individual to:

- Be out of work for 30 consecutive days; or
- Be forced to change to another type of work or another employer;
or
- Markedly reduce the extent of work activity in his/her regular employment.

UWA Requirements

In all cases:

- The individual worked less than 6 months; and
- The work must have ended or reduced to the non-SGA level due to the impairment or the removal of conditions essential to further performance.

Work That Is Never UWA

A period of SGA-level work that lasted six months or more is never considered an UWA regardless of why the work changed.

NOTE: Seasonal or other patterned or recurring work should not be regarded as a series of UWAs since the termination of each period of work is unrelated to the impairment and does not infer that the individual could not work.

DDS Role

DDS has final authority for a UWA determination in initial claims and medical CDRs; FO has final responsibility in work continuing disability review cases without a medical issue.

SGA Determination Chart

STEP 1:

Determine monthly countable income:

- Start with gross wages
- Subtract all subsidies/IRWEs

STEP 2:

Compare monthly countable income to current year SGA amount:

- Countable income equals current year SGA amount or more.

STOP—Determine SGA exists.

STEP 3:

Income is below current year SGA amount:

- Are sheltered workshop wages involved?
- If yes, determine SGA does not exist.

STOP—Determine SGA does not exist.

NOTE: Monthly countable income is not the same as Federal SSI ONLY countable income (FCI).

Monthly countable income is a term we use to signify the wages (after appropriate deductions) that we use in an SGA determination.

Federal countable income (FCI) is earned and unearned income that is used (after taking all deductions) to determine eligibility and/or payment amount.

EXAMPLE:

Betty Boyd works as a cashier 15 hours a week in a dry cleaning store and earns \$400 per month. Other cashiers are able to work 20 to 40 hours weekly and earn \$600 to \$800 per month.

OUR DETERMINATION:

Betty's monthly countable income is \$400, which is below SGA.

Her low earnings can readily be explained by the fact that she only works 15 hours a week and there is no evidence to show that her work is comparable in terms of hours, responsibilities, etc., to that of unimpaired individuals who derive their livelihood from such work.

There is no indication that her work is worth more than the current year SGA amount.

NO DDS DETERMINATION IS NEEDED WITH REGARD TO SGA.

Betty's wages do not demonstrate an ability to engage in SGA. We can determine that the work is "clearly not SGA," by annotating the DROC screen and the 3367 in EDCS and continue to process the case. (See [DI 10505.003](#) for documentation instructions).

OBJECTIVE 3:

Identify situations where self-employment represents SGA.

Evaluation of Self-Employment

[DI 10510.001](#)

Individual's Activities

In self-employment cases, consideration must be given to the individual's activities and their value to a business. The earnings level alone in self-employment is not a reliable factor in determining SGA.

An individual may receive substantial income from a business while performing little or no work. Conversely, little income may be received for a great deal of work.

A self-employed individual will be considered to be performing SGA if his/her work activity compares to any of three tests.

Test 1: Significant Services and Substantial Income

[DI 10510.010](#); [DI 10510.015](#)

Person Business

For services to be significant, we need to evaluate the individual's actual work activity. Consider these factors:

- In a one-person business, such as a carpenter, handyman, bookkeeper, consultant, etc., the services are always significant.

NOTE: A one-person business has no partners, employees, or assistants.

Two or More Person Business

In businesses that involve the services of more than one person, services are significant if the individual provides more than half of the total time required to manage the business or provides management services of more than 45 hours per month.

EXAMPLE:

Larry and Marilyn Rice operate a small cafe with 2 employees. Larry had a stroke and he is unable to come to the restaurant at all. Marilyn occasionally consults with Larry regarding suppliers and vendors. This consultation involves about 5 hours a month. Marilyn estimates that she spends about 45 hours per month on management tasks.

Larry's services clearly are not significant, as they are not more than 45 hours a month and do not comprise more than half of the total management time needed to operate the business.

Farm Landlord

RS 02505.110

A farm landlord rents land to another farmer. If the services of the farm landlord are considered "material participation" in the farm activities, they will be considered significant services for the purpose of test 1. (See [RS 01803.700](#) and [DI 10510.015B.2](#) for more information on material participation.)

Substantial Income

A self-employed individual will have a substantial income from a business if:

"Countable income" from the business (see [DI 10510.012](#)) averages more than the amount shown in the SGA Earnings Guidelines; or

"Countable income" from the business does not average more than the amount referred to above, but the livelihood that he or she derives from the business is:

- Comparable to the livelihood he or she had before becoming seriously impaired; or

- Comparable to that of unimpaired self-employed individuals in his or her community engaged in the same or similar businesses as their means of livelihood.

Determining Net Income

[DI 10510.012](#); [DI 10510.015](#)

Work Activity Evaluated

The evaluation of a self-employed person's work activity for SGA purposes is concerned with only that income representing the person's own productivity. To determine what portion of the individual's income represents the actual value of the work (s)he performed, we must determine the individual's net income.

Unpaid Help

Unpaid help may be a factor. If it is, we need an estimate of the reasonable value of any significant unpaid help. This help would be of a nature specific to the business, not general activities as a member of the household of the self-employed person.

EXAMPLE:

Mary Ann Lowe operated a fruit stand by herself. After an accident in May, she required assistance to unload and stock produce. Her nephew did this work 10 hours per week without pay. Such part-time help would normally cost \$5.00 per hour. Mary received \$50.00 worth of unpaid help per week.

Mary's net income from May through December was \$7,200. After deducting the value of the unpaid help, her countable income was \$5,500. Her average income was less than the monthly SGA limit over the 8-month period.

Deduct IRWEs

IRWE further reduce net income. The entire amount paid for an item or service is deducted from the net income.

Expenses Paid By Others

Deduct from net income:

- Any business expense incurred, but paid by another person or agency; or
- The value of things provided even though no actual expense was incurred or paid by anyone for the disabled person. (Determining the deductible above is dependent on the kind of things provided.)

EXAMPLE:

Ray Skaggs runs a small bait shop at the lake. He had net earnings of \$16,500 per year. His utility expenses and building rent are provided free of charge by the Vocational Rehabilitation Department at an expense of \$1,200 per year. Ray's countable income is \$15,300 annually.

Average Income

Average the individual's "countable income:"

- Determine the countable income over the representative period.
- Divide by the number of months in that period.
- When there is a regulatory change in the SGA earnings level, or there are distinct patterns of work involved, it is necessary to use the distinct periods for averaging.

SGA Performed

If countable income does not average more than the current year SGA amount, it will still be considered SGA if:

- The individual's livelihood from the business is comparable to the level (s)he had before becoming disabled, or
- The individual's livelihood is comparable to that of unimpaired individuals in the same community, operating the same or similar business as their means of livelihood.

EXAMPLE:

Level of activity:

Jeanne Daniels has operated a small flower stand at the airport for 15 years. She had a heart attack six months ago, but continues to operate the stand for a reduced number of hours. Her net income for the past 5 years has averaged \$4,000. She expects her net income to be \$3,200 this year. Further development established that unimpaired individuals in the same business expect to earn between \$4,000 and \$5,000 per year. It is determined that income from the business is not substantial. Her livelihood from the business is not comparable to her livelihood prior to becoming disabled, nor is it comparable to that of unimpaired self-employed individuals in her community engaged in the same business for their livelihood.

Test 2: Comparability of Work Activity

[DI 10510.020](#)

Comparability

Self-employment activity may not be SGA under the significant services and substantial income test. However, it will still represent SGA if the individual's work activity in terms of hours, skills, energy output, efficiency, duties and responsibility is comparable to that of unimpaired individuals in the same community engaged in the same or similar business as their means of livelihood.

EXAMPLE:

Comparability Chart

	Disabled individual Ms. Greenwood	Unimpaired Individual
Occupation		
Hrs. worked per week		
Average monthly earnings		

Completed chart should look like this:

	Disabled individual	Unimpaired Individual
Occupation	Housekeeper	Housekeeper
Hrs. worked per week	35 hrs./week	35 hrs./week
Average monthly earnings	\$1050/month	\$1000-1100/month

QUESTION: Is Ms. Greenwood’s work comparable to that of an unimpaired individual?

ANSWER: Yes, therefore her work would be considered SGA.

Test 3: Worth of Work

[DI 10510.020](#)

Worth

Self-employment activity may not be SGA under the significant services and substantial income test but may still represent SGA if the work, while not comparable to that of unimpaired individuals, is still clearly worth more than the current year SGA amount.

Determine the worth of the work activity by:

- Its value to the business; or
- The salary the owner would pay to an employee to perform similar services.

Documentation

Documentation of comparability and economic worth should consist of the individual's description of his/her work and also a statement from a knowledgeable source of how the work is performed by an unimpaired individual in the community. The source could be the employer or local job service. The statement should include the time, energy, hours, duties, responsibilities, and the worth of the individual's work.

The comparability and worth tests are applied separately. If the work meets either test, it is considered SGA.

SGA Decision Guide–Self-Employment Income

TEST #1:

Does self-employed individual render significant services and receive substantial income?

TEST #2:

Is work activity comparable to that of unimpaired individuals in the community engaged in the same or similar businesses as their means of livelihood?

TEST #3:

Is work activity clearly worth more than the SGA level a month?

DEFINITION OF SIGNIFICANT SERVICES AND SUBSTANTIAL INCOME

TYPE OF SELF-EMPLOYMENT	SIGNIFICANT SERVICES	SUBSTANTIAL INCOME (FOR ALL BUSINESS)
<p>Other than farm landlord (one-person businesses)</p> <p>Other than farm landlord (more than one-person business)</p> <p>Farm landlord</p>	<p>Any salary is necessarily salary significant</p> <p>Contributes more than half of total management time</p> <p>OR</p> <p>Renders management services for more than 45 hours per month</p> <p>Takes active role in conduct of rented farm by “materially participating”</p>	<p>1. Countable income more than current year SGA amount</p> <p>2. Countable income does not average more than current year SGA amount per month; however, (a) livelihood from the business is comparable to livelihood before becoming disabled, or (b) livelihood from the business is comparable to that of unimpaired persons in the community engaged in same or similar business as a means of livelihood.</p>

For test #1, both significant services and substantial income must be above the current year SGA limit, which can be found in [DI 10501.015](#).

OBJECTIVE 4:

Complete an SSA-821-BK, SSA-820-BK, and SSA-823.

Work Activity Forms

[DI 10505.035](#); [DI 10510.025](#); [GN 00201.015](#)

Forms and Documentation

Special forms have been designed for developing SGA issues. They are:

- SSA-821-BK – Work Activity Report – Employee
- SSA-820-BK – Work Activity Report – Self-Employment
- SSA-823 – Report of SGA Determination

The information requested is to document work, earnings and resolve work issues in initial entitlement cases and Continuing Disability Review (CDR) cases. The field office (FO):

- Reviews and when appropriate, verifies the information collected;
- Completes the identification section of the SSA-821-BK and/or SSA-820-BK;
- Makes substantial gainful activity (SGA) and related determinations; and prepares and releases any required forms, notices and/or inputs.

The SSA-821-BK or SSA-820-BK must be completed for all work CDR cases (T2) and for initial application cases involving employment or self-employment:

- After the alleged onset date (AOD);

- After the potential onset date (POD) when the POD is earlier than the AOD;
- After the controlling date in disabled widow(er)'s benefit (DWB) claims;
- Any time in childhood disability benefit (CDB) claims;
- After the filing date in Supplemental Security Income (SSI) claims;
- After age 55 in certain blindness claims;
- Under sheltered conditions; or
- That may represent an unsuccessful work attempt (UWA).

When To Use an SSA-821-BK

The FO and PC use the form SSA-821-BK to document work activity and work incentives prior to making an SGA determination for initial claims, appeals and CDR cases. However, you do not have to complete a form SSA-821- BK in “clearly not SGA” cases detailed in DI 10505.003.

Refer to [DI 10505.035](#) for completion of the various sections. The questions are self-explanatory and the claimant provides the answers. If the forms are mailed back to the office, review the form to make sure the claimant answered all pertinent questions.

When to Use an SSA-820-BK

Form SSA-820-BK (Work Activity Report-Self-Employment) is used to document self-employment activities and income for both initial claims, and continuing disability review (CDR) cases.

It is especially important to assist with the development and documentation of self-employment cases whenever possible because of the varied and complex situations that can occur.

When you mail or give the SSA-820-BK to the claimant, be sure to include the “Working While Disabled” publication.

The following steps will be used to determine if an SSA-820-BK is needed:

1. Complete the SSA-820-BK for work CDR cases and for initial application cases involving self-employment when self-employment occurs under the following conditions:
 - After the alleged onset date;
 - After the date the claimant alleges his or her impairment(s) first began to interfere with his or her ability to work;
 - After the controlling date in disabled widow(er)'s benefit (DWB) claims;
 - Any time in childhood disability benefit (CDB) claims;
 - After the filing date in Supplemental Security Income (SSI) claims; and
 - After age 55 in certain blindness claims.
2. If there are multiple instances of self-employment that differ substantially from period to period, use separate forms, when necessary.

Refer to [DI 10505.035](#) for completion of the various sections.

When to Use the SSA-823

[DI 10505.035](#)

This form is for SSA use only. Complete the SSA-823 in all initial claim determinations that and in CDR situations that require an SSA-820 or SSA-821. In most cases, completion of the form is optional if you are using eWork to process your decision. However, if you cannot use eWork to process your decision, you must complete the SSA-823.

There are three sections to the SSA-823.

1. Initial Claim

This section is for Social Security Disability Insurance (SSDI) and/or Supplemental Security Insurance (SSI) initial claims.

2. CDR/PE

This section is for SSDI CDR/PE cases.

This section covers considerations and evaluation of work, whether the work is SGA and a space to provide an evaluation of the three tests.

3. Signature and Date

This section is used for you to mark the basis of the SGA determination. As the CS, you will sign, date, and write your component code and telephone number.

Saving the SSA-823

It is extremely important to retain the SGA determination. Once it is completed, you will need to print it and fax into either eView or NDRed.

Completing Work Activity Reports during an Initial Claim

[DI 81010.120](#); [DI 11010.250](#)

Use signature proxy for the following forms when developing SGA issues in initial claims:

- SSA-820 (Work Activity Report - Self-Employed); and
- SSA-821 (Work Activity Report – Employee)

NOTE: If creating the SSA-820/SSA-821 for a CEF exclusion case with an MDF as the official folder, print and insert the report and attestation cover notice (when applicable) into the Modular Disability Folder (MDF).

Completing the SSA-821 during an Initial Claim

As the attestation script is performed at the beginning of the interview for Disability benefits, it is not necessary to perform the script specifically for the SSA-820/821 ([GN 00201.015](#)).

When using form attestation for work activity reports in the Electronic Disability Collect System (EDCS):

- Annotate the “Signature page” on the SSA-820/821 with “ATTEST” along with the office code and name of the interviewer;
- Upload the SSA-820/821 into the CEF at the point of intake;

NOTE: If the SSA-820/821 cannot be uploaded into the CEF via EDCS, print the form from inForm and fax a copy of the SSA 820/821 into the CEF.

- Document the Development Worksheet with an “ATTEST” issue and enter the receipt date;
- After entering the receipt date on the Development Worksheet, the ATTEST issue locks and the SSI Claims System indicates the office code and name of the interviewer in the remarks section. The system retains the issue as the electronic equivalent of the claimant’s signature.
- Give or mail the claimant a copy of the attestation cover notice and the SSA 820/821.

OBJECTIVE 5:

Correctly prepare a SSA-831-C3/U3 and the appropriate notices, and make the systems input for an SGA denial.

FO Processing of SGA Denials

[DI 11055.095](#); [DI 81010.140](#); [DI 81020.075](#)

Work Issue

Title XVI Claims Specialists make the SGA determinations on Title XVI only cases.

Complete a work activity report (SSA-820-F4 or SSA-821-BK) whenever an individual works after an alleged or established date of onset.

SSA-831-C3/U3 – Disability Determination and Transmittal

Once the FO has determined that the work is SGA, a formal determination must be prepared.

A SSA-831-C3/U3 is prepared for initial denials and in reconsideration affirmations of initial SGA denials.

Completion of SSA-831-C3/U3

[DI 11055.130](#); [DI 11055.135](#)

In concurrent claims, only one SSA-831-C3/U3 is prepared. In addition, enter “Concurrent Title II/Title XVI SGA denial” in item 11 of the SSA-831. It is not necessary to prepare a SSA-831 for the Title XVI claim. If this is a

MDF, make one photocopy of the “Folder Copy” of the Title II SSA-831. Along the left-hand margin of the photocopy, lengthwise, write “SSI filing date (date)” followed by “DI,” “DS,” or “DC” to indicate disabled individual, spouse or child, respectively, followed by “Basis Code N33.”

If this is an electronic file, the SSA-831 will be created in EDCS and saved in the CEF.

In Title XVI only cases, the SSI Claims Specialist will prepare the SSA-831-C3/U3.

Always process SGA denials electronically unless an EDCS exclusion applies. SGA denials may be recognized before case transfer to Disability Determination Services (DDS) or after case transfer to DDS.

To process an SGA SSA-831 Denial:

- Select “Key” to enter the disability report and key the Disability Report - Field Office (3367); and

NOTE: This step applies only if the SGA Denial is made prior to case transfer.

- Select “Claims Action” on the EDCS tool bar at the top of the screen and select “Denial”.
- On the Select Determination Type page, select “Denial.”
- Complete the “Field Office Determination – Denial” screen including the fields for Reg Basis (N33-920(b)), Prior Action, Work and Education, and a Rationale (These fields are necessary for completion of the SSA-831);
- Select “OK” at the bottom of the screen.

After completing the “Field Office Determination – Denial” page:

- EDCS closes the claim as an SGA denial;
- The Claims Action screen displays the Determination/Disposition of the claim along with the date of the last action taken on the claim; and
- The SSA-831 created by EDCS saves to the Certified Electronic Folder (CEF).

For claims involving systems limitations or exclusions, manual completion of the SSA-831 may be necessary. In those instances, the FO must complete items 1-14 on the SSA-831 for Title XVI claims transmitted to the DDS for a disability determination. Refer to section [DI 26510.000](#) for instructions on how to complete the different sections of Form SSA-831.

Title XVI Notices

[DI 26015.010](#), [DI 11010.345](#)

Notices

Personalized notices are required in all cases where the application is being denied for not meeting the disability/blindness requirement. DDS is responsible for issuing manual notices for all applications that are medically denied. The FO is responsible for sending a personalized notice when an application is denied due to SGA. Notices can be prepared in the Document Processing System (DPS).

If the notice is not stored in the Online Retrieval System (ORS), fax a copy of the notice into the CEF if it is an electronic folder. If it is a paper folder, retain a copy of the notice in the MDF.

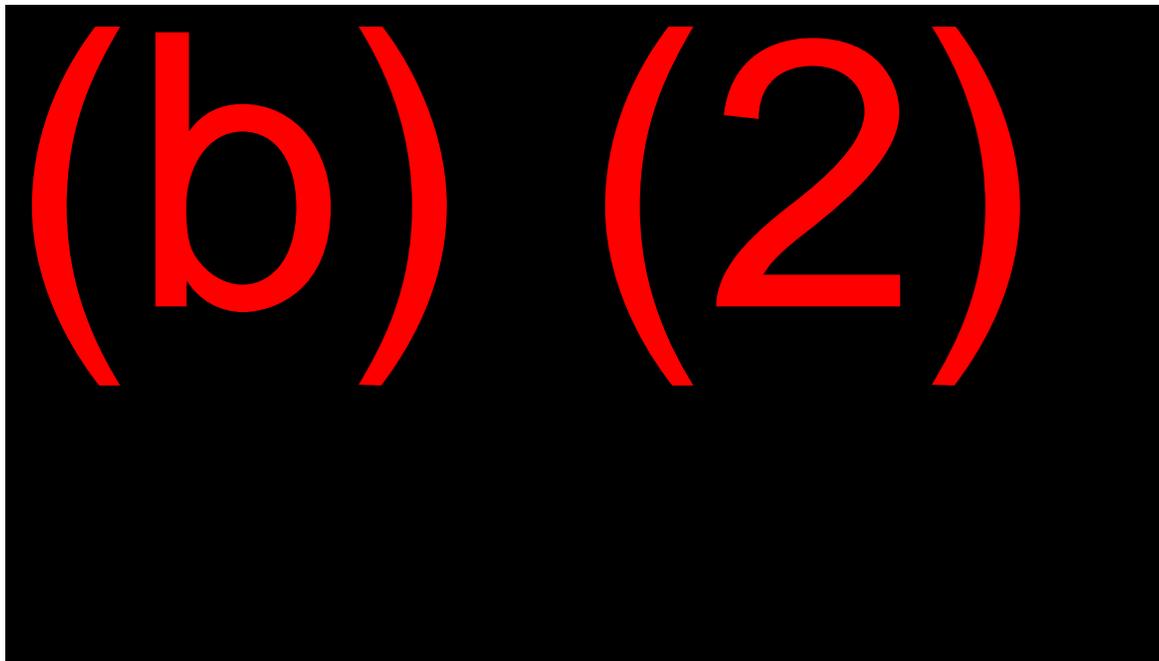
Title XVI System Input

SSI Claims System

The SGA page documents if the wages/SEI represent SGA.

Below is a facsimile of the Substantial Gainful Activity page.

[MS 08114.031](#)



Answer the question “IS SGA INVOLVED?” only if the claimant is disabled and the amount of countable wages, self-employment or sick pay is greater than the SGA limit in any month of eligibility.

- Select “Yes” if the work is considered substantial gainful employment.
- Select “No” if the work is not substantial gainful employment.

When denying an initial claim for SGA you will place the denial code N33 on the Adjudicative Decision Screen.

Below is a facsimile of the Adjudicative Decision screen.

[MS 04425.003](#)

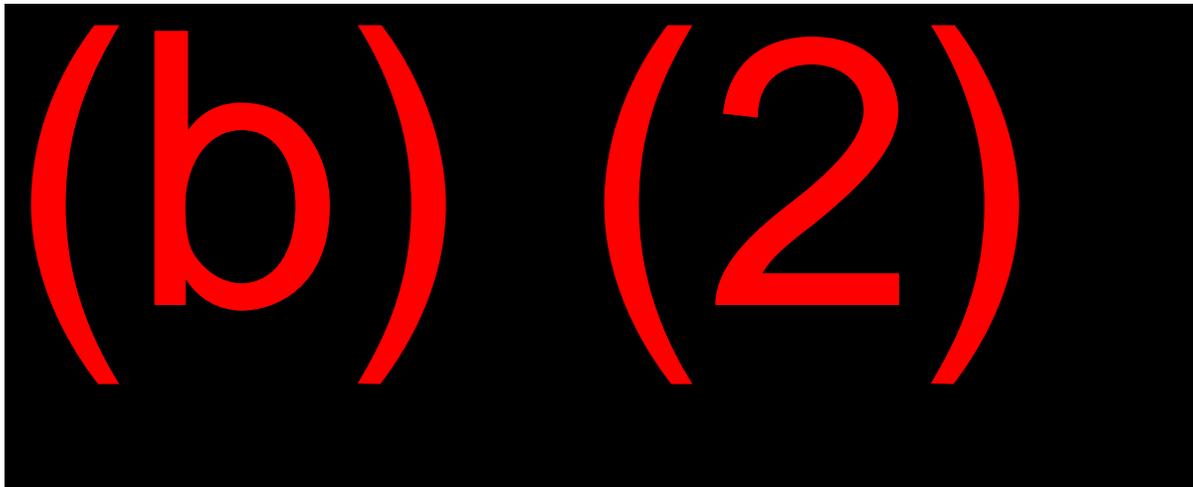
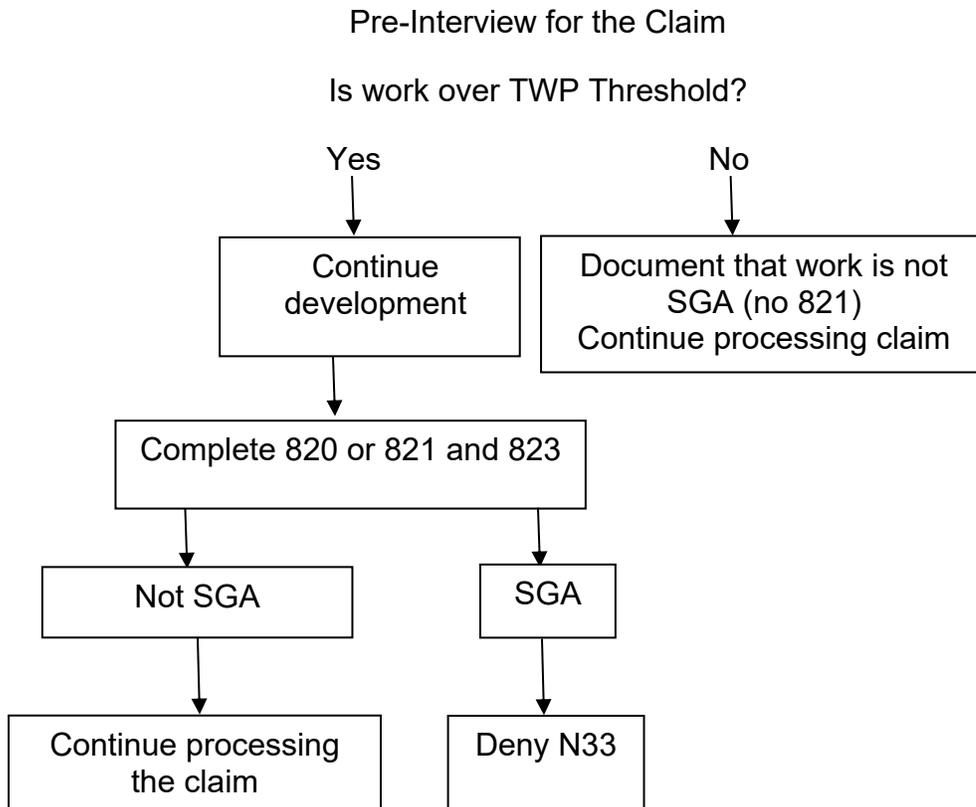


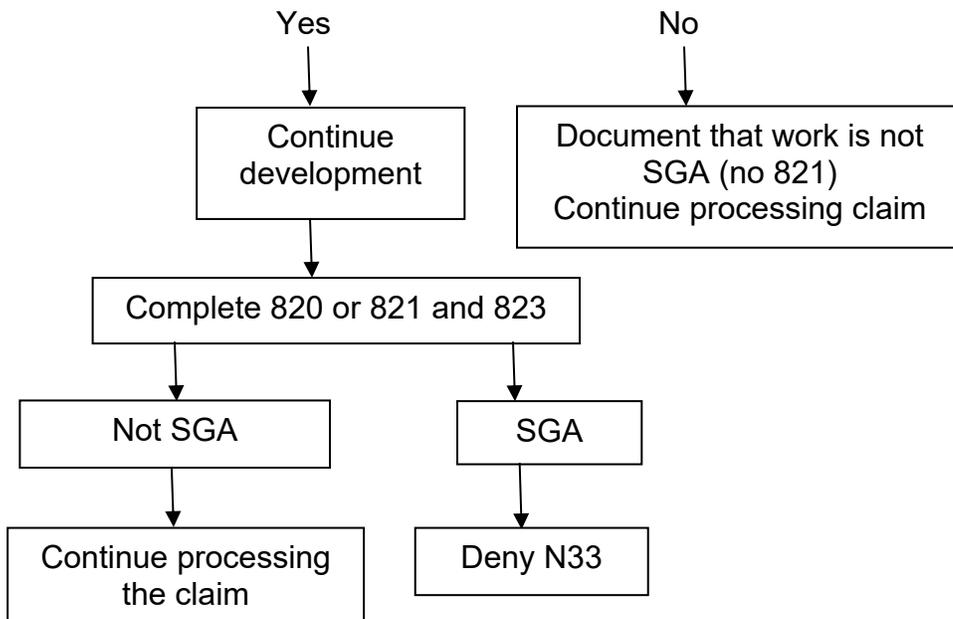
EXHIBIT 1 - SGA FLOW CHART

Work at Time of Application



SGA after Time of Application

Prerequisite Month?



OFF-AIR ACTIVITIES

OBJECTIVE 1: Define SGA as it relates to work and earnings and explain its effect on SSA's definition of disability.

- Trainees should complete Exercise #1.
- Trainees should become familiar with forms SSA-820-F4, SSA-821-BK and SSA-831-C3/U3. Trainees should look over completed forms.
- Trainees should review how SGA affects SSI eligibility.

OBJECTIVE 2: Identify situations where wages represent SGA.

- Trainees should complete Exercise #2.
- Trainees should complete the following online training on Substantial Gainful Activities (SGA).

OBJECTIVE 3: Identify situations where self-employment represents SGA.

- Trainees should complete Exercise #3.
- Emphasize that work activity alone can result in SGA for the self-employed individual, regardless of income.

OBJECTIVE 4: Complete the SSA-821-BK, SSA-820-BK and SSA-823.

- Trainees should complete Exercise #4.
- Trainees should pair up and complete the SSA-820-BK or SSA-821-BK and SSA-823. Be aware of the rationale behind the

questions on both forms (i.e., questions pertaining to IRWEs, SGA, etc.). Trainees may refer to [DI 10510.025](#) and [DI 10505.035](#).

OBJECTIVE 5: Correctly prepare an SSA-831-C3/U3 and the appropriate notices, and make the systems input, for an SGA denial.

- Trainees should complete Exercise #5.
- Trainees should practice completing forms SSA-820, SSA-821, and SSA-831-C3/U3.
- Trainees should review notices in DPS to become familiar with denial letter for SGA.

EXERCISES

Exercise #1

1. Give a brief definition of SGA.
2. If a person is determined to be performing SGA, what effect does it have on the decision?

Exercise #2

In the following problems, decide whether or not the work represents SGA or if further development is needed to reach a decision. Give POMS references and a brief rationale of your decision.

1. John Miles files a claim on June 11. He is a resident of the City Vocational Training Center. He is also an employee in the center's workshop. It has been determined that the workshop provides sheltered employment for its residents and other handicapped individuals. Mr. Miles is currently earning \$30 per day and works 21 days a month. His work involves simple assembly of household products that are marketed by the workshop.
2. Tom Scott files a claim in December. His alleged date of onset of disability is January of the previous year. He stated that since that time, he has been working a few hours per night at a local restaurant. He helps wash dishes when they have a higher than normal number of customers or when a regular employee calls in sick. The most he works is 12 to 15 hours per week and some weeks only 2 to 3 hours. He receives \$5.80 per hour. In the past year, the most he earned in one month was \$580.00. Contact with the restaurant indicates that he worked every month last year and his total earnings were \$5,760.
3. Sylvia Wilson works 35 hours per week at a local laundry and dry cleaners and her earnings average \$1,350 per month. Her employer says she does about the same work, at the same level, and works the same amount of hours as other employees doing the same job.

4. Harold Jenkins is a clerk earning a fixed salary of \$1,400 per month. He says he is really too ill to work but needs the money to survive until he can secure some other assistance. He says he has missed many days due to illness and that his employer is giving him a break.

When you contact the employer, she states that Harold is using more sick leave than her other employees. His work is not as good as it used to be, and it takes him longer to finish routine projects. She has retained him because of his past loyalty, and Harold is struggling with a serious illness.

When asked to be specific, she says that he is doing about 75 percent of the quality and quantity of what she would normally expect. In arriving at that figure, she considered both his increased absences and his decreased speed and accuracy.

5. Derrick West sorts small parts in a factory. He states that he is blind but has no physical impairment. He earns \$300 per week. His employer claims his work is fully satisfactory. He needs some special assistance on occasion but more than compensates for this because he is so prompt and dependable.

Exercise #3

1. Mr. Russell operates a small automobile tune-up business out of his truck. He is the sole-owner and worker in the business. His gross receipts average \$1,500 per month. His expenses average \$250 per month. Is Mr. Russell performing SGA?
2. For years, Bernice Robbins operated a florist shop by herself and had an average net income of \$1,200 a month. After she broke her hip, she needed help with some of the work. She hired a high school student, part-time, for \$50 a week (\$200 a month). This reduced her average net income to \$1000 a month. In addition, her niece donates 15 hours a week without pay doing work Mrs. Robbins can no longer do. The prevailing rate of pay for the services performed is \$5.15 an hour. Unimpaired people in the community who operate floral shops comparable to Mrs. Robbins' shop have annual net earnings ranging from \$10,000 to \$12,000. Is Mrs. Robbins performing SGA? Explain your answer.

Exercise #4

1. Complete Form SSA-821-BK, based on the following information:

John Jacobs is filing for disability benefits today. It has already been determined that he is insured and meets all Title XVI non-medical requirements.

- His alleged onset date (AOD) is 10 months ago.
- Prior to the AOD, he was working full-time (40 hours per week) at the Brick Co., 1001 Brick St, Brickville, IL 62201. Phone number: 312-555-1234. He worked as a bricklayer and earned \$24.50 per hour.
- His alleged disability is a back injury.
- Mr. Jacobs' doctor feels that he will never be able to return to full-time work, but did release him to return to his job part-time.
- Mr. Jacobs returned to work six months ago for the same employer for the same rate of pay.
- He worked three days a week, 8 hours a day.
- Mr. Jacobs no longer did heavy lifting, but he performed all other normal duties of the job (i.e., building scaffolding, and laying bricks). He rested frequently.
- Mr. Jacobs was laid off two months ago because of his inability to perform the job satisfactorily due to his disability.

Exercise #5

1. What code is used for the SGA denial of an SSI claim?
2. What forms are used to record an SGA determination for Title II or Title XVI denial?
3. When is a personalized notice issued and what information is required on the notice?

EXERCISE ANSWERS

Exercise #1

1. SGA is the performance of significant physical and/or mental activities in work for pay or profit.
2. Performance of SGA removes from consideration any finding of disability, regardless of the severity of the physical or mental impairment. If the individual demonstrates the ability to engage in SGA, (s)he cannot be found disabled for Social Security purposes. An exception to that is when an individual starts to engage in SGA in a month after the month of application, but (s)he did not engage in SGA for at least 12 months before the date current SGA began.

Exercise #2

1. Not SGA. Mr. Miles's earns \$630 per month, which is not more than the SGA limit, and there is no evidence to suggest that he may be engaging in SGA. [DI 10505.020](#).
2. Not SGA. Mr. Scott's average monthly earnings of \$480 are below SGA.
3. Work is SGA. [DI 10501.015](#).
4. Work is not SGA. The employer alleges a subsidy of 25 percent per month. This reduces the average monthly earnings to \$1,050 per month. This is substantially below the primary earnings amount. [DI 10505.035](#) and [DI 10505.010](#).
5. Blind individuals have no SGA test of their earned income under the SSI program. Blind individuals have a higher SGA limit than disabled individuals under the Title II program. Mr. West's earned income is below the blind SGA limit without considering reductions in gross earned income such as IRWEs and subsidies. [DI 10501.015](#).

Exercise #3

1. Yes. Although most self-employed mechanics probably earn more, Mr. Russell is rendering significant services and receiving a substantial income from his business, over the SGA monthly limit.

2. Mrs. Robbins is not performing SGA. The \$77.25 a week ($\$77.25 \times 4.333 = \334.72 a month) in unpaid assistance she receives from her niece would make her monthly "countable income" only \$665.28.

She does not derive a livelihood from the business comparable to her livelihood before she became disabled or to that of the community standard. Therefore, her income is not substantial. Since she cannot perform all the duties of operating the florist shop, her work is not comparable to that of unimpaired people who do similar work as their means of livelihood.

In addition, there is nothing to suggest that her work is clearly worth more than what she is receiving for such activity.

Exercise #4

1. If trainees complete the SSA-821 and make an SGA determination, they will have successfully completed the exercise.

Exercise #5

1. N33
2. Forms SSA-823 and SSA-831-C3/U3 is completed in the FO for all SGA denials. The claim is not sent to the DDS for a determination of Medical-Vocational factors relating to SGA.
3. In Title XVI claims, prepare a personalized notice each time an SGA denial is recorded. The notice should include what information in file was used to make the decision and the rationale for the SGA decision.

AS WE REDESIGN ENTRY-LEVEL TRAINING, WE ARE ELIMINATING THE NEED FOR PAPER COURSE MATERIALS. THE MATERIAL PREVIOUSLY TAUGHT FOR THIS MODULE HAS BEEN CONVERTED TO ONLINE CONTENT. ALL NECESSARY INFORMATION IS EMBEDDED WITHIN THE ONLINE OBJECTIVES. THERE ARE NO CORRESPONDING PAPER MATERIALS. PLEASE VISIT THE [LINK](#) FOR MORE INFORMATION.

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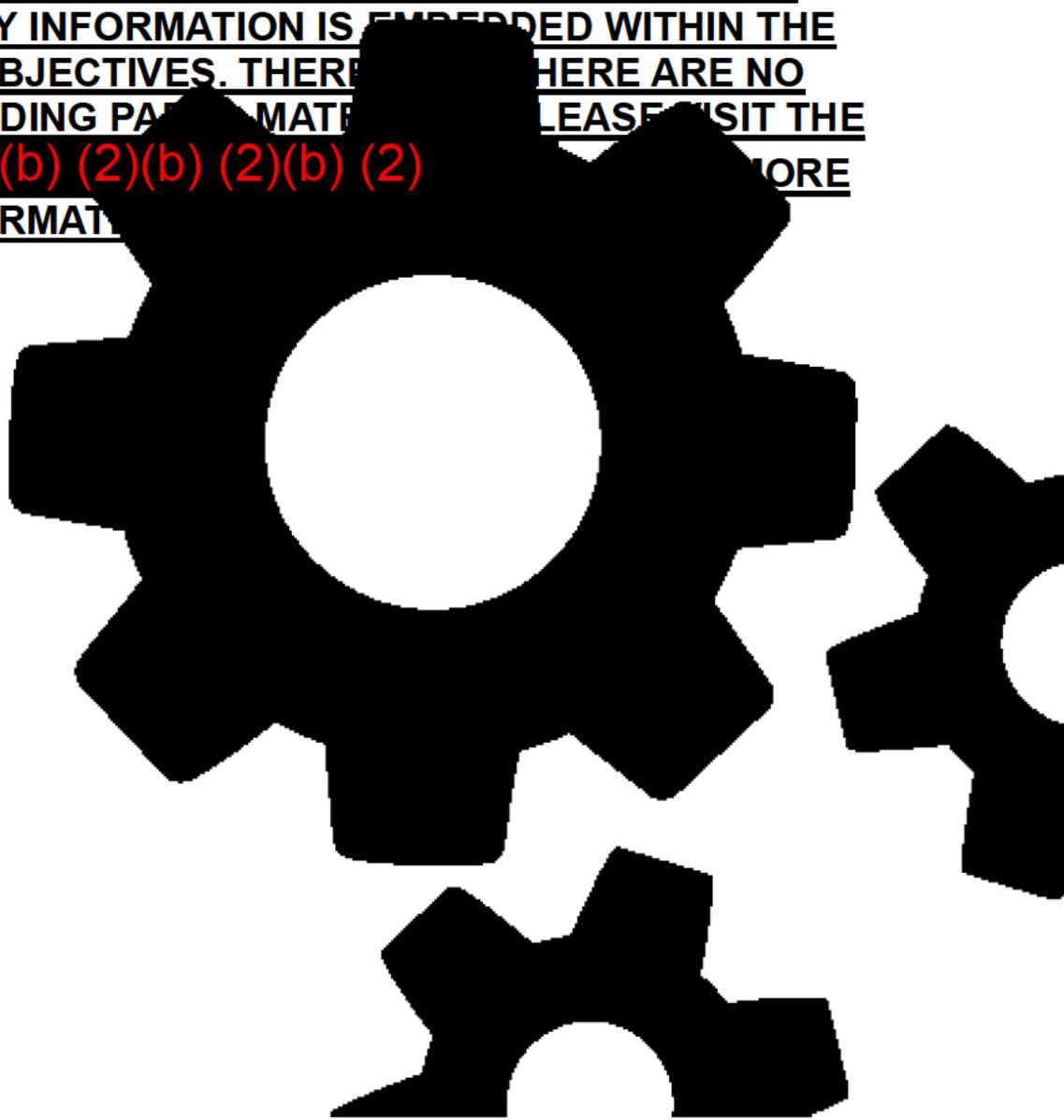


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LESSON PLAN

Module Objectives

At the end of this module, using appropriate references, the trainees will be able to:

1. Understand and explain the appeals provision and determine the time limits for requesting an appeal.
2. Determine and perform the proper reconsideration development.
3. Determine and perform the proper development for a hearing.
4. Determine and perform the proper development for Appeals Council (AC) reviews and litigation.
5. Understand appeals on disability cessation cases.
6. Input appeals into the system.
7. Understand the elements of the iAppeals online process.

Length of Module

4 hours

Forms

SSA-561-U2

HA-501-U5

HA-520-U5

SSA-1696-U4

SSA-795

SSA-8450

Helpful Resources

[Title XVI CS Resource Kit](#)

InForm

Query Readers (under DDSQ and OHAQ)

BACKGROUND AND RATIONALE

Our Responsibility

The Social Security Administration (SSA) is committed to making impartial and accurate decisions on individual claims.

The appeals process permits claimants who disagree with our decisions to protest them and obtain new decisions. The procedure requires that an agency representative who was not involved in the original decision decide each appeals decision.

A claimant can appeal through three levels within the administration and, if still dissatisfied, can carry the appeal to the Federal courts.

As a claims specialist (CS), you are responsible for maintaining the integrity of SSA's appeals procedures while explaining and processing the cases for claimants.

OBJECTIVE 1:

Understand and explain the appeals provisions and determine the time limits for requesting an appeal.

Appeals Provision

[SI 04005.010](#)

Overview

A person who disagrees with an initial determination or decision may request further review. This is called an appeal. The appeal consists of several levels of administrative review that must be requested within certain time periods and at the proper level.

The levels of administrative review are:

- Reconsideration (Recon)
- Administrative Law Judge (ALJ) Hearing
- Appeals Council (AC) Review

The AC review ends the administrative review process. If an individual is still dissatisfied, (s)he may request judicial review, which is done by filing an action in Federal court.

Neither a wet signature nor a proxy signature is required for appeal requests for any issue at any level. This includes completion of the following appeal forms: the SSA-561, HA-501, HA-520, and the SSA-789 for a medical cessation. However, the claimant or other appropriate person is still required to submit a written request that SSA review its prior determination or decision.

If the individual does not request review within the required time period, (s)he may lose the right of further review unless (s)he can show good cause for failure to make a timely request for review.

Reconsideration Determination

The first level of appeal is the reconsideration, rendered as a result of a request for review of the initial determination.

The reconsideration is an independent and thorough reexamination of all evidence on record, as well as any new evidence submitted at the time of the reconsideration request.

This review should consider the following:

- The issue raised by the reconsideration request; and
- All other eligibility issues.

Hearing Decision

The second level of appeal is the hearing before an ALJ of the Office of Hearing Operations (OHO). When the individual is dissatisfied with the reconsidered determination, (s)he can request a hearing. At this point, the individual and others may present oral testimony or other evidence to the ALJ before the judge renders a final decision.

Appeals Council (AC)

The AC is the body in OHO with final authority for SSA. It may affirm, modify or reverse the ALJ decision or remand the case to the ALJ to take further evidence.

Court Review

The court review provision of the Social Security Act allows the individual to ask a Federal court to review SSA's final decision once the individual has exhausted all the appeal steps. The Commissioner of SSA is the defendant.

Representation

The individual can appoint a representative by submitting a completed Form SSA-1696-U4. A wet signature by the claimant is required on the SSA-1696-U4. This representative can be an attorney or a non-attorney and may be appointed at any time by the individual.

Common representatives can include the following:

- Attorney representatives;
- Case managers/social workers;
- Advocates;
- Relatives/family members.

NOTE: A representative should receive copies of all notices and information sent to the individual.

Determining the Time Limit for Appeals

[SI 04005.012](#)

60 Days

For each level, the individual should file the appeal within 60 days after receiving the notice of determination, decision, or dismissal.

Plus 5

The receipt of the notice is presumed to be five days after the date of the notice, unless we have evidence showing a later receipt date.

Extended for “Holidays”

In addition to the five mailing days, if the appeal period ends on any non-work day, the period is extended to the next full workday.

Procedure for Determining the End of the Appeal Period

In this example, 04/14/19 falls on a Sunday. We must extend the appeal period date to 04/15/19, which is the next workday.

<u>STEP</u>	<u>ACTION</u>	<u>EXAMPLE</u>
1	Enter calendar date of notice	02/08/19
2	Convert it to a Julian date	039
3	Add 5 days for mail time	044
4	Add 60 days	104
5	Convert to calendar date	04/14/19

Good Cause

[SI 04005.015](#)

Timely Filing

You, as the interviewer, must establish whether a timely appeal has been filed and, if not, document the reason for the delay.

Not A Timely Filing

If the request for appeal is filed after the end of the 60-day appeal period, the individual must establish “good cause” as defined by regulation for extending the appeal period. Always allow the claimant to file an appeal request even if it is not timely.

Good Cause

SSA may extend the time limit for filing an appeal if the claimant shows good cause for failure to appeal in a timely manner ([GN 03101.020](#)).

NOTE: For GK payment continuation at the Protected Payment Level (PPL) when a recipient appeals an adverse action after the 10-day period but within the 60-day period, you will need to establish potential good cause to extend the time limit ([SI 02301.310](#)).

Administrative Finality

If the individual is unable to establish good cause for late filing, the decision maker must determine if it is possible to reopen and revise the decision based on the rules of Administrative Finality, which is the topic of the next module.

If there is no basis for reopening and revising an initial determination, you will:

- Dismiss a request for reconsideration. If an individual files a late request for hearing or AC review, send the request to OHO or the AC along with the statement of good cause and all other development.

Good cause for late filing exists if the claimant establishes that failure to file a timely request was the result of circumstances out of the claimant's control. Consider the following examples:

- Circumstances that impeded his/her efforts to pursue his/her claim; or
- Misleading or confusing action by SSA/Centers for Medicare and Medicaid Services (CMS); or
- A misunderstanding as to the requirements of the act resulting from amendments to the act, other legislation, or court decisions; or
- His/her physical, mental, educational or linguistic limitations (including lack of facility with the English language).

NOTE: Good cause for late filing may apply to any person standing in the place of the claimant.

EXAMPLES:

- The individual was seriously ill or had a physical or mental impairment, or significant communications difficulties and such

illness or impairment prevented him/her from contacting SSA in person, or in writing, or through a friend, relative or other person.

- There was a death or serious illness in the individual's immediate family.
- Pertinent records were destroyed or damaged by fire or other accidental cause.
- The individual was actively seeking evidence to perfect his/her claim and his/her search, though diligent, was not completed before the time period expired.
- The individual requested additional explanation concerning SSA's decision within the time limit, provided that within 60 days after receipt of such explanation, (s)he requested reconsideration or hearing, or within 30 days after receipt of such explanation, (s)he requested AC review or to begin a civil action.
- The individual was furnished incorrect or incomplete information or was otherwise misled by a representative of CMS or SSA about his/her right to request reconsideration, ALJ hearing, or AC review, or to begin a civil action.
- The individual failed to receive the notice of initial determination, reconsideration determination, decision of an ALJ, or a decision of, or a denial of the request for review by the AC (e.g., SSA used incorrect address or claimant moved).
- The individual transmitted the request for review to another government agency in good faith within the time limit and the request did not reach SSA until after the time period had expired.
- Unusual or unavoidable circumstances exist that demonstrate the individual could not reasonably be expected to have been aware of the need to file timely, or such circumstances prevented him/her from filing timely.

Procedure for Determining Good Cause

Always determine whether a timely appeal is filed. If an appeal is filed late, take the following actions:

- Step 1 – Obtain a written statement from the claimant explaining the reason for the delay; and
- Step 2 – Develop documentation concerning the delay from any FO record.
- Step 3 – Explain to the claimant that SSA will decide whether (s)he has shown good cause for filing late and SSA may either extend the time or dismiss the appeal.
- Step 4 – Evaluate evidence and document evidence and good cause determination in the system.

Who Decides Good Cause

An individual from the component that has the authority to adjudicate the appeal being filed determines whether good cause exists.

When making a finding of good cause, the finding must be based in the context of the type and facts of the case presented. A finding of good cause is made on a case-by-case basis.

OBJECTIVE 2:

Determine and perform the proper reconsideration development.

Request for Reconsideration**[SI 04020.020](#)****SSA-561-U2**

Any writing or timely submission of additional evidence by the claimant, his/her representative payee, or his/her representative after receipt of notice of an initial determination that clearly implies a disagreement with that determination constitutes a request for reconsideration. A request for reconsideration can be expressed or implied, but it must be in writing. It is not required that the claimant complete the SSA-561-U2.

If SSA receives something in writing, the implied request for appeal will be documented in the system.

A mere request for information or explanation is not a request for reconsideration. Likewise, an oral inquiry or request for forms is not a valid request for reconsideration and does not protect a request for appeal.

In SSI disability/blindness claims, medical issues can only be reconsidered through case review performed by the DDS.

Reconsideration of non-medical issues can be through either case review or informal conference by the FO.

In post eligibility (PE) adverse initial determinations, generally, the recipient has the right to request reconsideration and has the choice of case review, formal conference or informal conference by a FO decision maker. The determination that a claimant's disability or blindness has ceased because of medical improvement carries the right to a disability hearing.

The recipient has a right to case review or informal conference by a FO decision maker (non-medical determination) for a determination to increase or reinstate benefits.

Proper Person

A reconsideration may be requested by the claimant or any party to a determination whose rights are affected by an initial determination.

Case Review

[SI 04020.040](#)

A case review is a method of reconsideration in which an independent decision maker, other than the one who made the initial decision, performs a thorough review of all evidence contained in the file, including additional evidence submitted by the claimant, representative, and/or SSA. A case review can be selected in all cases, whether medical or non-medical, initial claims or post-eligibility.

Before the case review, the claimant or the representative may do any or all of the following:

- Examine the evidence in file.
- Present oral statements to be considered.
- Submit additional evidence.

Informal Conference

[SI 04020.050](#)

An informal conference cannot be selected in cases where an individual was denied for medical reasons or in cases where the onset date is being appealed.

An informal conference is a method of reconsideration in which the claimant or representative may do any or all of the following:

- Examine the evidence in file.

- Submit additional evidence.
- Present oral statements to be considered.
- Present witnesses to testify before the decision-maker.

Formal Conference

[SI 04020.050](#)

A formal conference is a method of reconsideration for a post-eligibility situation in which the claimant or representative may take all the actions shown above plus request that SSA require witnesses to appear, secure relevant documents and to cross examine adverse witnesses who may be compelled to appear by subpoena. A formal conference can only be chosen in cases where an individual's payment is being stopped or lowered.

Documentary Evidence

Accept any documentary evidence that the claimant has to offer. The FO may request new and material evidence that is available or assist the claimant in securing any additional evidence.

Allow the claimant to present witnesses to support his/her case.

The claimant may be represented by an attorney or any qualified person in his/her dealings with SSA. A representative may appear at the conference with or without the claimant and do all the things permitted by the claimant.

SSA-8450

[SI 04020.050](#); [SI 04020.060](#)

A reconsideration summary is recorded in the SSI Claims System in the appeals path. For cases not in the system, this must be recorded on form SSA-8450 and signed by the decision maker. For non-medical determinations not in the system, fax a copy of the SSA-8450 into NDRed.

The SSA-8450 must contain, at a minimum, the following information:

- Claimant's name and claim number;
- Date and location of conference or review;
- Statement of pertinent issues;
- If, and by whom, the claimant was represented;
- Nature of evidence submitted;
- Witnesses presented or cross-examined;
- A summary statement.

Medical and Non-Medical Appeals

[DI 12005.005](#); [DI 81010.150](#)

Medical Appeal

If a medical issue is in dispute, the FO gathers all necessary appeal forms. The following forms are required:

- SSA-561-U2, Request for Reconsideration; or
- Any writing or timely submission of additional evidence by the claimant, his/her representative payee, or his/her representative after receipt of notice of an initial determination that clearly implies a disagreement will constitute a request for reconsideration.
- SSA-827, Authorization to Release Medical Information, as well as any state specific medical authorization forms. A wet signature is required by the claimant on the SSA-827;
- SSA-3441-BK, Disability Report – Appeal
 - When a claimant files a request for appeal, but refuses or fails to provide the necessary forms, including the SSA-3441, the field office (FO) transfers the case to Disability Determination

Services (DDS) for a disability determination. (See Document and Develop the Reconsideration Request of an Unfavorable Medical Decision - [DI 12005.005.](#))

- For electronic cases, the FO will establish an EDCS SSA-3441 using minimal entries to maintain electronic processing. (See Processing Appeals in EDCS - [DI 81010.150.](#))
 - The FO annotates the EDCS Routing Form with the following remark to show that a limited EDCS SSA-3441 was prepared: “EDCS Transfer, 3441 Not Received”.
 - The FO documents all attempts to obtain the SSA-3441 in the "Remarks" section of the EDCS SSA-3367 (Disability Report – Field Office). The FO annotates in the “Remarks” section of the EDCS SSA-3441 “Claimant’s 3441 not received as of MM/DD/YY” using the date the case is transferred to the DDS.

DDS reviews the case file and performs the following functions:

- May request a consultative examination;
- May request new medical evidence that was previously unavailable;
- Evaluates all evidence that was previously obtained as well as any new evidence received;
- Renders the reconsideration determination.

If the decision is affirmed, DDS inputs the decision to the system, sends a notice of the decision, and returns the file to the FO.

If the decision is reversed, DDS inputs the decision, sends a notice, and returns jurisdiction of the CEF or the MDF to the FO for effectuation. DDS also completes item 29 on the SSA-831-U5 advising the FO of any specific information included in the notice, such as representative information or capability issues.

Objective 5 will discuss medical appeals occurring from the result of a CDR.

Non-Medical Appeal

The field office (FO) makes a reconsideration determination if the initial non-medical denial was under FO jurisdiction. See [GN 03102.175](#) for component responsibility in the reconsideration process.

Similar to a medical appeal, the SSA-561-U2 or any writing or timely submission of additional evidence by the claimant, his/her representative payee, or his/her representative after receipt of notice of an initial determination that clearly implies a disagreement with that determination constitutes a request for reconsideration. The reconsideration evaluation and determination is required to be made and reviewed by persons other than the one(s) who made the original determination.

Use the following procedure for reconsideration processing for an initial denial on a non-medical basis (i.e., denied for income or resources):

- Affirm or reverse the denial and document the new determination on the appropriate form.
- Prepare a manual SSA-L8456-U2 (SSI Notice of Reconsideration) explaining the basis for the reconsideration affirmation or reversal. If the reconsideration decision is an affirmation, include a brief statement that, because of the non-medical denial, no further action will be taken on the medical aspects of the claim.
- Retain the folder pending any hearing request.

Reminder: Recipients can qualify for GK payment continuation at the Protected Payment Level (PPL) when they appeal an adverse action within 10 days after receiving the advance notice or after the 10-day period and good cause exists for extending the time limit. ([SI 02301.310](#))

Reading the DDSQ in Medical Reconsideration Cases

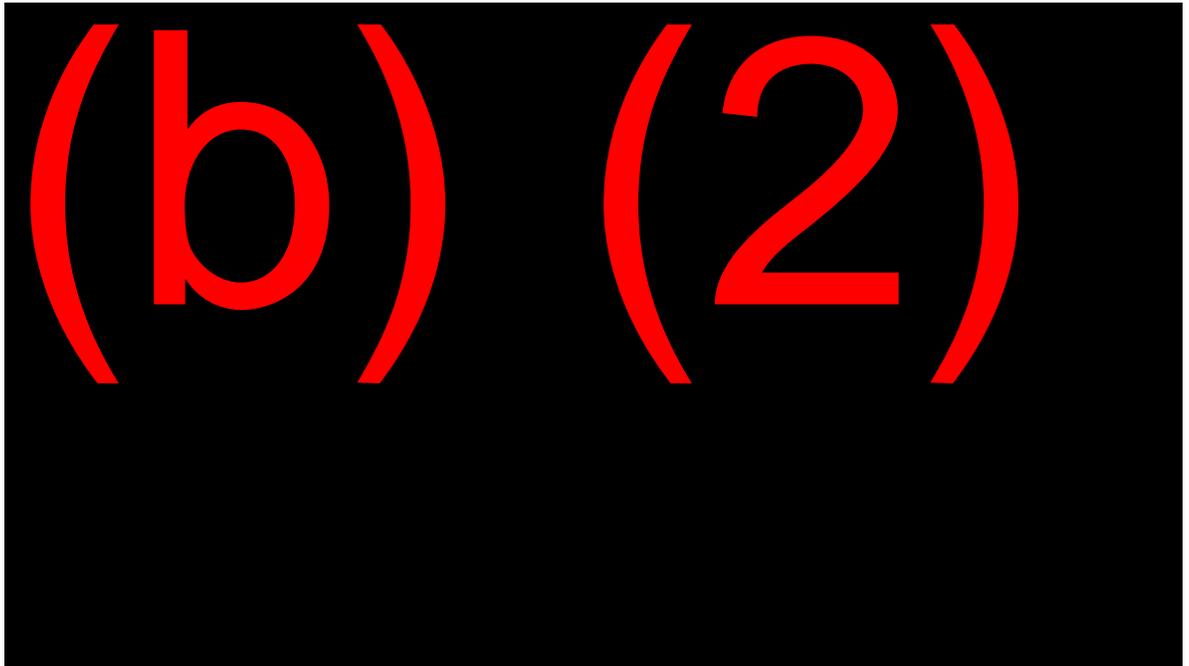
[SM 06002.000](#)

The DDSQ is a record created by the DDS. It reflects both Title II and Title XVI information. Use the query to call up DDS data input and identify the status or decision on a particular case.

DDSQ is triggered when a CS completes pages within the SSI Claims System before sending the claim to DDS. When the claim is received by DDS, they enter the date the folder was received and assign the case to a DDS analyst. To make sure DDS received the claim, check the DDSQ AP (application date) field.

Below is a facsimile of the DDSQ screen.

[SM 06002.200](#)



Systems limitation cases are the only exception in which a DDSQ cannot be established. (See [SM 05905.303.](#))

For all medical issues send all documents, forms, and folder to DDS to make a reconsideration decision. Before transferring jurisdiction or sending the folder, make the appropriate input into the system to create the APPE segment on the SSID.

When the adjudicator makes a decision (s)he also updates the DDSQ with the date of the decision, medical reason code(s) and diary, etc. Some updating may include capability issues.

Follow the steps to obtain a DDSQ query:

- Select "18" (NDDSS Master File Menu) on SSA Menu.

- Enter the Unit and select "1" (DDS (Query)), enter the letter "C" for the RS field, and enter the SSN on the DDSM screen.

(See [SM 06002.100](#) – How to complete the NDDSS Master File Menu (DDSM).)

All the descriptions for the acronyms are listed on [SM 06002.200](#).

Field "TYP:" is the type of claim level (RC is for reconsideration), and field "RCD" is the date of the Reconsideration.

Proper Notification

[NL 00802.050](#)

SSA-L8455

Appeals involving initial medical determinations, award notices are automatically generated by the system for favorable decisions. For all other cases (non-medical, post-eligibility, and all denials), notices of reconsideration are prepared manually either by the FO or, for medical decisions, by DDS. A copy of the notice is sent to the authorized representative as well as the claimant. The notice must include all the material facts of the claim and include this sentence, "This determination replaces all previous determinations for the above period."

FO Jurisdiction

The FO will undertake and/or finalize all non-medical factors of eligibility as quickly as possible.

After all systems inputs to effectuate DDS's determination have been made, send the claimant and his/her authorized representative notice SSA-8455 for fully favorable or partially favorable reconsideration decisions and notice SSA 8456 for reconsideration affirmations.

OBJECTIVE 3:

Determine and perform the proper development for a hearing.

Hearing Process

SI 04030.020

A hearing can be requested formally on HA-501-U5 or informally by writing a letter to SSA requesting a hearing.

When a letter is used as an informal request for a hearing:

- The date of the letter or mailing date is considered the date of the hearing request.
- The FO will mail forms HA-501-U5 and SSA-3441-BK to the claimant for additional information; it is not necessary to obtain the claimant's signature on the forms.
- In the cover letter, remind him/her of the time limits.

Good Cause

If the hearing is filed after the 65th day and the appeal period has ended, good cause for late filing could be found.

Obtain a signed statement (SSA-795) from the claimant explaining the delay. The FO should complete an RC with any additional information known at the FO about the delay.

The ALJ will consider the SSA-795 and the RC and decide whether or not good cause is found.

If good cause cannot be found, the ALJ will dismiss the hearing request. If the appeal is dismissed, the individual has two options:

- A new application may be filed (using the date of the appeal request as a new protected filing date); or
- The claimant may submit new evidence regarding their request for reconsideration.

Evaluate the new evidence to see if the claim can be reopened under rules of Administrative Finality. If revision is warranted and the reconsideration determination may be reopened, handle the case as if no request for hearing had been filed on the claim.

Development of a Hearing Request

[SI 04030.030](#)

Evidence

Accept any evidence the claimant wishes to submit and include it in the file. Do not initiate any development unless it is requested by the ALJ.

If the claimant wants to submit evidence after the hearing request is filed, indicate on the HA-501-U5 the nature of the evidence and the date it will be submitted.

If the issue is disability, complete an SSA-3441-BK to bring the information up to date and obtain a new signed SSA-827.

1. Forward the MDF or transfer the CEF hearing request to OHO while waiting for the additional evidence.
2. When the additional evidence is received, forward it on to OHO by SSA-408 (route slip) if this is a paper case; otherwise, fax the additional evidence into eDib or NDRED.
3. If the evidence is not submitted, it is not necessary to follow-up with the claimant nor is it necessary to notify OHO.

Review the file before forwarding or transferring it to OHO, making sure that the request for a hearing, all notices, letters, proofs, etc., are in file. Forward the hearing request to OHO within five business days.

Request a current payment history query and annotate it in red “in payment status” or “not in payment status.”

The claimant may waive his/her right to an oral hearing by completing form HA-4608. The request must be in writing. Associate the completed Form HA-4608 with the file going to OHO. Without the written request, the ALJ will dismiss the case for failure to appear.

Non-Medical Hearing Requests

A claimant has the right to request a hearing before an ALJ for a claim that was denied due to non-medical factors. Unlike the request for a medical denial, the claimant only needs to complete the HA-501.

Once the HA-501 is received in the field office, the claims specialist will complete the Electronic Non-Disability Summary Sheet (eNDSS). The eNDSS gives OHO a thorough summary of the case being appealed. All non-medical appeals requests must contain an eNDSS.

The eNDSS:

- Provides data from multiple query sources (MBR, SSR, HIQR, NUMI, CSR, MDW, THIS, Appointment);
- Creates an editable electronic summary sheet using the queries;
- Provides links to various sites, such as CPMS, Notices, and other programs.

eNDSS can be accessed by following the steps below:

- Open the eNDSS tool by accessing the OQP toolbar.
- Click the “Menu” button.
- Select “Programs, etc.”, and
- Choose eNDSS from the dropdown list.
- Enter the SSN of the case and follow the prompts.

Deferred Development and the Hearing

When the development of non-medical factors of eligibility or payment was deferred pending a medical decision, continue to defer these issues until after notification of an ALJ reversal unless:

- The claimant's situation has changed; and/or
- (S)he now meets criteria for deferral exclusion.

The FO will review non-medical eligibility factors in the case file during the interview with the claimant when the Request for Hearing is filed. You will also:

- Prepare a Report of Contact(RC) to document that the factors of eligibility were reviewed and the claimant appears to meet at least 1 month of eligibility.
- Note in file any new information that requires further contact with the claimant.

Appears Ineligible

If the claimant does not appear to meet eligibility requirements based on non-medical information (such as too much income) but additional evidence is needed to establish eligibility, you will:

- Forward the file to OHO along with an RC detailing the issue in question.
- Continue to develop the ineligibility issue.
- When you have concluded the development, summarize the evidence on an RC and forward everything to OHO so that the ALJ will have the opportunity to decide the non-medical issue if (s)he chooses to.

NOTE: The ALJ may, at his or her discretion, issue a decision on a new issue such as income when the hearing is directed to an issue previously determined, such as disability.

FO Determination of Ineligibility

When a Request for a Hearing is filed on a medical decision and the FO determines the claimant never met non-medical requirements in any month and the evidence that supports that determination is in file the FO will:

- Explain the denial issue(s) on an RC.
- Send the RC summarizing the new issue and completed development showing ineligibility to OHO along with the hearing request.

If the file is not in the FO, request it by telephone. Refer to [SM 01201.205](#) to process a systems request to retrieve an SSI file.

1. Distribute all copies of the HA-501-U5.
2. Send all completed forms, evidence submitted and the prior file to OHO.
3. Use transmittal sheet SSA-636-U3.
4. In the SSI Claims System, complete the appeals path to update the APPE segment of the Supplemental Security Record (SSR).

Informal Remand

[DI 33020.030](#); [DI 12010.015](#)

Pre-Hearing Review

An “informal remand” is a procedure that provides a pre-hearing review for those cases that have a strong likelihood of reversal. The claimant must allege significant new impairment or a dramatic worsening of his/her condition. Convincing evidence must be submitted showing that a favorable DDS decision is likely.

The claim folder must be available in the FO. The FO will not conduct extensive review of the evidence. If there is doubt whether an informal remand is indicated, send the claim file to OHO for the hearing.

If the criterion for informal remand is met:

- Send the file to DDS rather than OHO.
- Send the “Hearing Office copy of the HA-501-U5 to OHO.
- If DDS allows the claim, it is not necessary to send the file to OHO unless the claimant objects.
- If DDS is unable to allow the claim, DDS will send the file to OHO for a hearing.

Escalating to a Higher Jurisdiction

Occasionally, an initial claim is filed on one title while the other title has a claim already at a reconsideration or hearing level.

When the claims have a common issue that is under review, then the initial claim will be “escalated” to the same level as the appealed claim. A common issue is often a medical condition. Claims that do not have a common issue cannot be joined together for a decision.

Example of an Escalated Claim

Marge Brothers filed for Social Security disability benefits in March. She did not file for SSI at that time and she was given an informal decision denying her benefits to the SSI program.

In July, she was denied Social Security benefits based on a decision that she was not disabled.

While filing an appeal on the Title II disability decision, she decided to file a claim for SSI based on her disabling condition. An application was taken for SSI. For both claims, the common issue was her medical condition; therefore, the claims could be joined together for the medical decision. Form SSA-831 (Disability Determination) was sent to DDS with a comment in the remark section to escalate the Title XVI initial claim to the Title II reconsideration.

The last step is to show the appeal on the SSR by inputting appeal information in the system to indicate that the claim is at a reconsideration level.

ALJ Dismissal

SI 04030.020

The ALJ may dismiss a case or remand it to the FO without conducting a hearing under the following circumstances:

- A party requests dismissal.
- All parties abandon the hearing. This occurs often when the individual fails to appear for the scheduled hearing.
- Res Judicata applies. (Res judicata means, “the matter has been decided.”) SSA has already decided the same facts and issues involved in the same type of legal action for the same claimant and the same time period. Because SSI applications are not retroactive, res judicata should never apply to a TXVI claim.
- Collateral Estoppel applies and the claim dismissed when the decision has been made for the same person, on the same legal issue, but under a different program, e.g., Title II, Medicare, and Black Lung.
- There is no right to a hearing, e.g., if the individual has not yet received a reconsideration determination.
- The request is not filed timely and good cause is not shown.
- The claimant dies and there is no spouse, surviving child or parent, or IAR agreement in file.
- The FO or DDS renders a favorable determination.
- The case is remanded to the FO due to receipt of new and material evidence or change in the law, regulations, or legal precedent.

OHO Procedure

SI 04030.030

Normally, hearings are held within 75 miles of a claimant's home. The proceeding is considered informal, meaning such things as "rules of evidence" are not used to conduct the hearing.

A claimant has the right to have attorney representation, to present evidence, and to cross-examine witnesses, including SSA and DDS decision makers.

OHO may ask the FO for assistance. If this occurs, handle the request promptly.

- Regulations require that, in non-disability cases, the hearing be conducted and the decision issued within 90 days after the hearing is requested.
- Disability cases are exempt from this regulation, but still require that prompt decisions be made.

The ALJ will make a decision and issue notices to all parties including the appropriate FO.

OHO will forward the SSI file to the FO responsible for effectuating ALJ decisions.

Routing Procedures

In concurrent claims, OHO will separate the paper claim files and send the Title II file to the appropriate Program Service Center.

OHO will forward the SSI file to the FO responsible for effectuating ALJ decisions.

Effectuation Procedures

[SI 04030.050](#)

Effectuation of the Favorable Decision

When the FO is notified of a favorable hearing decision, the FO will follow regional instructions to effectuate the decision.

The lapse of time between initial or reconsideration determinations and hearings usually require an unscheduled redetermination be conducted before effectuating a hearing decision. This pre-effectuation eligibility review is referred to as a "PERC."

This review must be conducted within 20 days of receipt of the hearing decision, but in no case later than 60 days from the date of the hearing decision.

After 60 Days

[SI 04030.070](#)

If the review has not been completed at the end of 60 days, it is mandatory to certify payment and to continue the redetermination process. Benefits will be paid based on the information that is available.

Navigating CPMS

[DI 80550.001](#)

The Office of Hearings Operations (OHO) Case Processing and Management System (CPMS) allows OHO components to control and process hearings cases. CPMS contains information about cases under the jurisdiction of OHO with a few exceptions, such as hearings pending under Title XVIII (Medicare). Currently, CPMS permits tracking and processing of the paper folder and is a major component of the eDIB effort that enables OHO to interact with the electronic folder.

Field offices can query the cases pending in CPMS by accessing the following website: <http://cpms.ba.ssa.gov/cpms> or through your Title XVI Resource Kit under “Systems Information”.

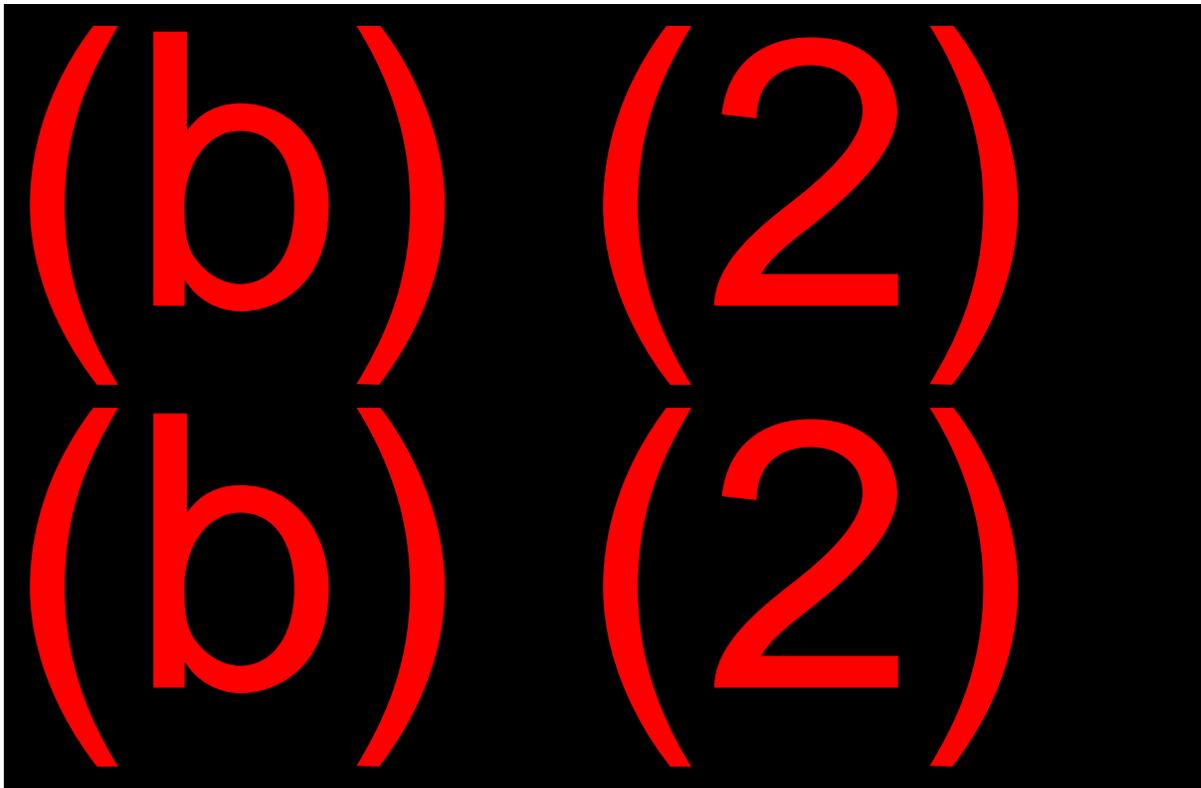
Once on the CPMS Homepage, you may search for a specific case:

- Select [Find/Add a Case]
- Enter the SSN
- Select the [Search] button.

Once the case is located, select [Query] to review the details of the case. All information is presented in plain language and should not require a query reader.

If no matches are found based on the SSN, the case has not been established in CPMS.

CPMS QUERY



NOTE: Hearing information on older pending cases may not be located in CPMS. The HA04 query is still available to FOs to provide information about hearing cases not established in CPMS.

To access the HA04 query:

- Select "17" (OHA DATA INPUTS/QUERIES) from the Main Menu.
- Enter your unit code and select option "1" (OHAQ).
- On the OHAQ screen, enter the Account Number and then select "1" (Summary).
- The query reader can be found in [Title XVI Resource Kit](#) under "Query Readers".

OBJECTIVE 4:

Determine and perform the proper development for AC reviews and litigation.

AC Review

[SI 04040.010](#); [SI 04040.020](#)

Right to Appeal

The claimant has a right to appeal a hearing decision to the AC, located in OHO central office in Falls Church, Virginia.

The claimant has 60 days from the date of the notice (plus five mailing days) in which to appeal the hearing decision.

When the appeal is filed after 65 days from the notice date, the claimant has the right to attempt to establish good cause for late filing.

Complete Form SSA-795 showing the claimant's reason for delay in filing and forward this statement with the appeal request to the AC.

AC Review

When an unfavorable hearing decision is rendered, the claims file is automatically sent from the local hearings office to OHO central office in Falls Church, Virginia to await a possible AC review.

The AC review procedure can be initiated at the time an AC review request is received from the dissatisfied claimant and also from:

- Regional offices—A regional office can protest a hearing decision based on an FO recommendation.

- The AC can, on its own motion, decide to review a hearing decision. This usually occurs when a substantive question involves interpretation of law, regulation, or policy, or a problem of broad policy concerns.

Written Request

A claimant's request for review must be in writing but no longer requires his/her signature.

Formal Request

A formal request is made on Form HA-520-U5. The HA-520-U5 is completed when the claimant is in the FO. When the request for appeal is made by telephone, mail an HA-520-U5 to the claimant with a cover letter reminding him/her of the time limits for submitting the written request.

Informal Request

An informal request would be in the form of a letter or other correspondence from the claimant. The procedures are similar to an informal request for a hearing. Prepare the appeal forms by:

1. Completing Form HA-520-U5 based on information in the correspondence.
2. No signature is needed on the form. Type the name in the space provided.
3. Attach the correspondence to the AC copy of the HA-520-U5.

FO Procedures

The FO will send the request to the AC along with any evidence submitted by the claimant. (The FO will not request evidence when the appeal is filed, but will assist the AC if assistance is requested.)

Show the appeals data in the APPE segment of the SSR by updating the appeals path in the system.

In deferred development cases, the FO will continue to defer development of non-medical factors of eligibility until a decision is rendered by the AC.

Jurisdiction

The AC will:

- Deny the request for review; or
- Remand the case to the ALJ; or
- Issue a decision affirming, modifying, or reversing the ALJ decision.

Litigation

[SI 04050.010](#); [SI 04050.020](#)

District Court

If the claimant continues to disagree with the decision, the last step in the appeal process is to file civil action in the U.S. District Court.

The FO has little or no involvement at this stage of an appeal.

The action must be filed within 60 days from the date the AC decision is received.

The judicial review is filed in the district court for the judicial district in which the claimant resides or has his/her principal place of business.

The Commissioner of SSA is the only proper defendant in court actions, and the service of the summons must be made to him/her or to another authorized person on his/her behalf.

If anyone attempts to erroneously serve summons upon you in any court proceeding against the Commissioner, SSA, or the U.S., explain that you are not authorized to accept service on behalf of the Commissioner. Always refer this situation to your manager. If the person insists on leaving the papers with you, mail the papers to the Office of the General Council with a covering memorandum that states:

- The name of the employee served;
- The date of service; and
- Whether received by mail or served personally.

Subsequent Claims

[DI 51501.001](#), [DI 51501.005](#), [DI 51501.020](#)

Procedure

SSA does not accept a new disability application if the claimant has a prior disability claim for the same title and benefit type pending at any level of administrative review, unless the prior claim is pending at the Appeals Council (AC) and the claimant has evidence of a new critical or disabling condition with an onset after the date of the hearing decision

This procedural change does not apply if the prior claim is:

- For a different title;
- For the same title, but for a different benefit type (e.g., claimant wants to file a new title II disabled widow(er)'s benefit application and the claimant has a claim pending for title II disability insurance benefits);
- A continuing disability review;
- An expedited reinstatement (EXR) claim;
- An age 18 redetermination; or
- In Federal court or was remanded from Federal court to the hearing or Appeals Council (AC) level.

If the claimant has a disability claim pending administrative review, you must explain the following:

- In general, the claimant cannot have two disability claims pending for the same title and benefit type.

- The claimant must choose either to continue the appeal of the prior claim or ask us in writing to withdraw the appeal and file a new application.
- If the claimant chooses to continue the appeal, we will forward any evidence to the office handling the pending appeal. (See Claimant Submits Additional Evidence, [DI 51501.015.](#))
- If the claimant wants to withdraw the appeal, he must ask us in writing to withdraw it. Also, if he requests to withdraw the appeal, he may lose benefits or not qualify for benefits at all. The decision on the prior claim will be the final decision, and the claimant will not have the right to ask for further review of the decision. (See Claimant Requests to Withdraw Pending Appeal, [DI 51501.020.](#))
- SSA must approve the request to withdraw the appeal, and we do not always grant the request.
- If we approve the request to withdraw the appeal, we will process a new disability application.

Withdrawal

If the claimant wants to withdraw the appeal, advise him or her:

- That by withdrawing the appeal he or she relinquishes all appeal rights on the claim.
- The withdrawal request must be in writing.
- He or she must include a statement in the withdrawal request that he or she fully understands the effect of the withdrawal and intends to file a new application.
- The claimant or claimant's representative must sign the withdrawal request.
- The claimant or claimant's representative need to submit the signed withdrawal request to the field office.

Expedited Appeals Process (EAP)

[SI 04060.010](#); [SI 04060.030](#)

Exhaust All Avenues

Under the doctrine of “exhaustion of administrative remedies,” a person must exhaust all avenues of appeal before taking the claim into district court. This means that a claimant cannot select a level of appeal. The claimant must go through all administrative appeal levels and, if still dissatisfied with the decision, can file a claim against the Commissioner in district court.

EAP

There are cases in which a dissatisfied claimant’s disagreement is not with the decision in itself, but with the law under which the determination was made; that is, the claimant believes the law is unconstitutional.

For these rare cases, SSA has instituted an expedited appeals process known as (EAP).

The EAP can apply only after initial and reconsidered determinations have been made. If the individual has requested a hearing or AC review, the EAP request must be made before receiving notice of the decision.

After an explanation of the EAP process as set forth in [SI 04060.030](#), if the individual still wants to file the request, secure a SSA-795 stating the pertinent facts and forward the statement and the file to the RO, ATTN: ARC, Programs. The RO will prepare the agreement and return it to the FO to obtain the claimant’s signature. After obtaining the claimant’s signature, the FO returns the agreement to the RO for signature of the RC and distribution.

When the agreement has been signed by both the claimant and the RC on behalf of the Commissioner, the claims folder is marked “EAP” and forwarded to the Office of Civil actions, OHO, at Falls Church, Virginia.

EXAMPLE:

Mary Kay Smith filed a claim for SSI and alleged that she was age 62, was not blind and not disabled. Also, she had no countable income and no resources. She met all eligibility requirements except for age. She maintained that, since SSA allowed individuals to “retire” and start receiving benefits based on “advanced age” at age 62, it was unfair and unconstitutional to set a higher age standard for the poor.

Mrs. Smith never objected to the way SSA interpreted the facts, nor did she believe that we failed to apply the law properly in her case.

She believed that the law was bad and that it was also unconstitutional since it deprived a whole class of individuals the right to a benefit afforded to others of a similar class.

SSA determined Mary Kay Smith’s appeal qualifies for EAP. She must, however, receive an initial determination and a reconsidered determination before taking the case into district court. The FO, when denying the reconsideration, will notify her of the EAP procedure. In the event she still wants to pursue the constitutionality of the law, she can file her next appeal directly in Federal court.

An FO employee who becomes aware that an EAP situation might exist should thoroughly review POMS procedures. (S)he should also be aware that it is improper for an employee to discuss EAP with a claimant prior to the time that reconsideration is filed.

OBJECTIVE 5:

Understand appeals on disability cessation cases.

Continuing Disability Review (CDR)**[DI 28001.001](#)****Purpose**

After an individual is determined to be disabled, we are required by statute to perform a review from time to time to determine if the individual continues to be disabled. To carry out this statutory requirement, CDRs are conducted at selected intervals.

Disability Cessation**[SM 00614.001](#)**

As a result of a CDR, if an individual receiving disability benefits is found by the DDS to have medically improved, a disability cessation occurs. Therefore, the individual is no longer disabled under SSA law and his/her benefits must be terminated. The individual has 60 days (plus five mailing days) to file request for reconsideration on the disability cessation.

FO Role**[DI 12026.020](#)**

A reconsideration continuing disability review procedure is used when the reconsidered issue is a medical cessation. The FO starts the process by obtaining the following forms/information from the recipient:

- SSA-789-U4 (Request for Reconsideration-Disability Cessation),

- SSA-3441-BK, Disability Report Appeal,
- SSA-827 (Authorization to Attending Physician),
- Other forms may also be needed (refer to [DI 11005.016](#)) such as an SSA-3881 for a child's case.

Payment Continuation

When an appeal is filed within ten days from the date of receipt of the disability cessation notice and the appeal is based on a medical issue, the recipient may elect to continue to receive his/her benefits until a determination is made on the appeal.

NOTE: On non-medical issues an appeal filed within ten days will be considered a request for benefit continuation under the Goldberg/Kelly procedures. The individual also has the right to waive benefit continuation to avoid the possibility of overpayment. ([SI 02301.310](#))

Complete form SSA-795 indicating the claimant's preference in receiving disability benefits while the decision is under appeal.

Statutory Benefits Continuation (SBC)

[DI 12027.001](#)

SBC is different from GK payment continuation in that election of this option applies only during the appeal of:

- A medical cessation determination where the disabled individual's physical or mental impairment(s) has ceased, never existed, or is no longer disabling, i.e., medically improved; or
- A medical adverse reopening/revision determination.

Appealing the medical cessation (or medical adverse reopening/revision determination) is required to have the option of SBC.

- A recipient that elects SBC is required to sign a specific statement (SSA-795) to that effect.

- A recipient that declines SBC is required to sign a specific statement (SSA-795) to that effect.

See SSA-795 Election Statement - Exhibits, [DI 12095.171](#) for the exhibits of the specific election statements.

Explain to the individual that the election statement is required whether he/she elects or declines SBC. Place election statement in the individual's official folder.

NOTE: The continued benefit provisions do not apply to an initial determination on an application for disability benefits or to a determination that an individual was disabled only for a specified period of time.

Routing to DDS

The FO will complete the SSA-789-U4, authorizations and obtain any other evidence necessary.

A copy of the SSA-789-U4, any supporting forms, and any other evidence provided by the claimant is placed in the claimant's official folder.

Routing to DHU

The FO will send a copy of SSA-789-U4 to the disability hearing unit-scheduling office (DHU-S). The DHU is responsible for scheduling and holding a disability hearing when the DDS cannot issue a favorable reconsideration determination on a medical cessation. The claimant's official folder is routed to the DDS for reconsideration development.

DDS Role

DDS will follow normal reconsideration procedures. If the original decision can be reversed, DDS will issue a determination and will notify DHU of the determination. If DDS cannot make a fully favorable decision, it prepares a Summary of Evidence (SSA-887) and forwards the case to DHU.

DHU Role

DHU will arrange and conduct a hearing and will issue a notice as soon as possible after the hearing. Overview of the Disability Hearing Process.

DHU also prepares the SSA-832-U3, Disability Cessation or Continuance Form or SSA-831-U3, Disability Determination Transmittal when appropriate.

Decision Affirmed

When DHU affirms the cessation decision, the DHU will issue the notice and return the file to the servicing FO to:

- Hold the file for possible further appeal. (An ALJ hearing is the next level.)

NOTE: If a hearing is filed within ten days of the notice date, the recipient is entitled to payment continuation. Payments will be continued through the ALJ hearing, unless the election is changed by the recipient.

- Input the cessation decision and payment continuation if appropriate.
- The recipient can request “good cause” for filing the appeal after the 10-day period required for benefit continuation. If SBC is requested after the 10-day limit but before the expiration of the 60-day appeal period, the FO has jurisdiction to determine if “good cause” is met for payment continuation ([DI 12027.008](#)).
- “Good cause” for requesting a hearing after the 60-day appeal period ends is within the jurisdiction of OHO. The FO secures the recipient’s good cause statement and forwards this, with all other development, to OHO.

OBJECTIVE 6:

Input appeals into the system.

Systems Inputs

The last stage is to make the input to the computer system, showing any changes made as a result of the reconsidered, ALJ, AC review, or court case determinations and also showing the proper appeal code.

- You may take and process any appeal on a denied claim event that was taken and adjudicated in MSSICS by selecting the APPEALS function on SSI Menu (MSSI). If there is no MSSICS pending file, select the Direct SSR Update function on the SSI Menu (MSSI).
- To use this function, the denied initial claim event must not have been archived. The archival process locks the claim, preventing the filing of an appeal through the SSI Claims System.
- Selecting APPEALS on MSSI allows you to open an appeal event. Select the "FZI" (Frozen Image) pending file that appears on PMCS for your denied claim. Then, on APPEALS LIST (APLS), you must select "NEW APPEAL" to establish an appeal event. The new event allows you to access the denied claim information and to update the pending file data in the entire claims path, including the prior claim determination. It also allows you to print output for required writings if needed.
- Complete and document all appropriate MSSICS appeal screens, as required. Begin by completing CORE APPEAL DATA (ACAD) showing all necessary fields. In the screens that follow, you must indicate the issue(s) being appealed and document the claimant's reason for requesting the appeal, evidence submitted, and whether or not payment continuation applies. If the appeal is filed late, that issue must also be addressed and documented on the screens.
- On the JURISDICTION AND STATUS (AJAS), "Appeal Controlling Office" must show your FO code. The only time you enter a different code is when you are taking an appeal for a different FO

and you are transferring it there. For appeals on medical issues (refer to Medical Decision Appealed section), the disability file must be transferred to the DDS office with jurisdiction. Enter the DDS code in the “Referred or Remanded for Appeal Decision to Office” field. For non-medical appeals, leave this field blank.

- Print the appeal using the CLAIM DEVELOPMENT function on SSI MENU (MSSI). Select “Appeal Print Options” on CDW SSI MENU (DWME). Annotate the Development Worksheet (DW01) with the date reconsideration request was made.
- Post the appeal data to the system (Build Transaction SSR) using function DECISION INPUT on SSI MENU (MSSI).

After a Decision is Made

- Show the reconsideration, ALJ, AC review, or court case decision receipt date on the DW01.
- Document the decision by updating JURISDICTION AND STATUS (AJAS) and DISPOSITION (DISP). On DISP, the “Fully or Partially Favorable Effectuation Notice Date” field can be left blank for any appeal involving an initial medical determination that is favorable. This will automatically generate an award notice. For non-medical or post-eligibility decisions, and for all denials, enter the date of the manually prepared (or DDS prepared) notice here. (Refer to “Proper Notification” section below.)
- Post the appeal decision data to the system (Build Transaction SSR) using function DECISION INPUT on SSI MENU (MSSI).

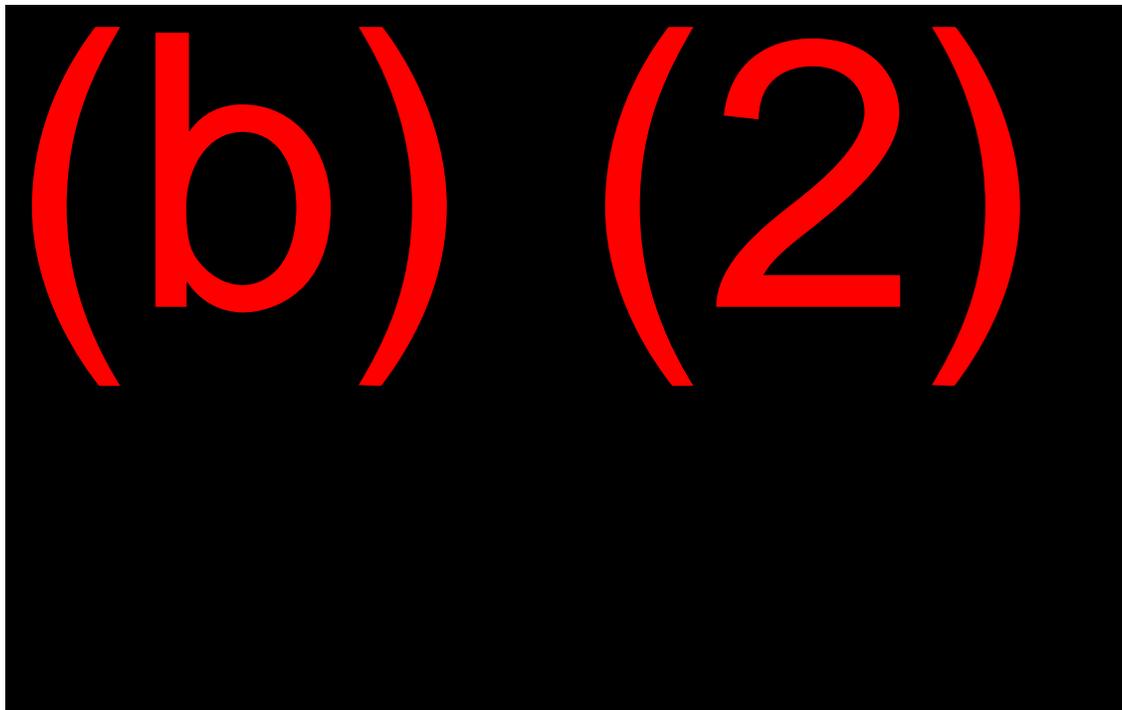
MSSICS

[MS 04420.001](#)

To establish an appeal event for medical and non-medical issues in MSSICS, select the APPEALS (“9”) function on SSI Menu (MSSI). The first appeal path is the Core Appeal Data (ACAD screen). On this screen, you can indicate the case level of appeal. The following screens display the appropriate screens to record the specific appeal data in MSSICS.

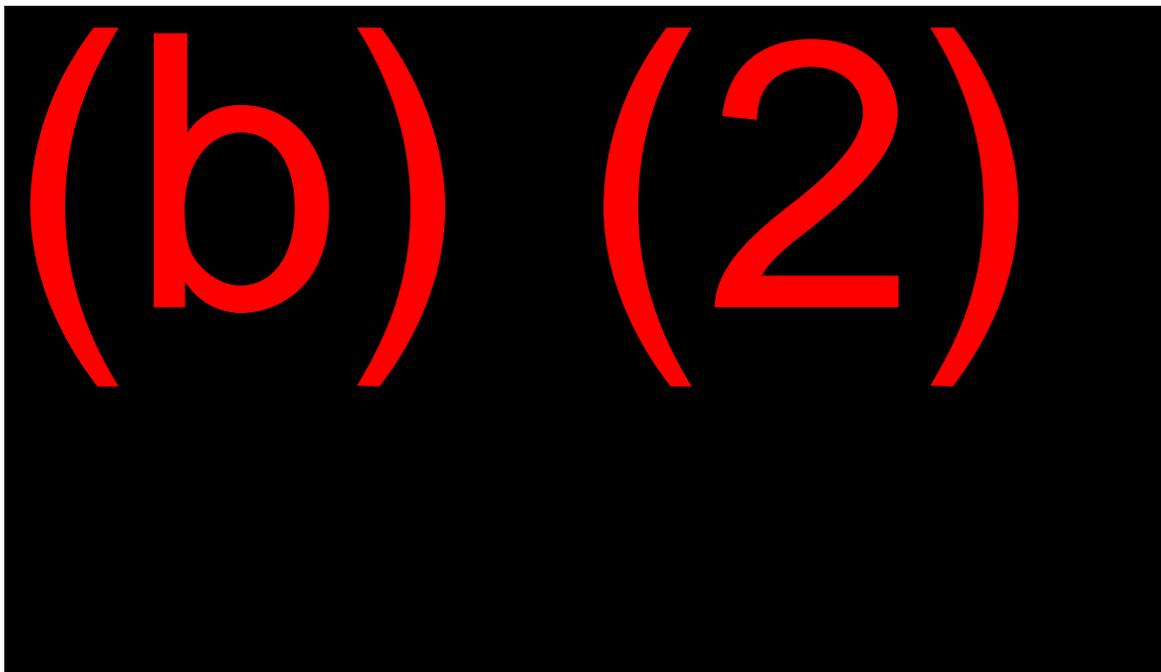
Below is a facsimile of the Core Appeal Data (ACAD) screen.

[MS 04420.004](#)



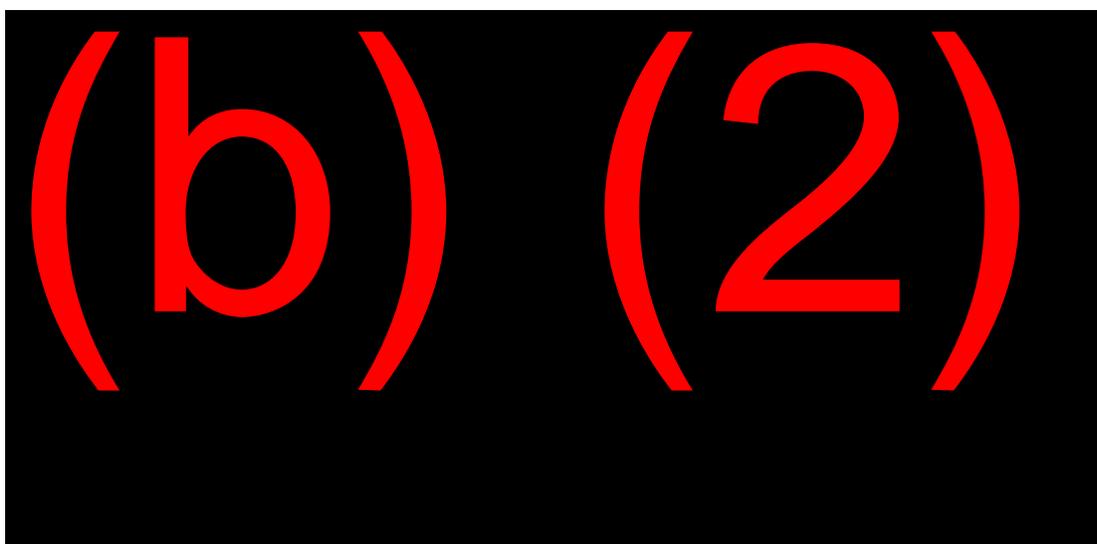
Below is a facsimile of the Appeal Issue (AISS) screen.

[MS 04420.006](#)



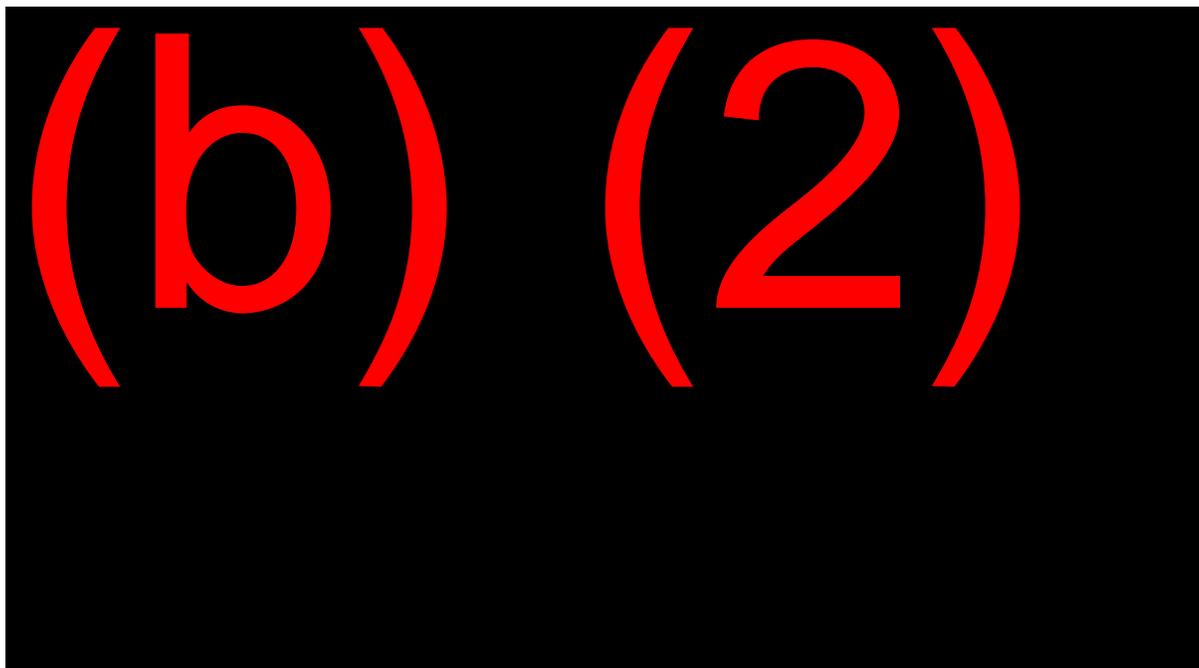
Below is a facsimile of the More Appeal Data (AMAD) screen.

[MS 04420.007](#)



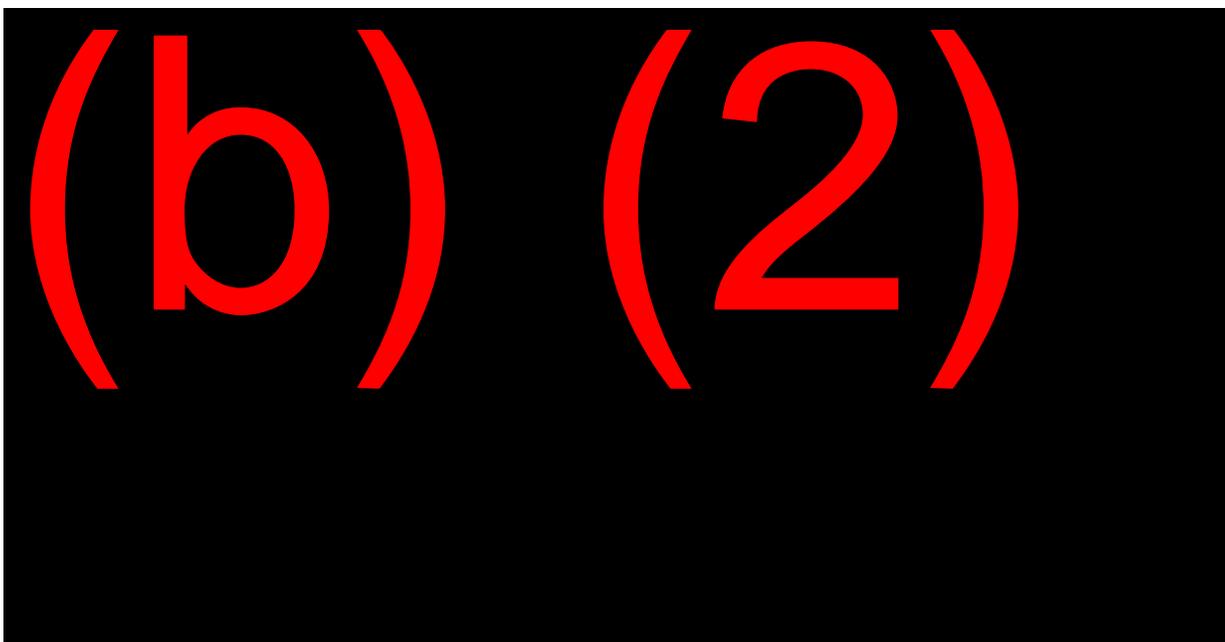
Below is a facsimile of the Claimant Disagreement Explanation (ACDS) screen.

[MS 04420.008](#)



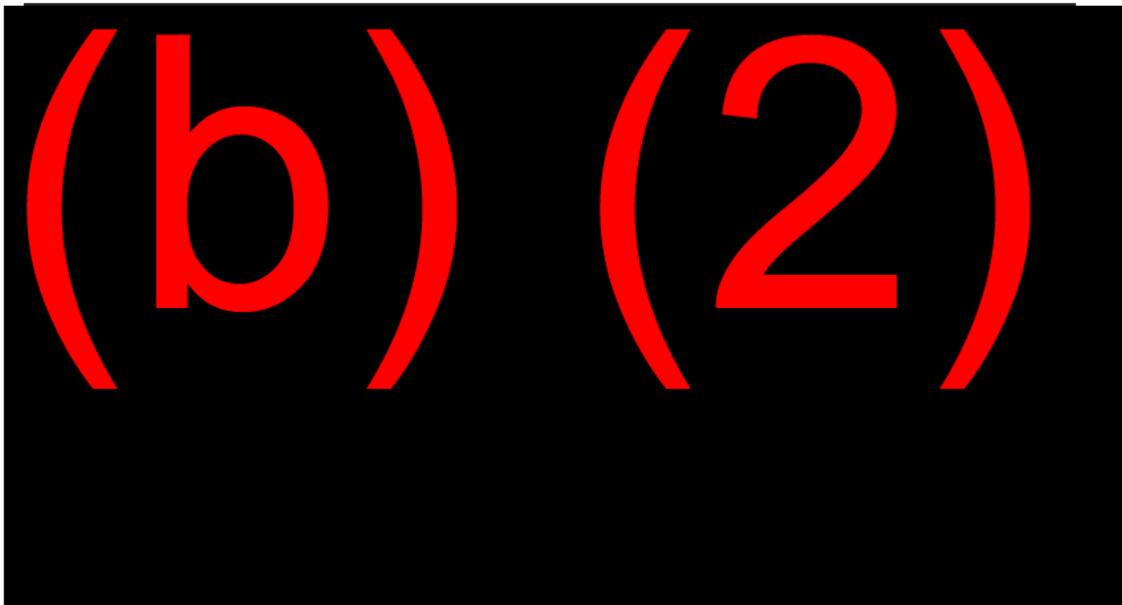
Below is a facsimile of the Jurisdiction and Status (AJAS) screen.

[MS 04420.023](#)



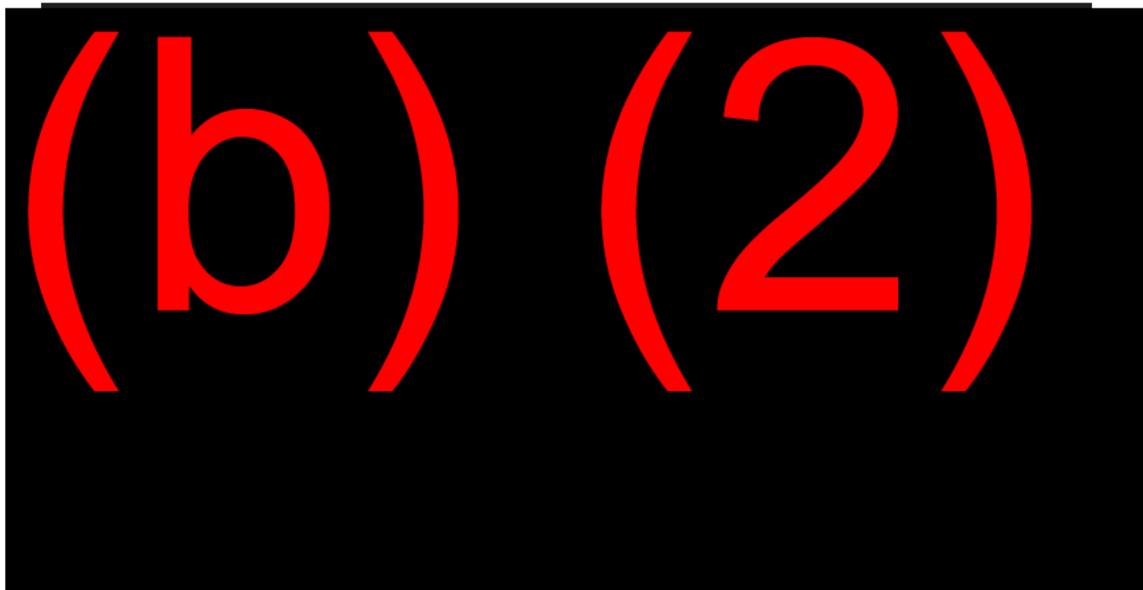
Below is a facsimile of the CDW SSI Menu (DWME) screen.

[MS 04422.002](#)



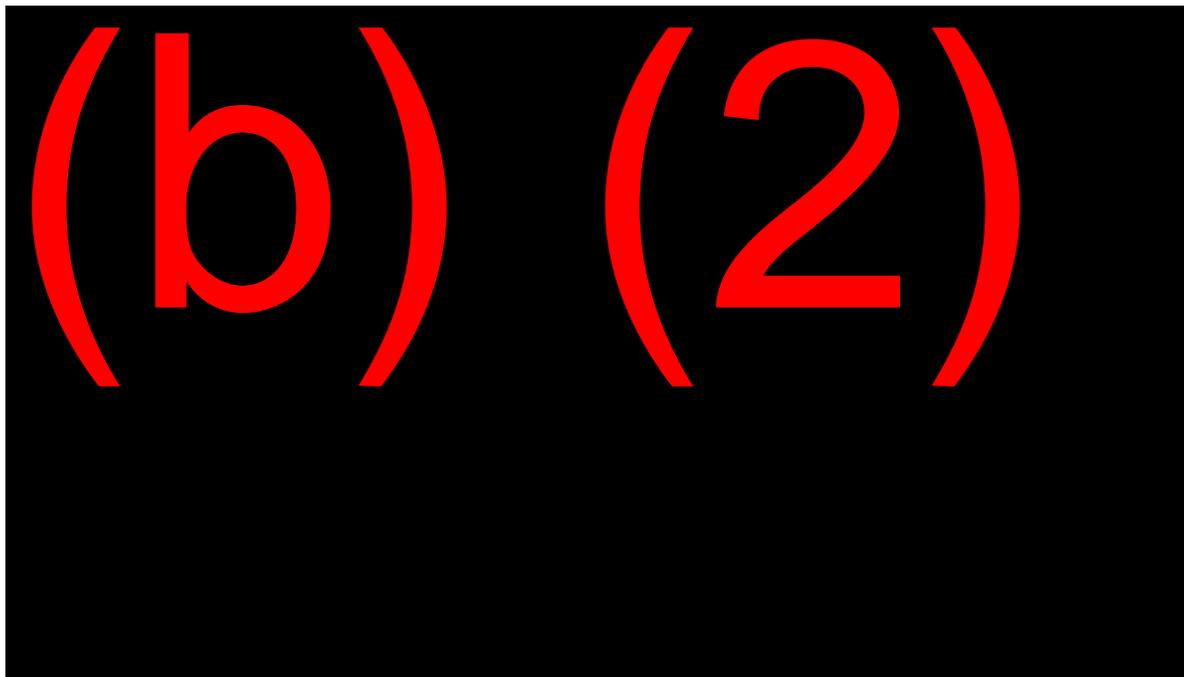
Below is a facsimile of the Appeal Print Options (DAPR) screen.

[MS 04422.021](#)



Below is a facsimile of the MSSICS Development Worksheet (DW01) screen.

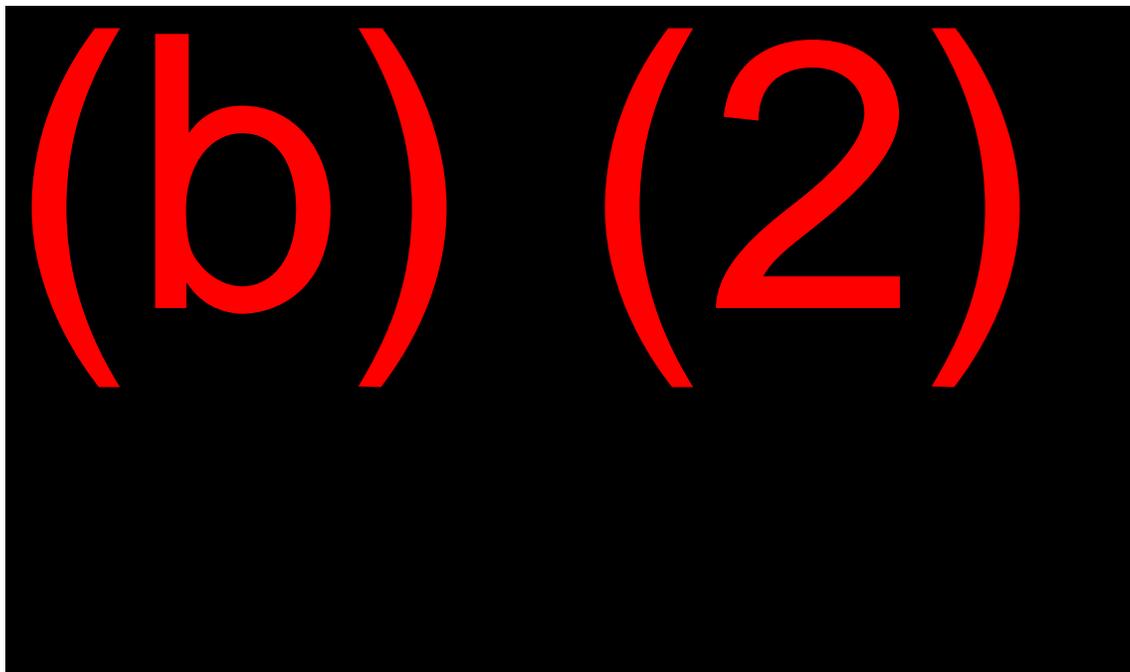
[MS 04422.004](#)



The following screens indicate how to transmit this collected information to the appeal segment of the SSR. (Refer to [MS 04420.001](#).)

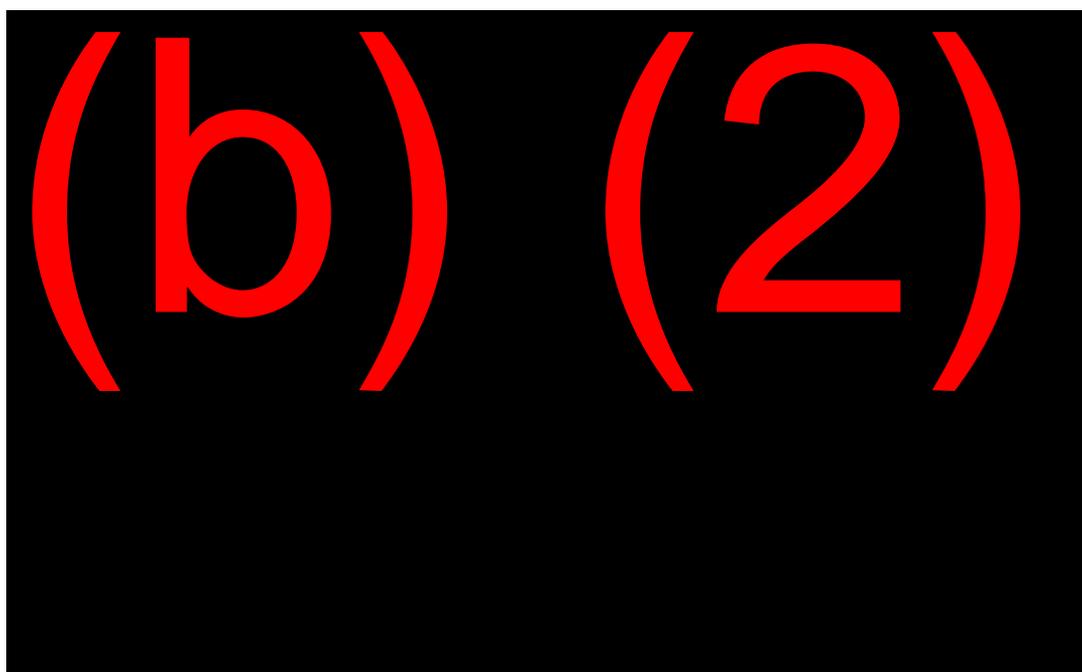
Below is a facsimile of the SSI Menu (MSSI).

[MS 04404.002](#)



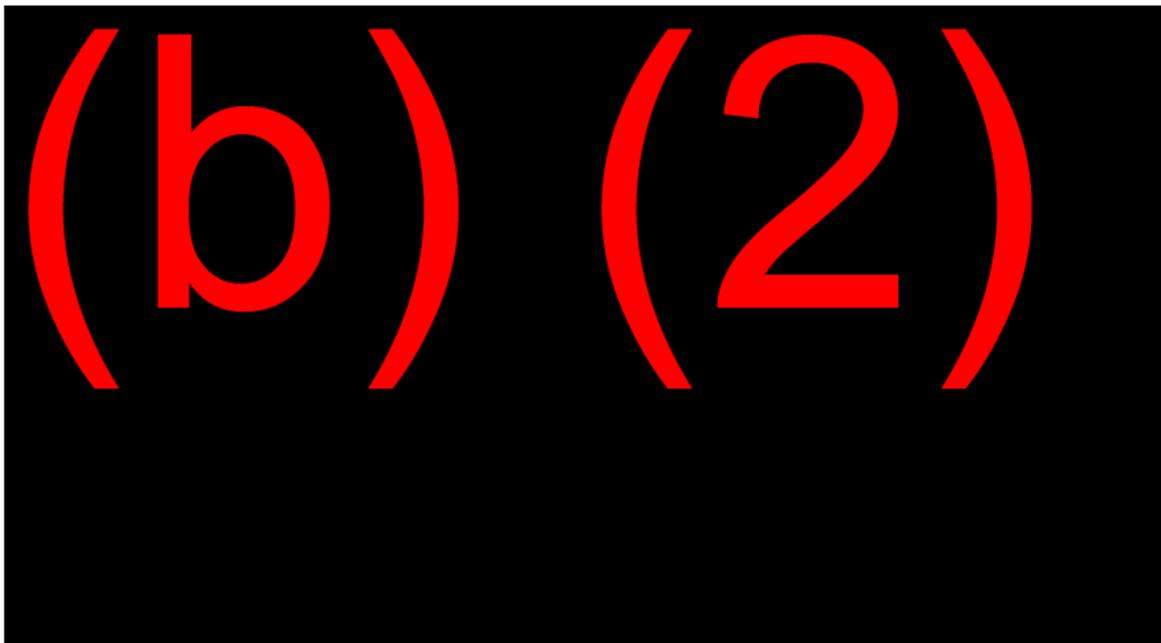
Below is a facsimile of the Build SSR (DSSR) screen.

[MS 04425.002](#)



Below is a facsimile of the Compare Menu (CPRM) screen.

[MS 04427.002](#)



Below is a facsimile of the Appeals Data Comparison (CPAP) screen.

[MS 04427.025](#)



Below is a facsimile of the Simulated SSR (SSIM) screen.

```

XXXXXXXX0909 DTE:01/27/07 SSIM          SIMULATED SSR          UN:          PG: 001+
  AKINA, <FIRST> SN:XXXXX0909 PSY:C01 TMR:DI ID:DI TDA:01/27/07
CMSC HUN:XXXXXXXX0909 RIC:G VER:3 CPD:01/24/07-P CPF:01/27/07
  MSI:3-1-06/26/03
CRZD RZ: S RZP T RZD          RZI RZC RTD          EE
  K          U 09/06/03
PRSN RE: AP:05/30/03 DF:06/25/03 DB: 01/17/19YY SX:F AR:Q- - -
  LPS:ENGLISH LPW:ENGLISH DOE:05/03 AK:HALVEN MCI:N
RCRD EST:06/23/03 XDO:166 IDD:07/07/03 SNV:3 CNV:5 LAF:C PCO:4 FSD:06/03
  FS1:Y FS2:N
ADDR 1 PIEDMONT RD CTY:ATLANTA STN:GA 30301-#### TL:404-555-1212 DIS:600
  ST:12050A ACD:01/24/07
RADR 5424 SECURITY BLVD., BALTIMORE, MD 21235
DIAR MR-07/20/10 OPJ:F-07/19/03
DISB DPC:F DDO:05/30/03 MDR:7 DIG:2500 DPM:P CDR:ERR
APPE ASI C T L RSN FIL          DSN          OFC EFT          SBC BEG END
  01 I R DI 01/23/07          S13
    
```

Below is a facsimile of the BTS Confirmation (BTCF) screen.

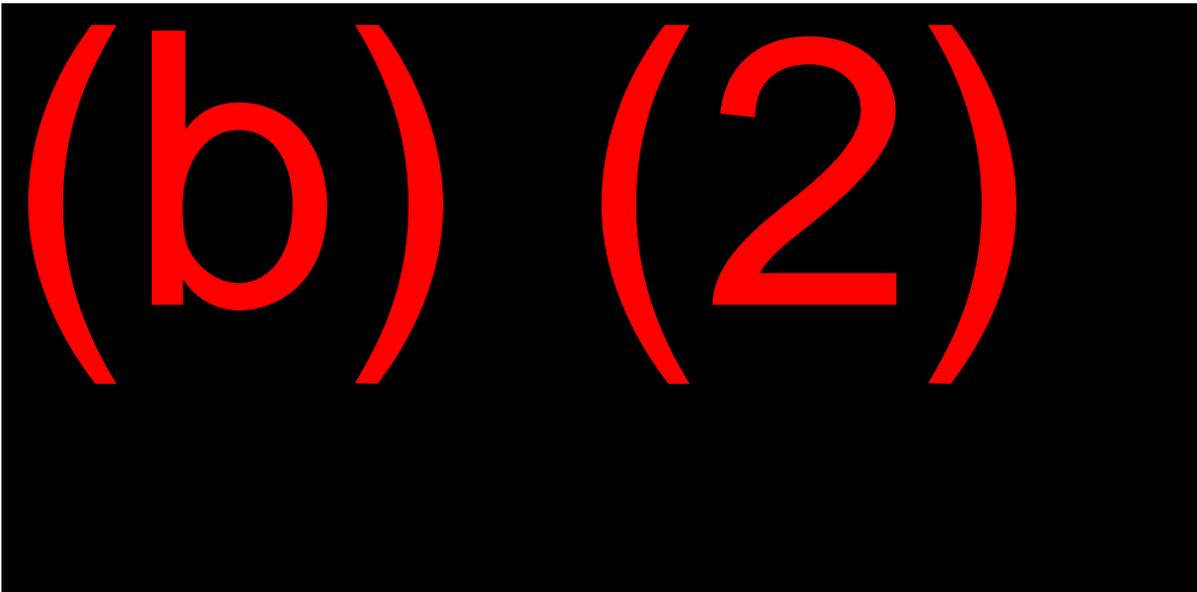
[MS 04427.024](#)




MS 04420.003

(b) (2)

After making the appropriate input to the APLS screen and pressing ENTER, the ACAD, AISS, AMAD, ACDS and DWME screens will follow next. It is then that the AJAS screen will be propagated and need to be completed accordingly.

MS 04420.023

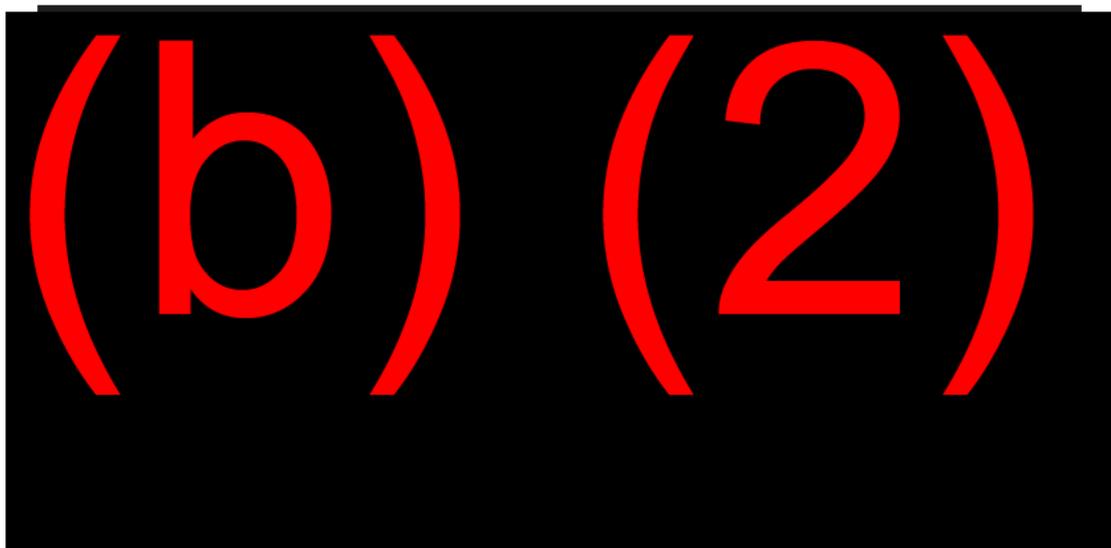
(b) (2)

After a Decision is Made

To update the appeal segment with a decision, select "2" to update and "9" appeals. Select the appropriate segment you want to update on the Appeals List screen, which appears before the ACAD screen. Numerous appeals, including hearing appeals, can be listed on this screen.

The Appeals List (APLS) screen, as well as the AJAS screen requires input to show the jurisdiction and status of the appeal.

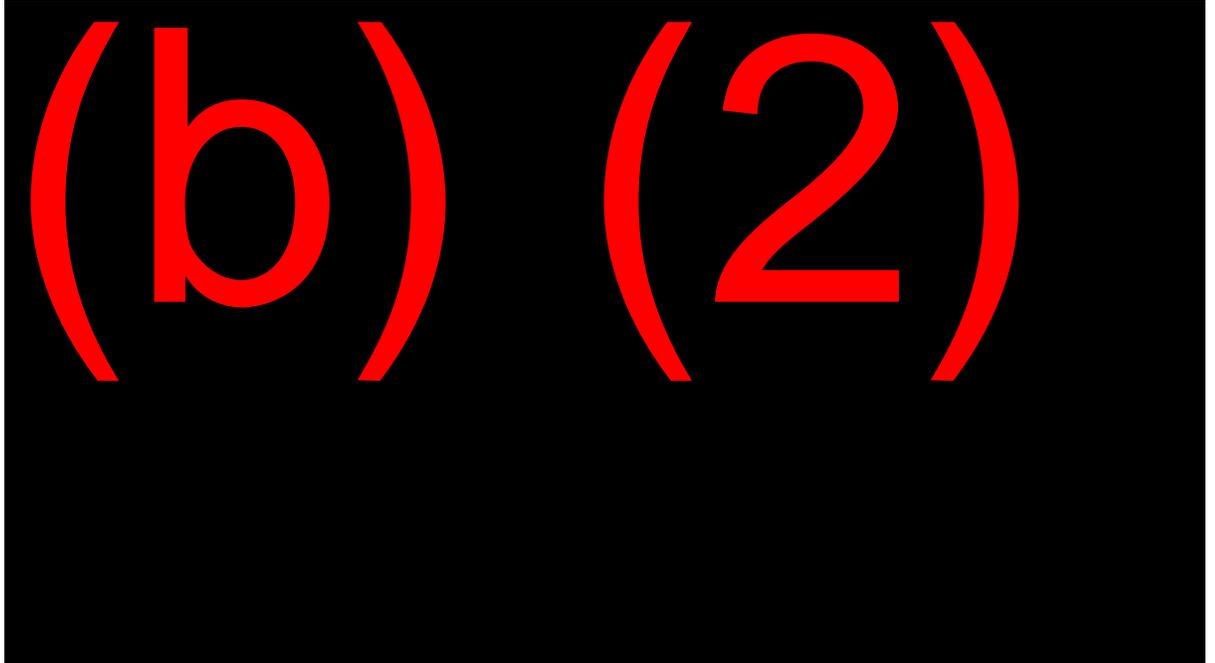
Below are facsimiles of the Appeals List (APLS) and Jurisdiction and Status (AJAS) screens.



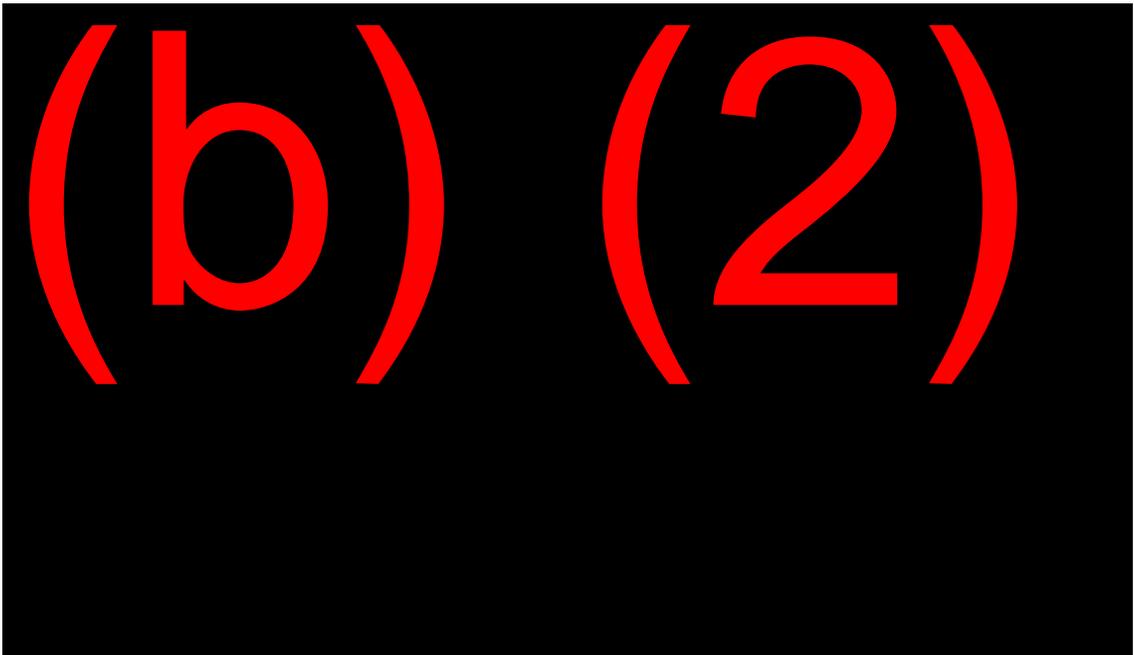
The following screens show the decision input and the screens that are propagated to post the final appeal decision to the SSR (in the APPE segment).

Below is a facsimile of the Disposition (ADIS) screen.

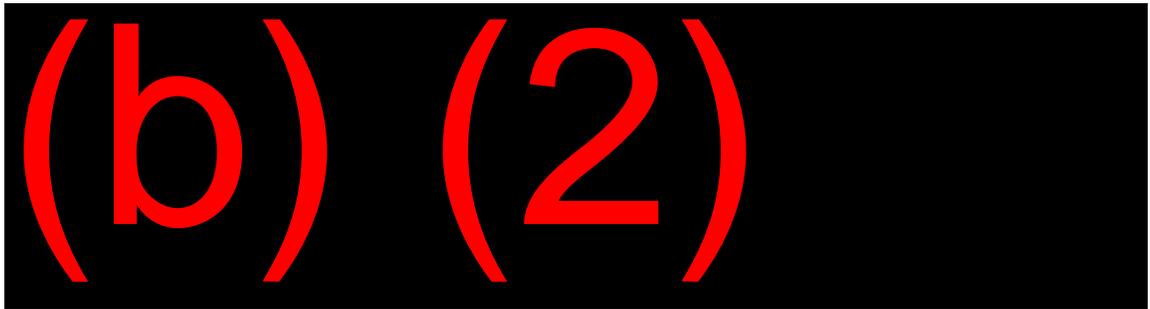
[MS 04420.025](#)



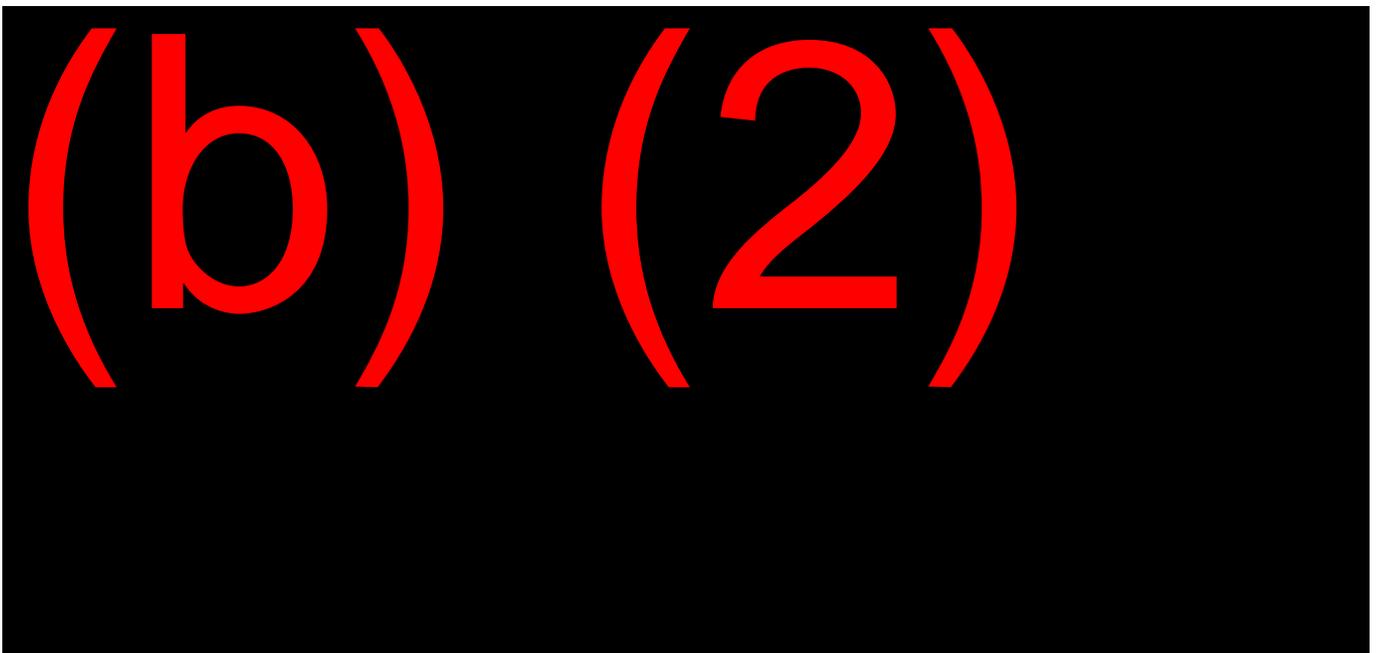
Below is a facsimile of the MSSICS Development Worksheet (DW01) screen.



Below is a facsimile of the Appeals Data Comparison (CPAP) screen.



Below is a facsimile of the Simulated SSR (SSIM) screen.



Non-MSSICS

[MS 00302.001](#)

To establish an appeal for non-MSSICS cases, select "2" Update and "19" Direct SSR Update on the MSSSI. Place a "Y" next to Appeals and page through the UMEN. Refer to the following exhibits to complete appeals actions for non-MSSICS cases.

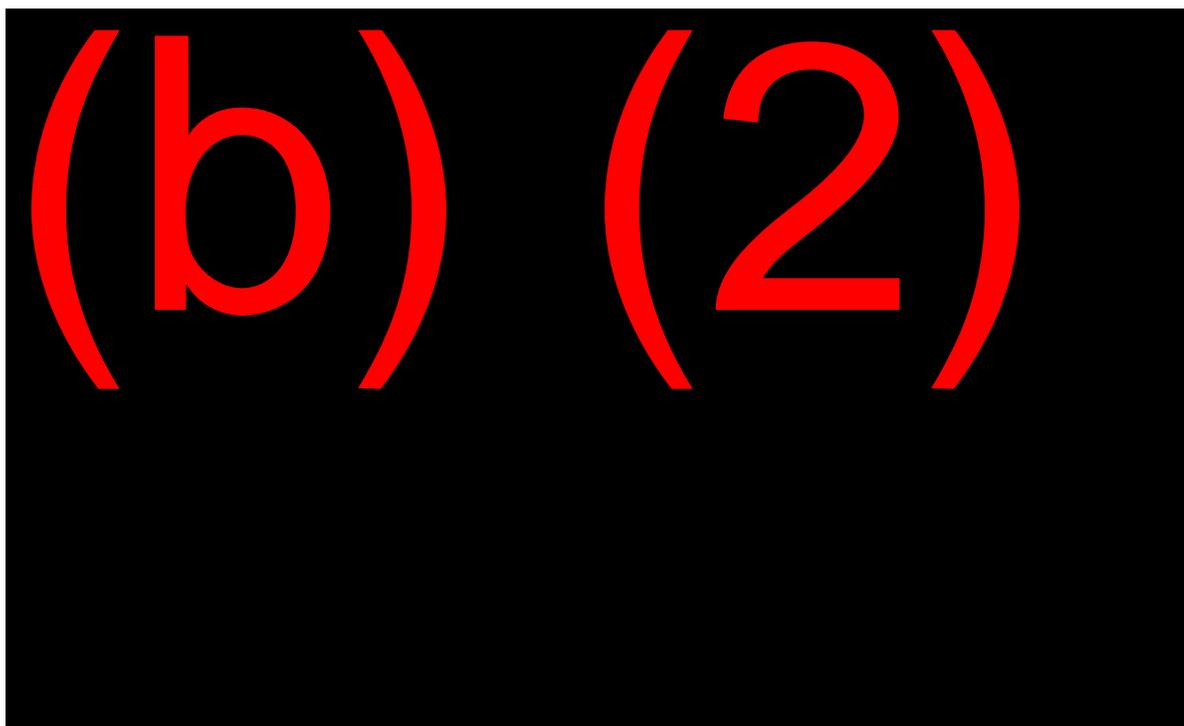
Below is a facsimile of the Appeal List (UPLS) screen.

[MS 00302.008](#)



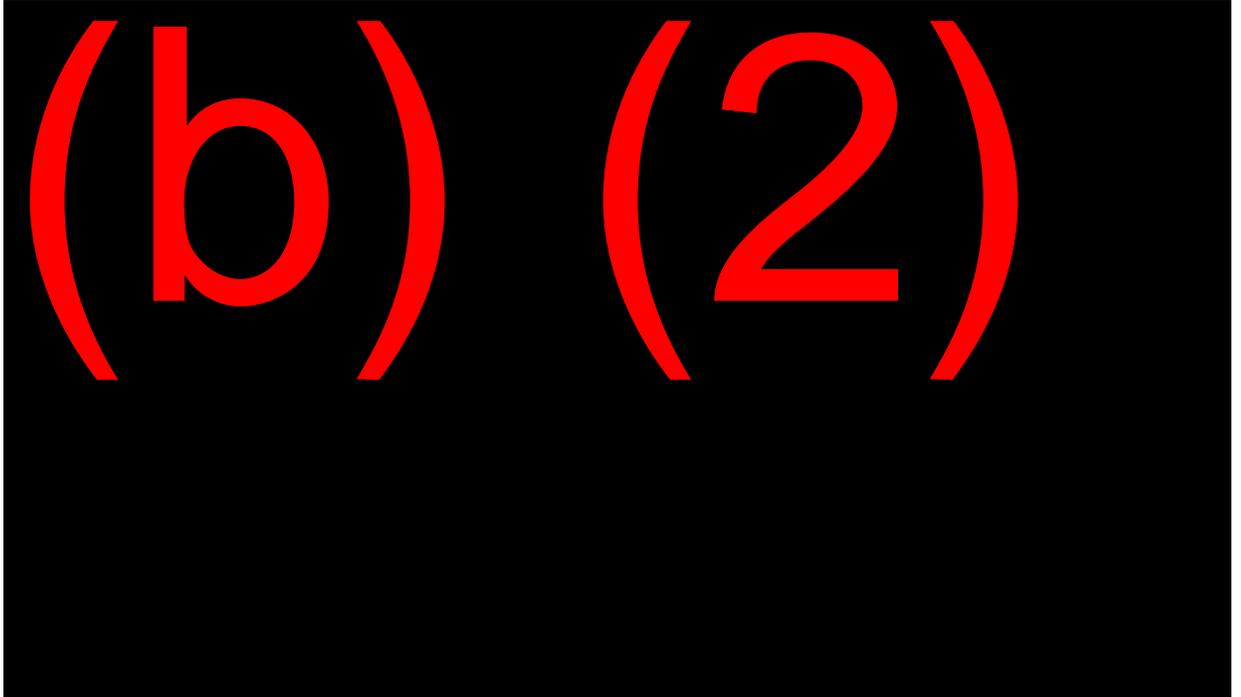
Below is a facsimile of the Appeal Update (UAPU) screen.

[MS 00302.009](#)



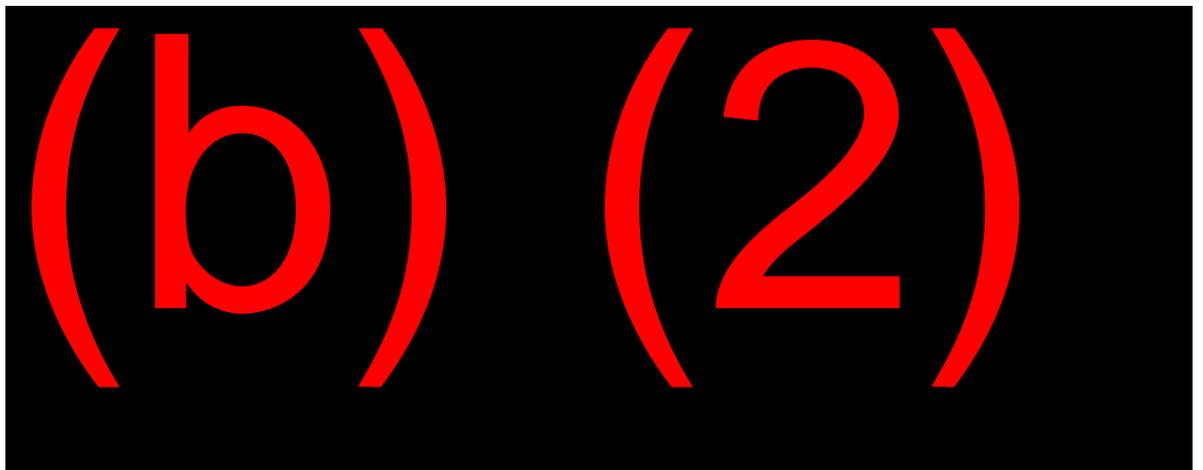
Below is a facsimile of the Appeal Disposition (UAPD) screen.

[MS 00302.010](#)

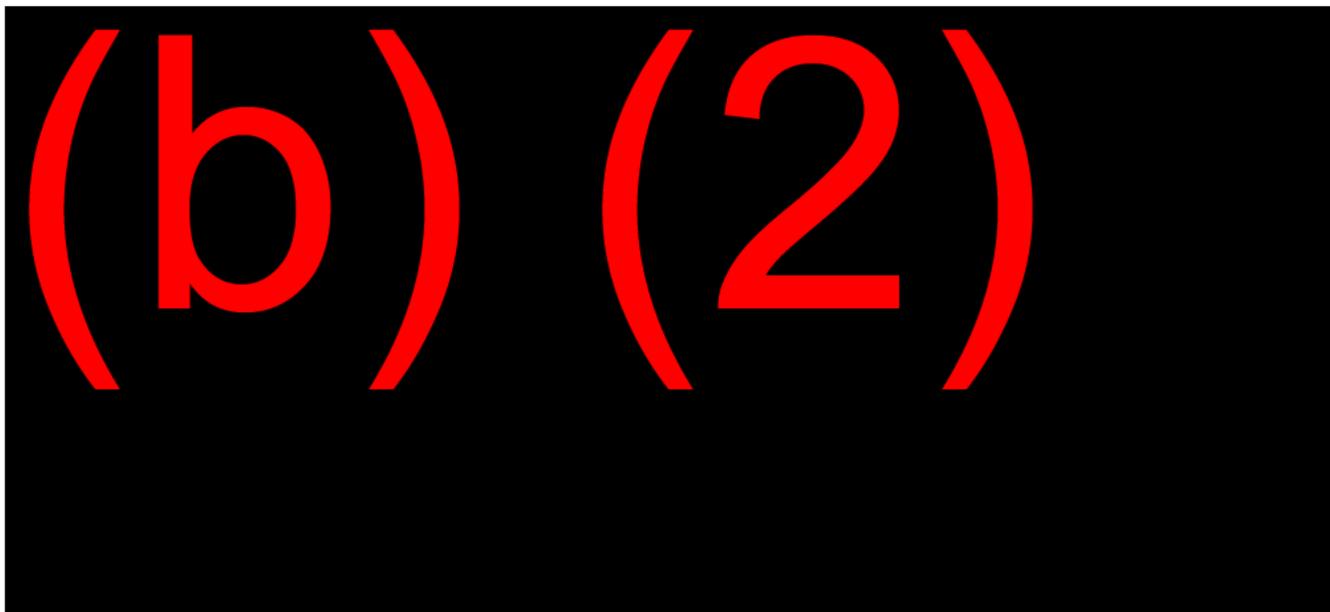


This exhibit indicates that the collected information is then transmitted to the appeal segment (APPE) of the SSR.

Below is a facsimile of the Appeals Data Comparison (CPAP) screen.



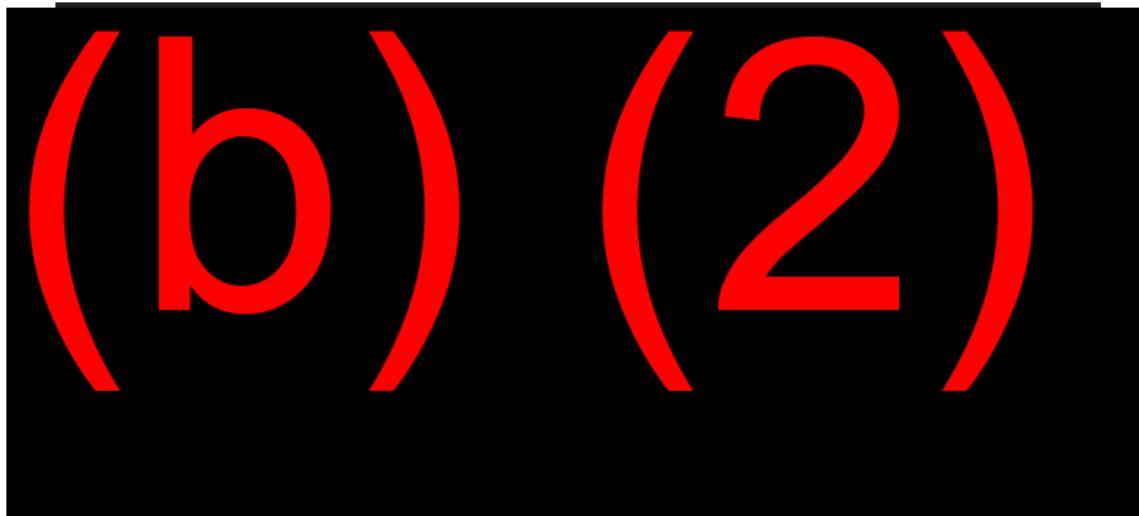
Below is a facsimile of the Simulated SSR (SSIM) screen.



The following exhibits show the required decision input and the screens that are propagated to post the final appeal decision to the SSR (in the APPE segment).

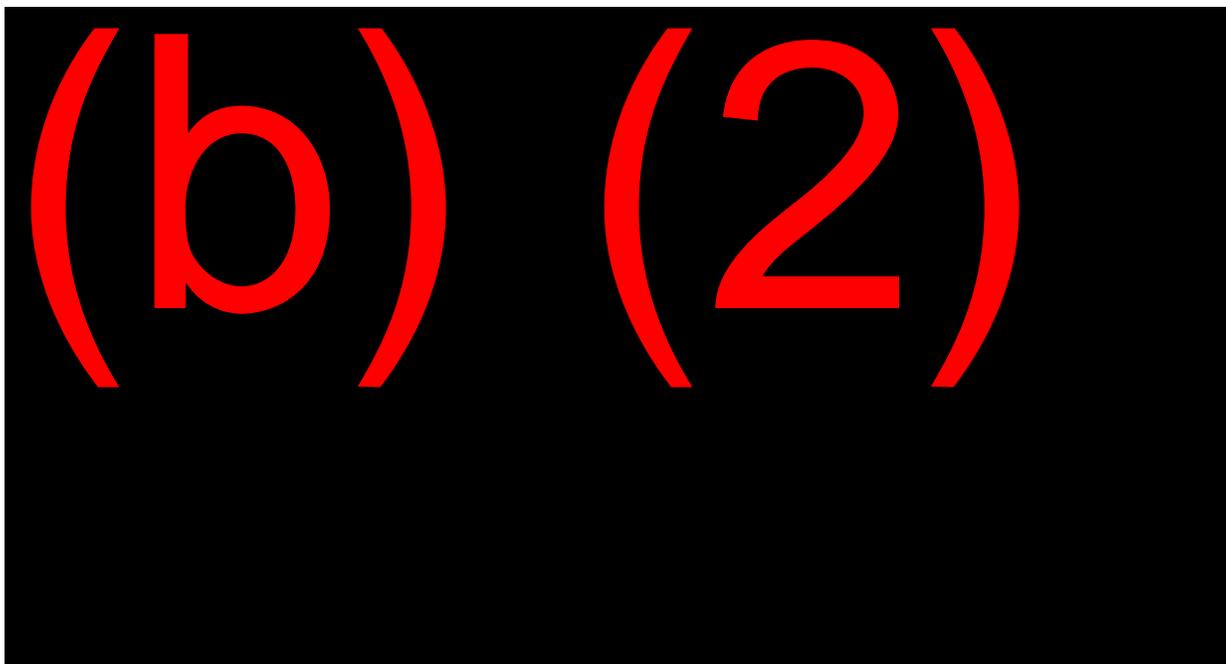
Below is a facsimile of the Appeal List (UPLS) screen.

[MS 00302.008](#)



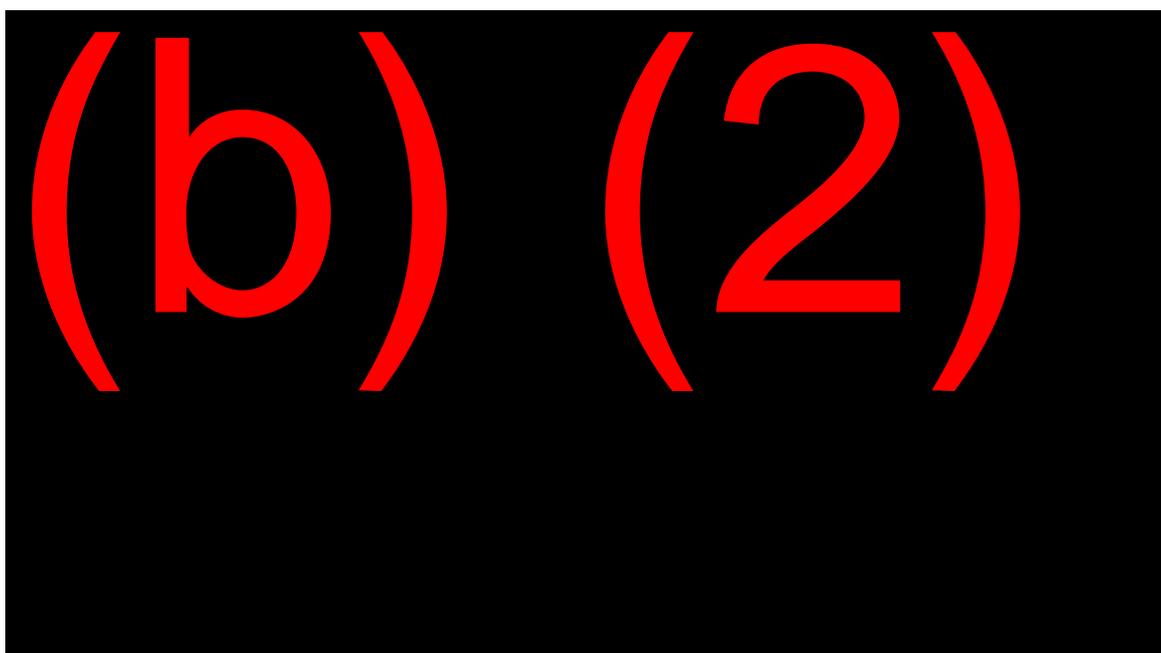
Below is a facsimile of the Appeal Update (UAPU) screen.

[MS 00302.009](#)



Below is a facsimile of the Appeal Disposition (UAPD) screen.

[MS 00302.010](#)



Below is a facsimile of the Appeal Other (UAPO) screen.

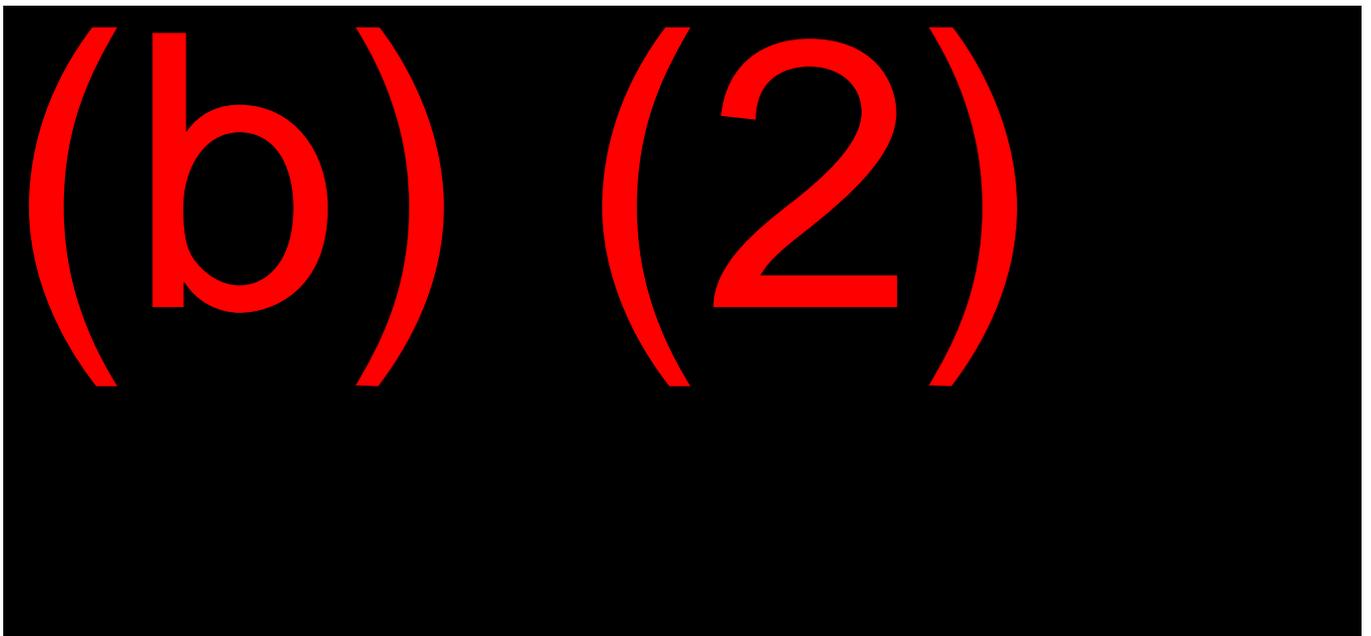
[MS 00302.011](#)



Below is a facsimile of the Appeals Data Comparison (CPAP) screen.



Below is a facsimile of the Simulated SSR (SSIM) screen.



OBJECTIVE 7:

Understand the elements of the iAppeals online process.

Process

[SI 04005.035](#); [SI 04005.040](#); [GN 03101.125](#); [GN 03101.127](#)

The iAppeals is an online process that allows the public to appeal medical and non-medical decisions via the internet. This software propagates information from the Modernized Claims System (MCS) and the Modernized Supplemental Security Income Claim System (MSSICS) for initial claims.

The internet user will complete the request for appeal, which will allow electronic submission of requests from individuals, and/or third parties for:

- i561 (Request for Reconsideration)
- i501 (Request for Hearing By Administrative Law Judge)
- i520 (Request for Review of Hearing Decision/Order)

IMPORTANT: The forms received from iAppeals meets the requirement that an appeal request be submitted in writing, and must be treated as a filed appeal request, whether the i3441 has been received or not.

For medical appeals, the internet user completes the Disability Report for Appeal (i3441) in the second part of the process.

The general public can access iAppeals at the following URL:

<https://secure.ssa.gov/iApplsRe/start>

To electronically file an appeal request, the iAppeal user must complete the i561 or i501, and i3441 (appeal forms) and submit all of the appeal forms, at one time, to us. The user may complete and submit the appeal forms in one session. The user may also start the appeal forms in one

session and then use his or her iAppeals reentry number to complete and submit the appeal forms in a later session(s).

Requirements to Use iAppeals

An iAppeal can be filed by a claimant, an authorized representative, or other third party.

iAppeals will not allow individuals who do not meet all of the following requirements to begin a request for appeal on a medical decision:

- Have previously applied for disability benefits; and
- Have received a “Notice of Disapproved Claim” or “Notice of Reconsideration” and have it with him/her when beginning the report; and
- Disagree with the initial or reconsideration disability decision; and
- Have had their disability claim processed in EDCS; and
- Is not barred from using the Social Security Administration’s (SSA) Internet Services due to blocked access or special indicator codes on the Numident.

iAppeals will not allow individuals who do not meet all of the following requirements to begin a request for appeal on a non-medical decision:

- The claimant received an initial determination notice or Notice of Reconsideration concerning the non-medical issue. The claimant disagrees with the initial or reconsideration determination.
- The claimant is not barred from using the Social Security Administration’s (SSA) Internet Services due to blocked access or special indicator codes on the Numident, Appeals and SSI Claim System

[SI 04005.035](#); [SI 04005.040](#)

When the appeal request is completed (submitted) via the Internet using iAppeals, the iAppeals system passes the SSI appeal request information to the system immediately and online for appeals on medical decisions.

SSI Claims System:

When an iAppeals user submits an appeal request, an appeal event automatically opens in the system with the event unit code of "NEWINT" on the Jurisdiction and Status Screen. The next day, the appeal event appears on the field office (FO) Supplemental Security Income Management Information List.

Within five business days, the employee can develop and process the appeal request in the system. The employee must access the appeal in update mode.

Most of the information normally input into the Banana program will be propagated from the i561 or i501, but the Claims Specialist (CS) must still complete remaining information, e.g., an explanation of why an appeal request was not filed timely and some other fields. If there are differences, the CS must resolve the discrepancies and verify the information in the system is correct.

IMPORTANT: Once the appeals path in the system is complete, the CS MUST print out the appeal request from the system and send a copy to the claimant with a receipt. This ensures the claimant is always notified that SSA has received the Internet appeal request from him/her.

Management has the ability to request a list of the online appeals.

Non-medical appeal requests submitted through iAppeals Non-Medical do not propagate to the system. Therefore, technicians must manually key information from these appeal requests into the system appeal screens and process the appeal requests and evidence, if any, per the instructions in [SI 04020.030](#) - request for reconsideration or [SI 04030.020](#) - request for hearing.

Technicians take the following actions to process non-medical appeal requests in the Non-Medical iAppeals Tracking System:

1. Technician views the appeal request in the non-medical appeal tracking system:
 - a. Access the Non-Medical iAppeals Tracking System on the IMAIN Menu.
 - b. Enter the case social security number on the Search for a Case Screen and select "Search." The Case Details Screen appears and allows the technician to complete the following actions:

- View the case information for the appeal request;
 - Document the system used to process the appeal request;
 - Mark the appeal request as complete; or
 - Transfer the appeal request to another office.
2. Technician processes the appeal request:
- a. Use the information on the Case Details Screen to complete the appeals path in the SSI Claims System and process the appeal request per the request for reconsideration instructions in [SI 04020.030](#) or request for hearing [SI 04030.020](#). If a claimant has attached documents, select the “View Attached Files”, and then “View,” “Print,” and “Process” the documents along with the appeal request.
 - b. Complete the Attached Files Screen. Indicate where the documents are stored and select “Save”. If needed, you may change the document name. If you do, remember to “Save.”
 - c. Complete the “Case Details” Screen. Indicate the system used to process the appeal request, “Save,” and then “Mark as Complete.”

EXHIBIT 1: FORMS NEEDED FOR APPEALS

Forms Needed for a Medical Reconsideration:

- SSA-561-U2
- A request for reconsideration can be expressed or implied, but it must be in writing. It is not required that the claimant complete the SSA-561-U2.
- SSA-827
- SSA-3441-BK
- 1696-U4 (if represented)

Non-Medical Reconsideration:

- Obtain signed SSA-561
- A request for reconsideration can be expressed or implied, but it must be in writing. It is not required that the claimant complete the SSA-561-U2.
- Evaluate submitted evidence
- Make determination
- Summarize facts on SSA-8450 (or on the appeals page)
- Systems input, and
- Issue manual notice

Forms Needed for a Request for Hearing:

- HA-501-U5
- A request for hearing can be expressed or implied, but it must be in writing. It is not required that the claimant complete the HA-501-U2.

- SSA-3441-BK (if issue is disability)
- SSA-827s
- HA-4608 (if the claimant does not wish to appear at the hearing.)
- SSA-1696-U4 (if represented)

Form Need for a Request for Appeals Council Review

- HA-520-U5.
- A request for a AC review can be expressed or implied, but it must be in writing. It is not required that the claimant complete the HA-520-U5.

OFF-AIR ACTIVITIES

OBJECTIVE 1: Understand and explain the appeals provision and determine the time limits for requesting an appeal.

- Trainees should complete Exercise #1.
- Discuss the appeals workflow in your office (e.g., who takes concurrent appeals, how mailed-in appeals are assigned, etc.).
- Trainees should discuss with mentor the use of the function “Denied Claim Reopening.” Review [MS 04404.003](#) for procedure and [DI 27501.005](#) for policy.

OBJECTIVE 2: Determine and perform the proper reconsideration development.

- Trainees should complete Exercise #2.
- Trainees should review mailed-in reconsideration requests (both medical and non-medical).
- Trainees should review [SI 04020.020](#) for reconsideration policy and procedure.

OBJECTIVE 3: Determine and perform the proper development for a hearing.

- Trainees should complete Exercise #3.
- Trainees should review mailed-in hearing requests (both medical and non-medical).
- Trainees should read and interpret the DDSQ field “SC2.” They should discuss screening unit cases and the routing of these cases with their mentor.
- Trainees should use Query Master to help read the DDSQ.

OBJECTIVE 4: Determine and perform the proper development for AC reviews and litigation.

- Trainees should complete Exercise #4.
- Trainees should review [GN 03104.370](#) and [DI 12045.027](#) for policy and process for subsequent claims.
- Trainees should discuss with mentor the process of taking a new claim from someone with a pending appeal.
- Trainees should review the case study on Exercise #5.

OBJECTIVE 5: Understand appeals on disability cessation cases.

- Trainees should review CDR and cessation cases. They should also find out local office procedures.

OBJECTIVE 6: Input appeals into the system.

- With mentor's assistance, trainees should load live reconsideration and hearing requests with the banana appeal program.

OBJECTIVE 7: Understand the elements of the iAppeals online process.

- Trainee should discuss office procedure on assignment of iAppeals with mentor or supervisor.
- Trainee should process an iAppeal with mentor assistance.

EXERCISES

Exercise #1

1. From the list below, identify the order of the stages of appeal.
 - Appeals Council Review
 - Reconsideration
 - Litigation
 - Hearing
2. Ms. Mary Hollis filed for SSI January 3. Her claim was subsequently denied. Her notice was mailed to her March 17. She contacted the FO on May 29 to question the decision on her claim. What action will you take?
3. What action would you take if Ms. Hollis were requesting a hearing or AC review?
4. Using the example above, on what date did Ms. Hollis' appeal period end (assume it is not leap year)? Explain.

Exercise #2

1. Ms. Hargrove's initial disability claim was denied on August 15 for medical reasons. She received her notice on August 23. (Assume these dates do not fall into a leap year) She disagrees with the decision and comes into the FO to see you. When will her appeal period end? What do you tell her?
2. What FO employee can act as the decision maker on a non-medical reconsideration?
3. After receiving disability benefits for 5 years, Mrs. Bullock's SSI benefits are ceased because of medical improvement. What would you advise her?

Exercise #3

1. Ms. Cora Harwood files a request for a hearing and indicates that she does not wish to attend the hearing. She believes the information already in file will prove her case and, therefore, believes it would be a waste of her time to add anything further. What action would you take?
2. You receive a letter from Mr. Stevens stating that he wishes to file for a hearing. His initial claim and reconsidered claim for disability were denied, and he says in his letter that his disability keeps him from working. Does Mr. Stevens need to complete an HA-501-U5?
3. What additional proofs, forms, etc., does Mr. Stevens need to submit?
4. Mrs. Olson's son comes into the FO on her behalf. Her reconsideration was denied despite the fact she has been unable to work due to severe heart problems for over a year. Her son brought in the signed hearing request forms for her as she is hospitalized due to a severe heart attack complicated by pneumonia. How would you route the hearing request?

Exercise #4

1. Mrs. Bass's hearing was denied. What recourse does she have if she continues to disagree? What form is used to formally file her appeal?
2. The person at your desk wants to serve summons on you. Mrs. Bass was denied at the AC level and now wants to take you to court. What do you do?
3. What is the purpose of the EAP and when is it used?

Exercise #5**CASE STUDY**

Marie Burns comes into the district office for an explanation of a denial notice she has just received. You locate her record and review the information with her.

Her record states she alleged the following resources:

- The home she resides in.
- Her automobile that she uses monthly for trips to the doctor.
- A savings account valued at \$1,000 that she never makes deposits into or withdrawals from (interest is paid to her when it accrues).
- An empty lot in another city that she inherited from her mother; she believes the lot is worth \$500 since that is what her mother paid for it when she bought it 10 years ago.
- A burial fund worth \$1,500 with the local funeral director.
- A checking account with an average balance on the first of the month of \$400.

The evidence in file consists of a:

- Savings account statement, balance \$1,000,
- Checking account statement, balance \$400,
- Burial contract with the funeral home, and
- Real Estate Tax bill for the empty lot showing the taxed assessed evaluation is \$500. The tax value is 1/3 the actual value.

No evidence showing the value of her automobile or her home was required and none was submitted.

The following is a summary of Ms. Burns' resources:

RESOURCE DETERMINATION

<u>EXCLUDED RESOURCES</u>	<u>COUNTABLE RESOURCES</u>	<u>(CMV) \$</u>
HOME	SAVINGS	\$1,000
AUTOMOBILE	CHECKING	\$ 400
<u>BURIAL FUND</u>	<u>EMPTY LOT</u>	<u>\$1,500</u>
TOTAL COUNTABLE RESOURCES:		\$2,900

=====
 It was determined that Ms. Burns had countable resources that were over the limit for SSI and conditional payments did not apply. Ms. Burns was notified of the determination.

You explain her appeal rights to her, including the different methods of reconsideration. She requests a case review. You complete an SSA-561-U2 and an SSA-795 in which she states that she believes SSA is wrong about the value of the lot and she will submit a current appraisal to us.

You show the appeal on the SSR by completing the Appeals path in the system and pending 10 days for the additional evidence.

Nine days later, the appraisal has come in.

It shows the lot is worth \$1,000.

You compare the new evidence to the evidence in file and determine the countable resources are less than previously determined, but are still over the resource limit.

You complete SSA-8450 where you explain all the facts of the disputed issue. You show her countable resources to be:

Savings	\$1,000
Checking	\$ 400
Lot	\$1,000
Total =	\$2,400

You prepare the notice on SSA-8455-U2 and input the appeals disposition in the system, updating the SSR. Ten days later, Ms. Burns calls the toll free (800) telephone number and tells the teleservice representative that she does not agree with SSA's determination of the value of her lot.

She specifically does not believe the lot's appreciation in value should be held against her and she doubts if she could actually sell the lot for \$1,000.

The hearing process is explained to Ms. Burns. In addition, a Form HA-501-U5 was mailed with instructions on completing it and tells her to forward it to the local SSA office for processing when it is completed and signed. The TSR then sends the FO a message about the inquiry and the actions she took.

Eight days later, the HA-501-U5 and the file is prepared and forwarded to OHO. The appeal was input to the SSR.

In 3 months, Ms. Burns returns to the FO. She has just received an unfavorable decision, reaffirming the denial of her claim.

Ms. Burns insisted on appealing the ALJ decision and Form HA-520-U5 was completed and signed by her. The FO sent the form to the AC in Falls Church, Virginia and input the appeal to the SSR.

Eventually, Ms. Burns receives a decision from the AC. Once again, the decision is upheld. She comes to the FO to ask what her next step in the appeal procedure should be.

You explain to her that she has exhausted all appeals in the administration and that, if she wishes to appeal further, she must file a civil action in the U.S. District Court within 60 days from the date she received the AC decision. Input the decision information to the system and send the date to the SSR.

EXERCISE ANSWERS

Exercise #1

1. (1) Reconsideration
(2) Hearing
(3) Appeals Council Review
(4) Litigation
2. Ms. Hollis is outside her appeal period. First, you will attempt to establish good cause for late filing. If good cause cannot be established, then review the file to see if the determination can be reopened under Administrative Finality rules. If she does not meet good cause for late filing and reopening is barred, Ms. Hollis can still file a new application.
3. If Ms. Hollis were requesting a hearing or AC review, the FO would secure her statement about good cause for late filing, but prior to sending her request to OHO or AC, would review the file for reopening. If rules of administrative finality applied, the FO would immediately initiate reopening and revising the determination.
4. Convert March 17 to Julian date (076); add 5 mailing (081); add 60 days (141); convert 141 back to the calendar date. Her appeal ended on May 21 (for any year except a leap year).

Exercise #2

1. Her appeal period ends 60 days from the date she received her notice on August 23. The ending date of her appeal period is October 22.

First, explain the decision to her. Once the claimant fully understands the rationale behind the decision, she may be satisfied and not appeal the decision. If she still disagrees, ask her to complete an SSA-561-U2 and an SSA-3441-BK (Disability Report – Appeal).

2. A CS or higher-level employee who had no involvement in making the original determination.
3. Ms. Bullock should be advised of continued benefits during an appeal and her right to request them. She should also be informed of the appeal process including her right to appear in person before the individual charged with making the determination on her claim.

Exercise #3

1. Explain the hearing process to her and that it is an independent review performed by an ALJ. It would be to her advantage to appear at the hearing to present additional information, clarify information in the file, or to answer questions the ALJ may have. If the issue is her disability, you should explain that it might be helpful for the ALJ to observe her in person.

If, after your explanation, she still does not wish to appear in person at the hearing, have her complete and sign Form SSA-4608 (Request for Waiver of an Oral Hearing).

2. No, his letter is treated as an informal request for a hearing. Complete an HA-501 based on information in the correspondence. He does not need to sign it. Attach his letter to the HA-501-U5.
3. He can submit any additional evidence he wishes. Since it is a disability case, complete an SSA-3441-BK over the phone to update the information in file. Again, he does not need to sign the form. Send him a new SSA-827 to sign. If this is a deferred development case, continue to defer development until the ALJ decision unless he appears to be ineligible in all months. If he appears ineligible, continue to develop the factor(s) of ineligibility, but do not delay sending the file with an RC to OHO explaining the outstanding development on the case.

When all development is complete, send it to OHO with an RC summarizing the evidence.

4. Since there has been significant worsening of her condition, the informal remand procedure must be used. Request medical evidence of her current medical condition and route her case to DDS first for another medical review.

Exercise #4

1. She can file an AC Review. HA-520-U5
2. Refuse to accept the summons. Explain that the Commissioner is the only proper defendant in any court action of this type. Also, explain that the summons must be served to someone authorized to accept it and you are not an authorized person. (See [SI 04050.010](#).)
3. The EAP process allows a claimant to move faster through the appeals process. The claimant does not have to exhaust all levels of appeal, but can move the case into the district court after only one appeal. The EAP is used when the only issue is the claimant's belief that the law was unconstitutional as applied to him or her.

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LESSON PLAN

Module Objectives

At the end of this module, using appropriate references, the trainees will be able to:

1. Identify when a determination or decision becomes final.
2. Determine if a determination can be reopened and revised; and, if so, under which rule and for what reason.
3. Determine how administrative finality rules affect the redetermination process.
4. Determine how administrative finality affects the reopening of events that caused overpayments/underpayments.
5. Identify when and what types of notices are required for administrative finality purposes.

Length of Module

2 hours

Forms:

SSA – L8100 (C1) or (U2) Notice of Revised Determination

SSA – L8155 (C1) or (U2) SSI Notice of Planned Action

SSA – L8156 (C1) or (U2) Notice of Planned Action – Medical

Helpful Resources:

[Title XVI Resource Kit](#)

SSI Desk Aid (under “Program Information”)

Click on “Administrative Finality”

BACKGROUND AND RATIONALE

Our Responsibility

Once it is rendered, a determination becomes final unless a timely appeal is filed. After the time limit for an appeal has expired, a determination may be reopened and revised under certain conditions. The discretionary rules that SSA uses to reopen and revise final determinations are known as the rules of administrative finality. This segment covers the circumstances under which determinations can be reopened and revised, the time limits, and the notices that must be sent.

Claims Specialists are responsible for:

- Assuring that the policy is applied properly; and
- Explaining the policy to recipients.

OBJECTIVE 1:

Identify when a determination or decision becomes final.

Determinations**[SI 04070.001](#)****General**

When SSA has determined that an individual is eligible for SSI payments, the individual should be able to rely on that determination. SSA should be able to make determinations on current information and not have to establish findings of fact after the lapse of a considerable time from the date of the events involved. The regulations, therefore, prescribe time limits for the reopening of determinations and decisions.

An initial, reconsidered, or revised determination, or a decision or revised decision of an ALJ or the AC becomes final and binding on the parties to it after the expiration of the time limit provided for the appropriate appeal:

- If the recipient has not filed a timely request for such appellate review; and
- Unless special circumstances exist that permit its reopening and revision.

Title XVI Administrative Finality Definitions

[SI 04070.005](#); [SI 04010.010](#)

Definitions

Administrative Finality

Administrative finality is the concept that determinations of eligibility to receive payments and payment amounts become final and binding on both parties immediately, unless they are appealed on time or later reopened and revised for special reasons. It protects both parties from having to readjudicate claims ad infinitum.

Determination

A determination is an adjudication of eligibility and/or payment amount by a decision maker below the level of administrative law judge (ALJ). With respect to nonmedical elements of eligibility, this occurs in the field office (FO).

Initial Determination

An “initial determination” is the first determination on an application, post-eligibility (PE) event or periodic redetermination of eligibility.

EXAMPLE:

Mrs. Weaver reported she permanently moved from the home she owned into her daughter’s home. While there, she does not pay anything on the household or food expenses. She does not expect to sell her home.

The reviewer made the following initial determination:

- Mrs. Weaver has in-kind income. (The amount will be determined under unearned income rules.)
- Mrs. Weaver’s house is a countable resource. (The value will be determined under resource rules.)

Deemed Initial Determination

An initial determination is deemed to occur (i.e., no notice is sent) on the first day of each month that a recipient is shown on the record as eligible and the payment amount remains unchanged. If there is no payment in any given month, there is no deemed initial determination for that month or for following months in which no payments are made. Deemed initial determinations always follow actual initial determinations of eligibility or payment amount, beginning in the month following an actual initial determination as long as there is no break in eligibility or change in payment amount.

Decision

A decision is an adjudication of a claimant's appeal of a determination by an Administrative Law Judge (ALJ) or the Appeals Council (AC).

Revised Decision

A revised decision is one in which either the end result or a finding with respect to a factor of eligibility involved in a prior decision has been changed.

Affirmative Action in Writing

Affirmative Action In Writing is the establishment of a record in writing by SSA or a claimant that questions the correctness of a determination or decision.

Reopening

Reopening is the process of investigating and reexamining a claim that may result in revision of a prior determination or decision after the most recent determination or decision has become final. Reopening implies the possibility of error, even if none is later found.

Time Limits

Extension Period

The 60-day period is extended for:

- Five mail days (and if the period ends on a non-work day, it extends to the next workday).
- Good cause for filing an appeal after the end of the appeal period. (This is covered in a separate module.)

OBJECTIVE 2:

Determine if a determination can be reopened and revised and, if so, under which rule and for what reason.

Reopenings

[SI 04070.010](#); [SI 04070.015](#)

Administrative finality or reopening applies ONLY when final determinations or decisions are being changed. If the action being changed is not a final determination or decision, administrative finality rules, including the time frames, do not apply.

Dates to Consider

SSA can reopen and revise a determination under the rules of Administrative Finality:

- Within one year of the date of notice of an initial determination for any reason.
- After one year, but within two years, upon a finding of “good cause”.
- At any time if the determination or decision was procured by fraud or “similar fault”. ([SI 04070.005](#); [SI 04070.020](#))

How to Measure Time Limits

Time limits are measured from the date of the initial determination, regardless of the level of the determination or decision being reopened and are not extended by subsequent steps of the appeals process. In other words, the administrative finality time limits are based on the date of the notice of initial determination rather than on the date of the appellate determination or decision to be reopened. There is no additional five days

for mail time for re-openings; but, when the period for re-openings falls on a non-work day, the period is extended to the next full work day.

Deemed Determinations

[SI 04070.030](#)

Deemed initial determinations are based on the assumption that the recipient's circumstances remain the same as in the prior month. An initial determination is deemed to occur (i.e., no notice is sent) on the first of each month that a recipient is shown on the record as eligible and payment amount remains unchanged. A deemed determination cannot occur in any month that is an effective month of a notice of an initial determination. Deemed initial determinations are important in that they allow the Agency to effect change for past months that are not governed by written notices of initial determinations

NOTE: The concepts of deemed initial determinations and effective months of notices of initial determinations apply only for purposes of administrative finality with respect to nondisability issues. They do not apply to disability determinations.

Level of Decision

Jurisdiction Rule

A determination can be reopened at the same or higher level as the prior determination.

EXAMPLE:

If a reconsideration, determination was made by the FO that determination can be reopened by:

- An FO,
- An Administrative Law Judge (ALJ) (hearing),

- Appeals Council (AC),
- Federal Court.

The FO cannot reopen and revise determinations made by DDS, ALJ, or AC.

- This is still true when the circumstances have materially changed since the ALJ or AC decision.
- For a period that is included in the ALJ decision, the FO would forward any new information or evidence to the ALJ or AC per instructions in [SI 04030.050](#).

Who May Request Reopening

A person who is a party to a determination or decision, or the eligible spouse of any person who is claiming or receiving SSI payments, the representative payee or legal guardian of the person, the ineligible spouse, or a person who is eligible for an SSI underpayment may request that it be reopened and revised.

SSA Policy

SSA is not legally required to reopen a determination or decision when it is requested. It is the policy of SSA to consider the requests in ALL cases. When a request is received, we determine if reopening applies. If it applies and the evidence shows that the prior determination was incorrect, it is SSA's policy to make the correction in all cases.

A refusal to reopen and revise is not an initial determination and there is no right to appeal.

Affirmative Action in Writing

[SI 04070.015](#)

Affirmative action in writing is a writing that questions the correctness of a prior determination or decision. Affirmative action in writing will take the process beyond a threshold review and initiate a reopening.

Requirements for Affirmative Action in Writing

- It must be by an SSA employee or as the result of an SSA business process; e.g., a computer matching run that results in an alert.
- It must be in writing. It can be a Report of Contact or on the Development Worksheet annotation, an alert (e.g., resulting from an interface alert, etc.), a statement from a party to the determination or decision (SSA-795), a redetermination form with a specific question annotating the possibility of error in some manner, or a Quality Assurance (QA) report. It must identify an error or possibility of an error in a specific case.
- It requires a conscious and deliberate questioning of the correctness of a prior determination or decision in a specific case either by a person or as a result of a computer alert. It does not apply to a class of cases, or the date that a redetermination (RZ) is initiated.

Diligent Pursuit

SI 04070.040

Diligent pursuit exists if, in light of all the facts and circumstances of a case, necessary action was undertaken and carried out as promptly as circumstances permitted.

A determination may be revised after the 1- or 2-year time limit, but only if the investigation was initiated before the time limit to reopen has passed.

If the investigation is diligently pursued, the determination may be revised, regardless of whether the revision is favorable or unfavorable to the recipient as long as all of the other administrative finality requirements have been met.

If the investigation is not diligently pursued:

- The determination must not be revised if it is unfavorable to the individual.
- The determination may be revised if it is favorable to the individual.

Diligent pursuit may be presumed if the investigation is completed and the determination is revised within the 6-month time period after the date the investigation began.

Diligent pursuit may not be presumed if the investigation is not completed within six months after the affirmative action in writing date. In that instance, the entire time period of the investigation must be analyzed and periods of inaction must be evaluated to determine whether they constitute a reasonable or an unreasonable delay. Heavy workloads that do not result from an emergency are NOT a reasonable delay. Examples of unreasonable delay include workloads as a result of understaffing, heavy leave use by FO staff, legislative changes, lack of planning, etc.

Reasonable Delay

Reasonable delay occurs when a determination is revised more than six months after the investigation began (i.e., the date of affirmative action in writing) and the delay was caused by factors beyond SSA's control.

Examples of reasonable delay include:

- Failure by recipient or his/her representative to cooperate
- Failure by a third party to cooperate
- Heavy workloads due to an unforeseeable emergency that results in an office closing for all or part of what would otherwise be a Federal workday; e.g., natural disaster, weather conditions, etc.

Unreasonable Delay

Unreasonable delay occurs when a decision cannot be revised within six months after the investigation began (i.e., the date of affirmative action in writing) and there is a period of inaction that is unexplained or within SSA's control. Examples of unreasonable delay include:

- Loss of folder by the FO
- Long periods of inaction with no effort to contact or follow up with the recipient, an employer, a bank, or other source of information

To determine if there has been diligent pursuit, we begin with the date the investigation began. This is the date of affirmative action in writing.

Documentation

Whenever the revision does not occur within six months, the delay must be documented in writing regardless of whether it is found to be reasonable or not. The documentation must include an explanation of why the delay was or was not reasonable. If for some reason the cause of the delay is not documented, it is presumed to be unreasonable.

A Revised Determination

[SI 04070.005](#)

Changing the Decision

A revised determination occurs when:

- The end result is changed; or
- A finding with respect to a factor of eligibility is changed even though the end result is not changed, e.g. an individual is N01 due to wages, but during the RZ, s/he reported unemployment, too. The end result of N01 is not changed, but the factor of eligibility has changed.

2-Year Rule

[SI 04070.010](#)

Good Cause

A determination or decision can be reopened and revised for up to two years from the date of the notice of the initial determination or decision upon a finding of “good cause.” A specific finding of good cause must be expressly found if the 1-year rule does not apply. Good cause exists when:

- New and material evidence is submitted and shows facts that can result in a conclusion different from that previously reached;
- There is a clerical error, i.e., mathematical, coding, or input error, that resulted in an incorrect decision; or
- There is an error on the face of the evidence that resulted in an incorrect decision.

Change of Position

SI 04070.040

A change of position occurs when legal precedent or policy is changed due to court decision or policy considerations.

Instructions will advise whether a new ruling or legal precedent constitutes a “change of position”, and if so, the date of the change. The transmittal or teletype will say, “The new instructions will apply to all applications filed and redeterminations initiated on or after (MMDDYY) the effective date of change.”

OBJECTIVE 3:

Determine how administrative finality rules affect the redetermination process.

Administrative Finality and the Redetermination Process**[SI 04070.060](#)****Formal Redeterminations**

A redetermination will be one of the following types:

Scheduled Redeterminations

SSA formally redetermines eligibility and payment amount on a periodic basis.

Unscheduled Redeterminations

SSA may formally redetermine eligibility and/or payment amount when:

- a recipient (or someone on his or her behalf) reports an event or a change or makes some other notification; or
- SSA on its own discovers a change.

ALL of the above redeterminations result in initial determinations or “deemed” initial determinations that may be reopened and revised under the rules of administrative finality.

Retrospective Monthly Accounting

Budget Month Considerations

The purpose of administrative finality rules is to determine a period when you can change a prior determination regarding a payment already received or a payment that should have been received.

First, determine the period that can be reopened using the above rules.

Then consider if income received in the budget month, which may be outside the period to be reopened, would affect payment in the reopened period. If yes, then use the income received in the budget month.

Period of Reopening

EXAMPLE:

Ms. Jones has been receiving SSI since her application date of January 15, 2015. In May 2017, you receive information from an IRS interface alert (run date April 10, 2017) concerning Ms. Jones. After contacting her about the alert, you verify that she started receiving a private pension in April 2015. The gross amount of the pension is \$130 monthly.

First Step

In the example above, consider if the issue of Ms. Jones' income is subject to reopening under administrative finality rules.

You determine that you have good cause due to new and material evidence and that reopening is proper under the 2-year rule.

Second Step

Next, determine the period to be reopened. SSA took affirmative action in writing with the IRS/SSI interface run on April 10, 2017. You will consider

reopening and revising your decision going back 24 full months from that date.

Note a deemed determination occurred on the first day of each month during this period.

For deemed initial determinations, go to 05/17 to start counting (this step will make it easier to count back full months). Now, count back 24 months. This will take you back to 05/15. The period we can reopen and revise is from 05/15 to the present.

Remember that you must diligently pursue resolving this issue until the decision is reached.

Third Step

Both payment and eligibility must be considered in the reopened period.

If the revised decision does not result in ineligibility in the first two months of the reopened period, then income in the respective budget months will be used to determine payment in those first two months, even though the budget months are outside the reopened period.

- Input pension income of \$130 per month beginning with 03/15.
- Fraud or similar fault must also be addressed in this case. If either fraud or similar fault were found, we would reopen the decision beyond two years.

OBJECTIVE 4:

Determine how administrative finality affects the reopening of events that cause overpayments/underpayments.

Reopening Overpayment/Underpayment Events**[SI 04070.070](#)****Event Detected**

When the late discovery of an event causes an overpayment or underpayment and:

- The event causing the overpayment occurred within the 1- or 2-year administrative finality period, then all actual or deemed determinations that are affected by the event can be reopened and revised as applicable. A revised determination and an overpayment determination can be made for all months affected by the event.
- The event causing the overpayment occurred before the 1- or 2-year administrative finality period, then some or all of the affected actual or deemed determinations may be barred to correction. All determinations occurring before the administrative finality period cannot be reopened or revised unless there is fraud or similar fault. All affected determinations occurring within the administrative finality period may be reopened and revised. A revised determination and an overpayment determination can be made only for those determinations that can be reopened and revised.

Period to be Reopened

If SSA subsequently discovers that the overpayment/underpayment determination is incorrect, it may be reopened and revised for up to two years after the date of the notice of the initial determination, regardless of the months affected.

If the initial overpayment/underpayment determination was made over one or two years from the date of the discovery of the error, the initial determination cannot be reopened and revised.

OBJECTIVE 5:

Identify when and what types of notices are required for administrative finality purposes.

Notice Requirements**[SI 04070.050](#)****Notice of Revision**

A notice of a revised determination must be given to the claimant and the notice must include:

- The basis for action or planned action.
- Appeal rights (this includes the right to appeal the entire determination, not just that which is being revised).
- Notification must be given whether it is favorable or not.
- The revision is final unless an appeal is filed within 60 days after receipt of the notice.

Appeal Considerations

The appropriate appeal of the revised decision depends on whether advance notice is required and whether a medical issue is involved.

If advance notice is not required, the appropriate appeal is an ALJ hearing, regardless of whether a medical issue is involved.

Notice Forms

The system will send the recipient a SSA-L8100-C1, Notice of Revised Determination.

NOTE: The suffix C1 means systems-generated notice.

The FO can suppress the automatic release of the C1 and a U2 (Manual Notice).

If advanced notice is required and a medical issue is involved, the appropriate appeal is a disability hearing reconsideration.

If advance notice is required and the issue is nonmedical, the appropriate appeal is the claimant's choice of the three types of reconsideration:

- Case review;
- Informal conference;
- Formal conference.

Notice Forms

If advance notice is not required:

- The system will send a SSA- L8100 C1,
- The FO can suppress this notice.

If advance notice is required, but there is no medical issue:

- The recipient will be sent a SSA-L8155-C1, SSI Notice of Planned Action.

If advance notice is required, and a medical issue is involved:

- The DDS will send a SSA-L1411, Notice of Planned Action—
Medical.

Disclaimer Sentence

Per [SI 04070.050](#), this sentence is required in all notices of revised decisions:

“This determination replaces all previous determinations for the above period(s).”

EXHIBIT 1: REOPENING UNDER RULES OF ADMINISTRATIVE FINALITY

STEP 1:

Determine the period affected by the new evidence.

STEP 2:

Decide if rules of administrative finality apply (can be reopened).

STEP 3:

Determine who can reopen the prior determination. The prior determination will be reopened at the adjudicative level at which the prior decision was made.

STEP 4:

If current eligibility is apparent:

- Obtain a new application if case is in suspense more than 12 months.
- Fully develop the event that caused the period of ineligibility if the suspense is more than 31 days.

STEP 5:

Notify the claimant of any revised determination/decision if:

- Eligibility or payment amounts are affected,
- The claimant questions the determination/decision, or
- It can be reasonably assumed that the claimant knows that new evidence has been submitted.

OFF-AIR ACTIVITIES

OBJECTIVE 1: Identify when a determination or decision becomes final.

- Trainees should complete Exercise #1.
- Trainees should explain the extensions for the 60-day period for appeals.
- Trainees need to understand the importance of evaluating all types of benefit eligibility in the SSI application and the open application.

OBJECTIVE 2: Determine if a determination can be reopened and revised; and, if so, under which rule and for what reason.

- Trainees should complete Exercise #2.
- Trainees should review [SI 04070.040](#). Trainees should pay particular attention to the sections on Diligent Pursuit.
- Trainees should review all available SSIDs with K6, K7, or 5B diaries paying close attention to the TRAN segment and dates for affirmative action in writings.

OBJECTIVE 3: Determine how administrative finality rules affect the redetermination process.

- Trainees should complete Exercise #3.

OBJECT 4: Determine how administrative finality affects the reopening of events that caused overpayment/underpayments.

- Trainees should complete Exercise #4.

- Trainees should observe redetermination interviews to understand how administrative finality impacts overpayments/underpayments when there is a prior period of change in income, resources, or living arrangements.

OBJECTIVE 5: Identify when and what types of notices are required for administrative finality purposes.

- Trainees should complete Exercise #5.
- Trainees should review and become familiar with the SSA-L8155, Notice of Planned Action.

EXERCISES

Exercise #1

Read the following questions and answer in the space provided.

1. Mr. Smith filed an application for SSI benefits on June 20. He received notification of the initial determination dated July 25. He filed for reconsideration on July 31. The date of notice of the reconsideration determination was August 5. No further appeals action was taken by Mr. Smith. When does the reconsideration decision become final?

2. Mr. Harris, born November 21, 1946, filed an application for SSI disability benefits on December 30, 2010. His claim was denied for medical reasons on February 15, 2011. The decision is not appealed. On May 6, 2011, he returns to the FO wanting to file for Social Security retirement benefits. What would you do?

3. Indicate which of the following statements are true:
 - The timing and frequency of payment is an initial determination.
 - Initial determinations are made only at the time (1) of initial adjudication; (2) an appeal is effectuated; or (3) a reconsideration is completed.
 - Any decision regarding the issue of income except income estimates for a future period are initial determinations.

Exercise #2

1. The date of initial determination was January 20. On August 5, the initial determination of January 20, was reopened and revised. The time limit for reopening the initial determination was based on January 20, not August 5. Which date would be the basis for a subsequent reopening of the revised determination?

2. Mrs. Britt filed an application for SSI on January 2, 2010. Her application was denied because of excess resources and the denial notice was dated February 1, 2010. On February 10, 2010, she filed a request for reconsideration. The FO affirmed the denial and issued a reconsideration determination dated February 20, 2010. On February 22, 2010, she requested a hearing. The ALJ issued a hearing decision dated December 15, 2010, affirming the denial.

The claimant filed a new application on January 3, 2011, that was denied again for excess resources. The notice was sent on January 14, 2011. A reconsideration request was filed on February 15, 2011 and a notice affirming the determination was mailed March 1, 2011. She requested a hearing on April 1, 2011 and the ALJ issued a hearing decision on January 5, 2012.

The decision reversed the denial and reopened and revised the hearing decision of December 15, 2010. During the second hearing, new and material evidence pertaining to the first application came to the attention of the ALJ. **NOTE:** This evidence was not available at any time prior to the second hearing. This evidence was the basis for establishing “good cause” for reopening and revising the prior hearing decision.

Was this action proper under administrative finality? Explain.

3. Mrs. Johnson was awarded SSI on January 26. In July, the FO received information from Mrs. Johnson that she had a previously unreported bank account. The balance in this account put Mrs. Johnson over the resource limit as of February 1. Can the initial determination be reopened and revised? Explain.

4. Mrs. Simpson filed for SSI on February 1, 2010, and advised the interviewer that she received \$150 unearned income per month. In typing the data into the SSI Claim System, the numbers were transposed to \$105.

Mrs. Simpson’s payment was calculated on the basis of incorrect income data and a notice of the initial decision was sent accordingly on February 23, 2010.

The “clerical error” was discovered in January 2011, during the course of processing a post-eligibility change reported by Mrs. Simpson.

Can any action be taken?

5. Mr. Adams' claim for SSI was allowed January 1, 2010. He submitted evidence verifying that he had half ownership interest in the home where his brother lived. This evidence was secured by the FO but was overlooked when the initial determination was made. Mr. Adams was found to be living in the household of another and subject to the 1/3 reduction. At the next redetermination, in March 2011, the evidence of ownership was reviewed. The evidence, on its face, indicated that the initial determination about the 1/3 reduction was incorrect. The revised initial determination would be that the 1/3 reduction did not apply. What is the basis for reopening?

Exercise #3

1. During a scheduled redetermination initiated in the FO on April 2, 2011, you recorded that Paul Grayson had received excess unearned income each month since May 1, 2009. The FO reopened all monthly "deemed" initial determinations back to May 1, 2009 and revised such determinations as appropriate. Explain the basis for this action.
2. On July 9, 2013, the FO discovers a clerical error on a record. The error was made in January 2008 when the FO input \$80 in "H" income through the In-Kind Support and Maintenance page. To what date could the case be reopened?
3. Mrs. Williams filed for SSI on January 3, 2012, and was determined to be eligible based on an initial determination dated January 10, 2012. On October 31, 2012, the claimant reports that she expects to receive an additional sum of money that would be countable income beginning November 1, 2012, and continuing for an indefinite period.

The FO concludes that an initial determination is needed for January 2013 based on the income change in November 2012. Mrs. Williams is issued a Notice of Planned Action and her January 2013 payment is adjusted.

On November 6, 2012, Mrs. Williams reported that her income would be reduced beginning December 1, 2012.

The FO confirmed that the income will not be received starting with December 2012. What action can be taken? What is the earliest eligibility month that can be reopened and revised?

Exercise #4

1. On March 1, an initial determination is rendered that establishes that the applicant is eligible for \$214 per month beginning February 1 (date of application). On July 1, the claimant presents evidence that establishes that he was actually eligible for \$290 per month beginning February 1. What notice should be sent? What level of appeal is offered?
2. On March 1, an initial determination is rendered that establishes that the claimant is eligible for \$710 per month beginning February 1. On July 1, the claimant presents evidence that establishes that he was living in the household of another and receiving support and maintenance beginning February 1 and, therefore, was only eligible for \$473.34 per month. What notice is sent and what level of appeal is offered?
3. On March 1, an initial determination is rendered that establishes that the claimant is disabled and eligible for payment. On August 1 of the following year, at a medical review, it is determined that the recipient has fully recovered from his disability and, therefore, is not eligible for SSI benefits. What is the appropriate notice and level of appeal?

EXERCISE ANSWERS

Exercise #1

1. The determination is final on August 5 unless a timely appeal is filed (60 days from the date of the reconsideration notice, plus 5 days mailing time).
2. The SSI application of December 30, 2010 was an application for all benefits. No determination has been made on his entitlement to Social Security retirement benefits. Action needs to be taken to allow or disallow that class of benefits. If he can establish proof of age, the effective date of the Title II application is December 30, 2010. He is eligible December 30, 2010 on.
3.
 - a. False. This is a question of law and policy and not of eligibility or payment for a specific individual.
 - b. False. An initial determination is made any time you make the first adjudication as an issue of the individual's eligibility or payment amount.
 - c. True. The amount of income, what constitutes income, the exclusions from income all deal with eligibility and/or payment and are initial determinations.

Exercise #2

1. The time limit for reopening the revised determination would also be based on the January 20 initial determination date and not the reopening date.
2. Although the prior determination appeared correct based on the evidence available at the time of original adjudication and subsequent actions, it could still be reopened under the 2-year rule. The material facts were:
 - The second application was dated January 3, 2011, less than 2 years from the date of the initial decision on the first application (February 1, 2010), thereby establishing affirmative action in writing within the required 2-year period.
 - "Good cause" for reopening existed due to new and material evidence being presented.

3. The determination of January 26 was correct when made and can be reopened and revised. The deemed determination for February 1 and after was incorrect and must be reopened and revised.
4. The error was discovered within 2 years of the initial decision and “good cause” for reopening due to clerical error existed. This claim can be reopened and revised back to February 1, 2010.
5. The 2-year period from the initial decision had not lapsed; “good cause” existed since there was an error on the face of the evidence.

Exercise #3

1. Because the FO made a record of the discovery, concerning the excess unearned income during the redetermination on April 2, 2011, “affirmative action in writing” was established on that date. This resulted in reopening and revision of 23 monthly “deemed initial determinations” for the 2-year period prior to April 2, 2011.
2. Since the error was made more than two years before it was discovered, it cannot be corrected if it was received before June 1, 2011. If “H” income was received during or after June 2011, corrections could be made for August 2011 and thereafter, as appropriate.
3. December 2012 is the budget month for February 2013. The FO will reopen and revise her SSI payment amount beginning with the eligibility month of February. The FO will use her December income to determine her February payment.

Exercise #4

1. An SSA-L8100-C1 should be sent reflecting the revised determination of \$290 per month beginning February 1 with opportunity to request a reconsideration on the revised determination.
2. An SSA-L8155-C1 (Notice of Planned Action) will be sent. Since the change involves a reduction of current benefits, the recipient will have the opportunity to request reconsideration of the revised determination ([SI 04070.050](#)).
3. An SSA-L1411 is sent reflecting the above revised determination. The appropriate appeal is a disability hearing medical continuing disability review reconsideration.

AS WE REDESIGN ENTRY-LEVEL TRAINING, WE ARE ELIMINATING THE NEED FOR PAPER COURSE MATERIALS. THE MATERIAL PREVIOUSLY TAUGHT FOR THIS MODULE HAS BEEN CONVERTED TO ONLINE CONTENT. ALL NECESSARY INFORMATION IS EMBEDDED WITHIN THE ONLINE OBJECTIVES. THEREFORE, THERE ARE NO CORRESPONDING PAPER MATERIALS. PLEASE VISIT THE (b) (2)(b) (2)(b) (2)(b) (2)(b) (2) TO FIND MORE INFORMATION CONCERNING THIS TOPIC.

