

**Part I Chapter 7 – Social Security
Disability Determinations,
Medical Disability Reviews,
Appeals Process, and
Overpayments**

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Chapter 7 – Social Security Disability Determinations, Medical Disability Reviews, Appeals Process, and Overpayments

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the application process for Supplemental Security Income (SSI) and the Title II disability benefits;
2. Describe Social Security’s definition of disability and identify the three core components of this definition;
3. Identify the steps the Disability Determination Services (DDS) follows when making disability determinations;
4. Describe how Social Security conducts ongoing medical reviews (called Continuing Disability Reviews or CDRs);
5. Describe the process beneficiaries may use to appeal initial disability determinations, CDRs, or other determinations when they disagree with Social Security’s decisions; and
6. Describe Social Security’s overpayment recovery process and how beneficiaries may request a waiver of overpayment.

List of Acronyms

- AC – Administrative Council
- LJ – Administrative Law Judge
- CDR – Continuing Disability Review
- CE - Consultative Examination
- CWICs – Community Work Incentives Coordinators
- DDS – Disability Determination Service

- EXR – Expedited Reinstatement
- FBR – Federal Benefit Rate
- IRWE – Impairment Related Work Expense
- MIE - Medical Improvement Expected
- MINE - Medical Improvement Not Expected
- MIP – Medical Improvement Possible
- MIRS – Medical Improvement Review Standard
- POMS – Program Operations Manual System

Introduction

This chapter will provide you with a basic understanding of the following key concepts:

- The application process for Supplemental Security Income (SSI) and the Title II disability benefits;
- How Social Security defines disability and the process the agency uses to determine if a claimant meets this definition;
- How Social Security conducts ongoing medical reviews (called medical Continuing Disability Reviews or medical CDRs) to ensure that disability beneficiaries continue to meet the disability standard after initial entitlement;
- The process beneficiaries may use to appeal initial disability determinations or CDRs when they disagree with Social Security’s decisions; and
- What happens when Social Security pays an individual more in benefits than is due, how the agency recovers those funds, and options beneficiaries have for dealing with overpayments.

For the most part, the processes we cover in this chapter apply in the same manner to both SSI benefits and the Title II disability benefits. However, there are a few notable exceptions to this rule that we will point out and explain. Our discussion of the processes in this chapter will be summary in nature as these processes fall outside of the main role Community Work Incentives Coordinators (CWICs) perform when working with beneficiaries. As a CWIC, you need to understand that you have a limited role in helping beneficiaries with initial applications, supporting beneficiaries during the medical CDR process, or helping

with appeals or overpayments. It is important that CWICs gain a basic understanding of these processes to better inform their primary duties, but Social Security does not expect CWICs to develop expertise in these areas or provide services in these areas beyond their work scope.

Applying for Social Security Disability Benefits

Before we discuss the disability determination process, let's provide a brief overview of how people go about applying for disability benefits. While CWICs work with individuals who are already receiving benefits, there can be times when a beneficiary is potentially eligible for a different Social Security benefit and you might need to provide information about the application process. Individuals may apply for the Title II disability benefits or SSI benefits in three ways:

1. **Apply online by going to the Social Security website** (<https://www.ssa.gov/applyfordisability/#a0=0>).
2. Apply at the nearest **Social Security field office**. You can find an office locator on the Social Security website (<https://secure.ssa.gov/ICON/main.jsp>). Individuals should call the local field office first to make an appointment rather than just stopping by. Due to the COVID pandemic, some field offices may not be able to accept in-person appointments.
3. Call Social Security's toll-free number, 1-800-772-1213, to make an appointment to file a disability claim at the local Social Security office or to set up an appointment for someone to take the disability claim over the telephone. The disability claims interview lasts about one hour. Individuals who are deaf or hard of hearing may call Social Security's toll-free TTY number, 1-800-325-0778, between 7 a.m. and 7 p.m. on business days.

Beneficiaries who choose to apply online can find a **checklist of information they will need to complete the online application** at Social Security's website (<https://www.ssa.gov/hlp/radr/10/ovw001-checklist.pdf>). An important part of the application process for adults is completing a form called the **Adult Disability Report** (<https://www.ssa.gov/forms/ssa-3368-bk.pdf>).

Individuals who apply in person or by phone need to be prepared to provide names, addresses, and phone numbers of the doctors, caseworkers, hospitals, and clinics that would have information about the disability. In addition, Social Security will ask for medical records from doctors, therapists, hospitals, clinics, and caseworkers and names of all medicines with dosage. The application process also requires claimants to provide a summary of work history and documentation of recent earnings such as a copy of the most recent W-2 form (Wage and Tax Statement).

Individuals who are applying for SSI need to provide some additional information such as proof of living arrangements with documentation of living expenses, proof of earned or unearned income, and proof of resources. This extra documentation is required because SSI is a mean-tested program with income and resource limits. There are also some special procedures for **children who apply for SSI** that you find on Social Security's website (<https://www.ssa.gov/benefits/disability/apply-child.html>).

Social Security offers helpful **Disability Starter Kits** (https://www.ssa.gov/disability/disability_starter_kits.htm) to help claimants get ready for a disability interview or online application. Kits are available for adults and for children under age 18.

The starter kits provide information about the specific documents and the information that Social Security will ask for. The kits also provide general information about the disability programs and Social Security's disability decision-making process that can help take some of the mystery out of applying for disability benefits.

Once an individual submits their application, Social Security will provide confirmation of receipt - either electronically or by mail. Social Security will contact the individual if they need more information or documentation. For more information about **how to apply for Social Security disability benefits** refer to Social Security's website (<https://www.ssa.gov/disability/disability.html>).

Overview of Social Security's Initial Disability Determination and Medical Review Processes

To be found eligible for disability benefits, claimants first need to meet certain non-medical requirements that we discussed in detail in Chapters 1 and 3. For example, in order to qualify for Social Security Disability Insurance (SSDI), individuals must have earned enough credits from working to be insured for disability. For SSI benefits, non-medical requirements include having income and resources under certain limits. Social Security field offices are responsible for verifying all non-medical eligibility requirements including age, employment, marital status, or Social Security coverage information. If the claimant meets all of the non-medical requirements, the field office then sends the case to a special state agency called the Disability Determination Service (DDS) for evaluation of disability. Social Security personnel do not make disability decisions – those are performed exclusively by DDS.

Understanding the Disability Determination Service Agencies

The State Disability Determination Services (commonly referred to as DDS) are fully funded by the federal government to perform disability evaluation. In some states, the DDS may go by another name such as the Disability Determination Bureau. These state agencies are responsible for developing medical evidence and determining whether the claimant is or is not disabled or blind under Social Security law.

When evaluating disability, the DDS usually tries to obtain evidence from the claimant's own medical sources first. If that evidence is unavailable or insufficient, the DDS may arrange for a consultative examination (CE) to obtain the additional information needed. The claimant's own medical source generally is the preferred source for the CE; however, the DDS may also obtain the CE from an independent source.

After completing its initial development, the DDS makes the disability determination using, at minimum, an adjudicative team that includes a medical and/or psychological consultant and a disability examiner. If the adjudicative team finds that it needs additional evidence, the consultant or examiner may re-contact a medical source(s) and request supplemental information.

After the DDS makes the disability determination, the case either returns to the Social Security field office for appropriate action or it is reviewed by quality review analysts at the state DDS office or at a federal Social Security branch. After quality review, cases are returned to the Social Security field office for final processing. If the DDS finds the claimant disabled, Social Security will complete any remaining non-disability development, compute the benefit amount, and begin paying benefits. If DDS finds the claimant not disabled, the field office notifies the claimant and retains the file in case the claimant decides to appeal the determination.

Ongoing Medical Reviews

Medical evaluation does not stop after Social Security initially determines a beneficiary to be disabled and eligible for disability benefits. Social Security is required by law to conduct periodic medical reviews of all disability beneficiaries to determine if they continue to meet the agency's disability standard. If Social Security determines that an individual no longer meets the disability standard, benefits will stop. These periodic medical reviews are called medical Continuing Disability Reviews (medical CDRs).

Social Security contracts with the DDS agencies to perform medical CDRs in addition to initial disability determinations. As with initial disability determinations, the local Social Security field office gathers the medical information and sends it to the DDS. For medical CDRs, the DDS uses a different standard from the one it uses to make initial determination. Once individuals are entitled to benefits, the DDS does not look for medical evidence to re-establish existing and documented impairments, because this was already completed when the beneficiary was first determined to be disabled. Instead, the DDS considers evidence to determine if the medical impairment(s) has improved. If there is sufficient medical improvement, Social Security terminates the person's benefits.

Understanding Your Role in Initial Disability Determinations and Medical Continuing Disability Reviews

Social Security has some important rules that CWICs who work for WIPA programs must follow when providing services to disability beneficiaries. These rules place certain limits on the kinds of services

CWICs are allowed to provide to ensure that CWICs spend the bulk of their time focused on work incentives counseling. As you review the information in this chapter, keep the following limits on your role in mind:

1. WIPA services are restricted to individuals who have already been found eligible for Social Security disability benefits. Since individuals who are not already on disability benefits are not eligible for WIPA services, CWICs would not typically be able to help with initial applications.
2. There will be instances when an individual who already receives a disability benefit from Social Security may potentially be eligible for another type of Social Security benefit. This possibility can have a significant effect on how paid work affects a person's benefits. CWICs should be alert to the possibility of establishing entitlement to other programs and should be aware of the events that could trigger eligibility. CWICs also need to provide information to beneficiaries about how to apply for additional Social Security benefits or other programs as appropriate. Your role in these cases is to provide information, but not to help with completing the application.
3. Social Security does not allow CWICs to assist beneficiaries during medical CDRs other than providing basic information about the process and answering questions.
4. CWICs are not permitted to assist with the appeal process beyond providing basic information and answering questions. Social Security prohibits CWICs from representing beneficiaries during appeals.
5. CWICs should be cautious about the amount of time they spend helping beneficiaries with overpayments. Your role is to provide basic information about the options available – appeal or requesting a waiver of overpayment recovery. You may help get the beneficiary the necessary forms and explain how to complete them. You should not provide direct assistance with completing these forms.

Understanding the Initial Disability Determination Process

To meet the definition of disability under the Social Security Act, an adult claimant must be unable to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months. The definition of disability under the Social Security Act quoted in the section above has three distinct criteria:

1. **The Earnings Test:** The person must be unable to perform SGA because of the impairment.
2. **The Medical Test:** The person must have a medically determinable impairment that can be documented by a qualified medical examiner. In addition, the disability must meet a certain level of severity as defined by Social Security.
3. **The Duration Test:** The disability must meet the duration requirement meaning that it must have lasted or can be expected to last for a continuous period of at least 12 months.

To receive benefits, the person must meet all three of these tests. In the Social Security system, there is no partial disability. A claimant either is found to meet the definition of disability or not. No benefits are provided to individuals who do not meet Social Security's definition of disability. In addition, during initial disability claims, the burden of proof lies with the person filing the claim, not with Social Security.

The Sequential Evaluation Process

Social Security's process for determining whether a claimant meets the definition of disability is called "the Sequential Evaluation Process". This is the process that Social Security and DDS uses when they perform disability evaluations. The Sequential Evaluation Process consists of five questions that are asked in a prescribed order:

Step 1: Is the claimant performing SGA?

Social Security uses specific dollar amounts of monthly earnings to evaluate whether work activity is SGA. We provided a detailed explanation of the SGA guidelines and how Social Security makes SGA determinations in Chapter 1, so that information will not be repeated here. You can find the **past and current SGA guidelines** in Social Security's Program Operations Manual System (POMS) (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501015#a>).

Basically, if a claimant's average countable earned income is above the applicable SGA guideline, they generally cannot be considered to have a qualifying disability. If the claimant is not working or is working but not performing SGA, Social Security will send your application to the DDS and they will complete Steps 2 - 5 of the sequential evaluation process to make the decision.

Step 2: Are the claimant's impairments "severe?"

For the DDS to decide that an applicant is disabled, a medically determinable impairment or combination of medically determinable impairments must significantly limit the claimant's ability to do basic work activities (such as walking, sitting, carrying, seeing, hearing, remembering simple instructions, and responding appropriately to the public and usual work situations) for at least one year. If the medically determinable impairment(s) has no more than a minimal effect on his/her ability to perform basic work activities, the DDS will determine that the individual does not meet the disability standard. If the impairment(s) is severe, the DDS continues to Step 3.

Step 3: Is the claimant's impairment in the Listing of Impairments?

To make medical disability determinations, the DDS uses the "Listing of Impairments". This describes impairments that are severe enough to prevent a person from doing any gainful activity. If a claimant has an impairment that is listed, the DDS will find the claimant disabled at Step 3. If the impairment (or combination of medical impairments) is not on this list, the DDS looks to see if the condition is as severe as a listed impairment. If the severity of the claimant's impairment(s) meets or medically equals that of a listed impairment, the DDS will decide that the claimant is disabled. The **Listing of Impairments** is available at

Social Security's website (<https://www.ssa.gov/disability/professionals/bluebook/general-info.htm>). If the medically determinable impairment does not meet or medically equal a listed impairment, the DDS goes to Step 4.

Step 4: Can the claimant do the work that they did before?

At this step, the DDS decides if the impairment(s) prevents the claimant from doing their past work as they performed it before, or as generally performed in the national economy. If past work is not precluded, the DDS will decide that the claimant does not meet Social Security's definition of disability at this step. If past work is precluded, the DDS goes on to Step 5.

Step 5: Can the claimant make an adjustment to any other type of work?

If the claimant cannot do the work they did in the past, the DDS looks to see if the claimant would be able to make an adjustment to other work. The DDS evaluates the individual's medical condition, age, education, past work experience, and any skills the claimant may have that he or she could use to do other work. If the claimant cannot do other work, the DDS will decide that the claimant's impairment meets the Social Security definition of disability. If the claimant can make an adjustment to other work in the economy, the DDS will decide that the beneficiary is not entitled to benefits based on disability.

To learn more about the sequential evaluation process, refer to **POMS DI 22001.001 - Sequential Evaluation of Title II and Title XVI Adult Disability Claims** found online (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0422001001>).

Understanding Statutory Blindness

In both the Title II and the SSI disability benefit programs, Social Security makes a distinction between individuals who are "disabled" and individuals who are "blind". Social Security does this because there are several significant differences in the disability benefit rules for individuals who are blind. For example, SSI claimants who meet Social Security's definition of statutory blindness are not subject to the first

step of the sequential evaluation – the SGA test. Statutorily blind SSI claimants are eligible for SSI payments even if they are performing SGA, provided the claimant meets the other requirements for eligibility, such as meeting income and resource limits.

To receive Social Security disability benefits due to blindness, individuals must meet the Social Security definition of being “statutorily blind”:

“Statutory blindness is defined in the law as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.” (20 CFR 404.1581)

To learn more about the differences in Social Security’s program rules for individuals who are blind, refer to a resource document on the NTDC website entitled **Disability Program Differences for Individuals who are Blind** (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=75>).

Childhood Definition of Disability in the SSI Program

In the SSI program, the definition of disability for children (anyone under the age of 18) is different from the definition applicable to adults. Social Security considers SSI claimants under age 18 disabled if they have a medically determinable physical or mental impairment or a combination of impairments that causes marked and severe functional limitations. In addition, Social Security must expect the impairment or combination of impairments to result in death or last for a continuous period of not less than 12 months.

This childhood definition of disability ONLY applies in the SSI program. The adult standard of disability applies to all claimants in the Title II disability program regardless of age. More information about the definition of disability for children in the SSI program is available in **POMS DI 25201.001 Childhood Disability – Introduction** found online (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0425201001>).

Age-18 Redeterminations in the SSI Program

Since the definition of disability for children in the SSI program is so different from the adult definition of disability, Social Security has to review the eligibility of all SSI recipients who turn 18 years of age as if they were applying for adult SSI for the first time without consideration of previous disability determinations. Social Security calls this unique review process the “age-18 redetermination”. The age-18 redetermination process only applies to SSI recipients. Title II disability beneficiaries are not subject to redeterminations at the age of 18 because there is only one disability standard in the Title II program. This standard is the same as the adult standard for SSI entitlement.

Because of the more comprehensive definition of disability for adults, when Social Security conducts age-18 redeterminations, the agency may determine an individual ineligible for SSI benefits as an adult. This is true even though there has been no change in medical condition or ability to function since Social Security found the beneficiary eligible for childhood SSI benefits.

The Age-18 Redetermination Process

The age-18 redetermination occurs for all childhood SSI recipients at some point after their 18th birthday. It may occur at a regularly scheduled CDR or at another point as determined by Social Security. In general practice, the age-18 redetermination usually occurs within 12 months after the 18th birthday. Social Security does not initiate the review prior to the month before the month the individual turns age 18. Social Security does not initiate an age-18 disability redetermination if the person was not eligible for SSI based on a childhood disability in the month before the month of his or her 18th birthday.

To conduct a redetermination at age 18, Social Security gathers information on the young adult and determines eligibility under the adult disability criteria. The agency considers age-18 redeterminations to be initial eligibility decisions and applies the sequential evaluation process to make determinations with one notable difference. Social Security bypasses the first step of the sequential evaluation (are you currently engaged in SGA?) during an age-18 redetermination.

All individuals for whom Social Security conducts an age-18 redetermination receive a written notice. If the determination is

favorable, the individual continues to receive SSI cash payments and Medicaid with no interruption. An individual who Social Security finds ineligible for SSI benefits as an adult will receive a written notice stating that he or she is no longer qualified to receive benefits. These individuals are entitled to receive two more months of payments after the date of this notice. Overpayment may occur if an ineligible individual continues to receive payments after the two-month grace period. Social Security will only seek to recover those payments after the agency makes its determination and the two-month grace period is over.

For more information about the age-18 redetermination process, refer to a resource document on the NTDC website entitled **Understanding Age 18 Re-determinations** (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=22>). You can also go to Social Security's online Program Operations Manual System (POMS) **DI 13006.000 Title XVI Age 18 Medical Redeterminations** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0413006000>) and read about age 18 redeterminations.

Understanding the Continuing Disability Review Process

Once an individual initially meets the disability requirements, the DDS sets a date called a "diary" when it will review the individual's disabling condition again to see if the disability continues. The "diary" is set for a certain period of time based on an assessment of how likely it is that the beneficiary's medical condition will improve. There are three primary diaries: Medical Improvement Expected (MIE), Medical Improvement Possible (MIP), and Medical Improvement Not Expected (MINE).

1. Medical Improvement Expected (MIE)

MIE reviews apply to individuals with impairments that Social Security expects to improve sufficiently to permit the individuals to engage in SGA. A CDR diary for MIE means that Social Security will review the medical file in less than three years.

2. Medical Improvement Possible (MIP)

MIP reviews apply to individuals with impairments who either at the time of initial entitlement or after subsequent review, Social Security considers to have the possibility of improving. In these cases, improvement may occur to permit the individuals to perform SGA, but Social Security cannot predict improvement with accuracy based on current experience and the facts of the particular case. An MIP diary means that Social Security should review the medical file within three to five years.

3. Medical Improvement Not Expected (MINE)

MINE reviews apply to individuals with impairments that Social Security does not expect to improve either at initial entitlement or later, after further review. These are severe impairments that have shown, on the basis of administrative experience, to be at least static but more likely to be progressively disabling. Improvement to permit the individuals to engage in SGA is unlikely. Social Security may consider the interaction of the individual's age, impairment consequences, and the lack of recent attachment to the labor market in determining whether it expects the impairment to improve. A MINE diary means that Social Security should review the file within seven years but no more frequently than once every five years.

Medical Improvement Review Standard (MIRS)

The DDS applies a different standard when conducting medical CDRs than they apply during initial disability determinations. First, during a medical CDR, the burden of proof is on DDS to produce evidence that the beneficiary's medical condition has improved. During an initial disability determination, the burden of proof lies with the beneficiary. Second, during medical CDRs, the DDS does not use the sequential evaluation process to decide if the beneficiary meets Social Security's definition of disability since that was already established during the initial disability determination. Instead, DDS applies a different process to determine if the beneficiary meets something called the Medical Improvement Review Standard (MIRS).

Under the MIRS standard, DDS considers current signs, symptoms, and laboratory findings related to the impairment(s) documented at the

time of the last favorable decision to determine if there has been any changes or improvement as the basis for finding medical improvement (MI). Like the initial determination, the MIRS definition has two parts: medical improvement and the ability to perform SGA. Under the MIRs, Social Security will determine that a beneficiary is no longer disabled only if the evidence demonstrates medical improvement related to work since the last favorable disability determination and the ability to engage in SGA.

In addition to the regularly scheduled medical CDRs, there are two additional times when the DDS applies the MIRS instead of the initial disability standard:

1. When Social Security conducts age 18 re-determinations in the SSI program, and
2. During medical decisions DDS makes for individuals who are applying for Expedited Reinstatement (EXR) of benefits.

The Medical CDR Process

When Social Security initiates a medical CDR, not all beneficiaries are subjected to a full review of medical evidence. In some situations, Social Security will simply review the folder and determine that the impairment could not have improved. In other cases, the beneficiary will receive a questionnaire in the mail, and the information he or she provides on the questionnaire will be sufficient for Social Security to determine continued eligibility. Sometimes, however, Social Security will need to gather medical evidence and interview the beneficiary to determine if the disability continues to meet Social Security's definition.

More information about the CDR process is available in the POMS starting with **DI 28005.000 - The CDR Evaluation Process** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0428005000>).

You can find a helpful brochure about the medical CDR process entitled **How We Decide If You Still Have A Qualifying Disability** on Social Security's website (<https://www.ssa.gov/pubs/EN-05-10053.pdf>).

Protection from Medical CDRs

The Ticket to Work and Work Incentives Improvement Act of 1999 created two provisions that protect beneficiaries from medical CDRs:

1. Social Security will not initiate medical CDRs for beneficiaries who are actively using their Ticket to Work. We discuss the Ticket to Work program in detail in Part II of this manual.
2. If an individual has been receiving disability benefits for at least 24 months, Social Security will not initiate a medical CDR solely because an individual goes to work. This is an essential protection for beneficiaries who decide to pursue employment. Beneficiaries who have received cash benefits for at least two years will only undergo the regularly scheduled medical CDRs based on the MIE, MIP, and MINE diaries set at the last medical determination of their benefits. A report of work activity will no longer solely “trigger” a medical CDR. A beneficiary does not need to have a Ticket or be using a Ticket to be afforded this second medical CDR protection.

Continued Payments under Section 301 of the Social Security Act

When Social Security personnel conduct a medical Continuing Disability Review (CDR) or an age-18 redetermination, they may find that a beneficiary no longer meets the medical requirements to receive disability benefits. If that happens, Social Security usually stops the individual’s cash benefits and associated health insurance (Medicare and/or Medicaid). However, Social Security may continue to provide cash disability payments and medical insurance (Medicare and/or Medicaid) to certain individuals who are participating in programs that may enable them to become self-supporting. This includes the Ticket to Work program or another program of vocational rehabilitation (VR) services, employment services, certain special education programs, or other support services if Social Security determines that completion or continuation of the program will increase the likelihood of the individual’s permanent removal from the disability benefit rolls. Social Security refers to this special continuation of benefits as “Section 301” because the initial legislative authority for continued payment of benefits to individuals in a VR program was provided in Section 301 of the Social Security Disability Amendments of 1980. Continued benefits under Section 301 applies to both SSI and title II disability benefits.

Beneficiaries may qualify for continued payments under Section 301 when they meet the following criteria:

1. They are participating in an appropriate VR program or similar services that began before the month of their disability stopped under Social Security's rules; and
2. Social Security reviews the program and decides that if the beneficiary continues in the program, they are not likely to resume disability benefits. Some examples of appropriate VR programs include:
 - An Individualized Education Program (IEP) for a youth who is age 18 through 21.
 - A VR agency using an individualized plan for employment
 - Support services using an individualized written employment plan.
 - A written service plan with a school under Section 504 of the Rehabilitation Act.
 - An approved Plan to Achieve Self-Support (PASS).

Under Section 301, benefits may continue until the beneficiary completes the program, stops participating in the program or Social Security determines that continued participation in the program is unlikely to keep the beneficiary from coming back onto disability benefits.

The process by which benefits may be continued under Section 301 is very complex. We provide a brief overview in this chapter so that CWICs gain an awareness that in some rare cases, benefits may be temporarily continued even after Social Security has determined that an individual no longer meets the disability standard. To gain a deeper understanding of Section 301 determinations, refer to a resource document entitled **Understanding Section 301** available on the NTDC website (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=25>).

When Beneficiaries Disagree with Social Security

A Social Security claimant or beneficiary who disagrees with an initial determination or decision has a right to request further review. This is

called an appeal and there are several levels to this process. Beneficiaries must make most requests for reconsideration within 60 days of the date they received the notice of the decision. Social Security assumes beneficiaries will have received the notice within five days of the date Social Security mailed it. If an individual requests an appeal past the 60-day appeal window, they may lose the right of further review unless they can show good cause failing to make a timely request for review.

Individuals must request an appeal in writing and there are several ways to start this process. Individuals may call Social Security and ask for an appeal form or mail in a written note requesting to make an appeal. Beneficiaries can also download the **Request for Reconsideration (Form SSA-561)** from Social Security's website (<https://www.ssa.gov/forms/ssa-561-u2.pdf>) and send the completed form to their local field office. The fastest and easiest way to file an appeal of a decision is by visiting **Social Security's appeal webpage** (<https://www.ssa.gov/benefits/disability/appeal.html?tl=0>). Individuals can file an appeal request online and upload documents online to support their appeal, which will help decrease the time it takes to receive a decision.

Levels of Appeal

The appeal process consists of several levels of administrative review that the beneficiary must request within certain time periods and at the proper level. The levels of administrative review are 1) Reconsideration 2) Administrative Law Judge (ALJ) hearing, and 3) Appeals Council (AC) review as listed below. The AC review ends the administrative review process. If an individual is still dissatisfied, he or she may request judicial review by filing an action in federal court.

1. Reconsideration

In most cases, reconsideration is the first step in the administrative review process for individuals who disagree with the initial determination. Social Security also provides the opportunity for an ALJ hearing as the first step in the administrative review process for those determinations involving a request for waiver of an adjustment or recovery of an overpayment. The method of reconsideration for Title II consists of a case review and disability hearing. The method used

depends on the issue involved. For non-medical issues, it's a case review. For medical issues, it's a case review for initial claims and a disability hearing, which is a face-to-face reconsideration, for all medical cessation cases.

2. Administrative Law Judge Hearing

If a beneficiary disagrees with the determination Social Security made at the reconsideration level, they may ask for a hearing. An administrative law judge who had no part in the original determination or the reconsideration of the case conducts the hearing. When Social Security schedules hearings they consider what's convenient and close for the beneficiary. They usually schedule hearings within 75 miles of a person's home. In certain situations, hearings may be held via video at a hearing site, in person at one of our hearing offices, or from another location.

3. Appeals Council

If the individual disagrees with either the ALJ decision or the dismissal of a hearing request, the individual may ask the AC to review the action. The AC may dismiss or deny the request for review, or it may grant the request and either issue a decision or remand the case to an ALJ. The AC may also review an ALJ decision (within 60 days of the hearing decision or dismissal) on its own motion. The AC has final review authority for Social Security.

The AC review completes the administrative review process. If an individual is still dissatisfied, they may request judicial review by filing a civil action in a federal district court.

Each of the appeal steps has required forms and timeframes. CWICs may not represent beneficiaries in appeals against Social Security. However, you may assist beneficiaries in understanding their appeal rights, accessing the forms, and understanding what additional information Social Security will need to make a decision.

For more information, refer to **[POMS GN 03101.001 - Summary of Administrative Review Process](https://secure.ssa.gov/apps10/poms.nsf/lnx/0203101001)** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0203101001>).

You can also find a helpful brochure entitled **Your Right to Question The Decision Made On Your Claim** on Social Security's website (<https://www.ssa.gov/pubs/EN-05-10058.pdf>).

Overpayment of Benefits

An overpayment occurs when Social Security pays a beneficiary more than they should have received. If this happens, Social Security will notify the beneficiary and the representative payee, if applicable. The notice explains why the overpayment occurred, the beneficiary's repayment options, and provides an overview of the appeal and waiver rights.

If the beneficiary agrees that Social Security paid them too much and that the overpayment amount is correct, the beneficiary has several options for repaying it. If the Title II beneficiary is in current pay status, Social Security will withhold the full amount of the benefit each month, unless the beneficiary requests a lesser withholding amount and Social Security approves the request. Full withholding begins 30 days after Social Security notifies the beneficiary of the overpayment.

If the beneficiary receives SSI, generally Social Security will withhold 10 percent of the Federal Benefit Rate (FBR) each month to recover the overpayment. If the beneficiary cannot afford this, they may ask that Social Security withhold less each month. Beneficiaries may also request that they pay back the overpayment at a rate greater than 10 percent. Social Security will not start deducting money from the SSI payments until at least 60 days after the agency notifies the beneficiary of the overpayment.

Beneficiaries who no longer receive SSI, but continue to receive Social Security disability benefits, can pay back the SSI overpayment by having Social Security withhold up to 10 percent of the monthly Title II benefit. If the beneficiary is not receiving any benefits from Social Security, their options to repay include:

- Sending a check to Social Security for the entire amount of the overpayment within 30 days; or
- Contacting Social Security to set up a plan to pay back the amount in monthly installments.

If the beneficiary is not receiving benefits and does not pay back the amount by using one of the above options, Social Security can recover the overpayment by withholding federal income tax refunds due to the beneficiary or, in some cases, from wages if the beneficiary is working. Social Security can also recover overpayments from future SSI or Social Security benefits.

Social Security provides lots of helpful information about **overpayments** on their website (<https://www.ssa.gov/overpayments/?tl=0%2C1%2C2%2C3>).

Overpayment Appeal and Waiver Rights

Beneficiaries who do not agree that an overpayment occurred, or believe the amount is incorrect may file an appeal using the same procedures described previously. The appeal request should also include any evidence the beneficiary has to support their argument. For example, if a beneficiary is appealing an overpayment related to work activity, and Impairment Related Work Expenses (IRWE) were not considered as part of the determination, the beneficiary should present IRWE receipts.

Beneficiaries who agree that an overpayment occurred, but believe they should not have to pay the money back may request a waiver of collection. Beneficiaries must submit Form SSA-632 to request a waiver and you can find this SSA-632 form **Request for Waiver of Overpayment Recovery** on Social Security's website (<https://www.ssa.gov/forms/ssa-632.html>). Beneficiaries can also get the form by calling or visiting the local Social Security office. To have the overpayment waiver request approved, the beneficiary will have to prove that:

- The overpayment was not their fault; and
- Paying it back would cause financial hardship or be unfair for some other reason.

Social Security will stop recovering the overpayment until it decides on the appeal or approves a waiver of overpayment recovery. There is no time limit for filing a waiver request.

Administrative Finality

The concept of administrative finality is an important protection for both beneficiaries and Social Security. These rules protect beneficiaries by allowing Social Security to re-examine certain decisions during a set period of time if it appears that the original decision wasn't correct. Administrative finality also protects Social Security because the agency should not be required to establish findings of fact after the lapse of a considerable time from the date of the events involved. The administrative finality rules describe the types of decisions that Social Security may re-examine, and establishes the time limits for this process. Social Security refers to this re-examination process as a "reopening".

Here are a few things to keep in mind about reopening:

- A beneficiary has the right to appeal any initial determination. Reopening, however, does not meet the definition of an initial determination. Beneficiaries do not have a "right" to have a decision reopened or re-examined by Social Security.
- Social Security may choose to reopen a decision for up to 12 months for any reason, in both the SSI and Title II disability programs.
- If Social Security finds "good cause" to reopen a decision, the agency may reopen an SSI decision within two years of the notice of the determination in question.
- If Social Security finds good cause, the agency may reopen a Title II disability decision up to four years after the notice date of the prior determination.
- CWICs should refer beneficiaries to the local Social Security office when questions about possible reopening arise.

For more information about the reopening process, refer to **DI**

27505.000 Rules for Reopening

(<https://secure.ssa.gov/apps10/poms.nsf/lnx/0427505000>); or **SI**

04070.010 Title XVI Administrative Finality - Reopening Policies

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0504070010>).

Next Steps

CWICs need to have a basic understanding of the concepts covered in this chapter, but should understand that these areas are all outside of the primary work performed by a CWIC who works in a WIPA program. In most cases, when you have a question about disability determinations, medical CDRs, Social Security's appeals process, or overpayments you should reach out to your assigned NTDC TA Liaison. If you would like to develop more advanced competence in any of these areas, you may complete the following next steps:

1. Beneficiaries often ask CWICs questions about what to do when an overpayment occurs. While CWICs do not spend a great deal of time helping with overpayments, they do need to provide information to beneficiaries about how to manage them. For detailed information about overpayments in the Social Security disability system, you may complete an archived training entitled **Social Security Disability Benefit Overpayments - What CWICs Need to Know** on the NTDC website (<https://vcu-ntdc.org/training/supplemental/archives.cfm>).
2. The SSI age-18 redetermination process is an area that CWICs need to have a solid understanding of when they provide services to transition aged youth. We have a resource document you may read to gain a deeper understanding of this process entitled **SSI and Age-18 Redeterminations** found at the NTDC website (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=22>). You will also find **an archived training that covers age-18 redeterminations** on the NTDC website (<https://vcu-ntdc.org/training/supplemental/archives.cfm>).
3. Finally, Section 301 Continuation of Coverage is a very complex topic that is particularly important to understand when you provide WIPA services to transition age youth. You will find a detailed resource document entitled **Understanding Section 301** on the NTDC website (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=25>).

