Title II Claims Specialist
Basic Training Curriculum

Unit 4
Modules 20 – 30
Disability
Student

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LESSON PLAN

Chapter Objectives

> At the completion of this chapter, the students will be able to:
>
> 1. Define substantial gainful activity (SGA).
>
> 2. Identify situations in which wages represent SGA.
>
> 3. Identify situations in which self-employment represents SGA.
>
> 4. Complete the SSA-821, SSA-820, SSA-823 and SSA-3033

Length of Chapter

> 18 hours

Instructional Aids

> SSA-820
>
> SSA-821
>
> SSA-823
>
> SSA-3033

BACKGROUND AND RATIONALE

We normally think of being disabled as being unable to work. There are instances in which people with severe impairments are working and receiving payment. SSA's guidelines do not prohibit a disabled person from working and earning a limited income. In fact, SSA encourages rehabilitation and returning to work whenever possible.

Our Responsibility

At the same time, we need to remember the ability to do significant work is a key factor in SSA's disability decision-making process. If a person is performing work at a substantial and gainful level, he/she is not eligible for disability benefits, even if the person has a serious medical impairment.

Generally, to be eligible for the disability program, a person must be unable to perform substantial gainful work activity (SGA). In most cases, we evaluate a person's ability to do SGA by considering both medical and vocational evidence. The field office (FO) will review and evaluate the work and earnings in a disability claim. The Disability Determination Services (DDS) will evaluate the medical and vocational factors.

This chapter is designed to familiarize you with work activities as they relate to an initial application for disability benefits. After a claim is approved, work at SGA level is also an issue. This is discussed in the advanced training chapter on Continuing Disability Reviews (CDRs).

OBJECTIVE 1:

Define substantial gainful activity.

SGA in the Disability Program

DI 10501.000ff; **DI 10505.000ff**

Definition of Disability

DI 00115.015

SSA defines disability as the inability to engage in substantial gainful work activity (SGA) due to medical or mental impairment expected to last at least 12 months or to result in the death of the claimant.

Definition of SGA

DI 10501.001

SSA defines SGA as the performance of **significant** physical and/or mental work done for payment or profit. **S**ignificant activity, this means doing work with enough economic value to meet the statutory Earnings Guidelines shown in the chart in **Exhibit 1**.

Payments for work activity may be in the form of cash or in-kind payments. Nevertheless, all activities are not considered substantial work. Activities generally not considered SGA include:

- self-care
- household tasks
- hobbies
- school attendance
- social programs and the like

Component Responsibilities

DI 25501.390

SGA Issues (FO) – You will develop and document whether or not wages and/or self-employment activities before and after the Alleged Onset Date represent Substantial Gainful Activity (SGA).

Medical Issues – DDS determines all medical and vocational issues relating to a disability application. A vocation is a person's regular occupation, trade, or profession. A DDS examiner decides if an applicant has the ability to engage in his or her usual or previous profession. DDS also decides if the applicant has the ability to engage in <u>any</u> type of SGA despite the alleged impairment.

SGA Earnings Guidelines

DI 10505.010, **DI 10501.015**, **DI 10505.020**

You make an SGA determination by looking at how much a person is earning. Evaluation of an employee's work activity for SGA purposes is concerned with only those earnings representing a person's <u>own</u> productivity.

Non-blind SGA Amount– Earnings exceeding the limit are considered SGA. The chart for non-blind individuals can be found in **DI 10501.015B** and in **Exhibit 1**.

EXAMPLE – In the year 2018, if a person's "countable earnings" are higher than $1,180.00 in a month, those earnings are considered SGA.

Blind SGA Amount – Blind individuals have a different SGA limit each year. This chart can be found in **DI 10501.015C** and in **Exhibit 2** at the end of this module.

EXAMPLE – In the year 2018, if a blind individual's "countable earnings" are higher than $1,970 in a month the earnings are considered SGA for the month.

Please note – beginning 01/01/2001, the SGA amount may be changed each year based upon the average wage index.

OBJECTIVE 2:

Identify situations in which wages represent SGA.

Determining Gross Earnings

Determining Earnings from Employment

DI 10505.005

Before we can make an SGA determination, we must determine when the individual worked and how much he/she earned for the work activity. To do this we first obtain a statement from the claimant regarding their work activity. Then, we verify the earnings following.

Earnings Clearly <u>NOT</u> SGA

DI 10505.003

When there is evidence indicating an individual's earnings are clearly NOT SGA, and there is no evidence the individual is in a position to hide or suppress their earnings, then you do not need to develop and determine the exact amount of monthly earnings.

"Clearly not SGA" definition is earnings from employment clearly below the trial work period (TWP) service month threshold level. For the TWP service months amounts, see **DI 13010.060**.

<u>EXAMPLE</u>:

Wayne Ivory states he earned $800 per month in 2018 working part time at the local grocery store. The earnings on his DEQY support his allegation. No further development is necessary. See the documentation requirements below to send this Clearly Not SGA decision to DDS. You will <u>not</u> need to complete a work activity report.

DOCUMENTATION:

1. Document the monthly earnings allegations and write "Clearly Not SGA" on the Remarks section of the Disability Report-Field Office in the electronic disability claim system (EDCS). For instructions on how to document the SSA-3367, see **DI 11005.045.**

2. If you have already transferred the case to the DDS when you make the decision, alert the examiner to your "clearly not SGA" determination in EDCS, via the update after transfer (UAT), following instructions in **DI 81010.095.**

NOTE: If an EDCS 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 00 301.322.** In addition, file your determination in the Medical Disability File (MFD). If the MDF is at DDS, forward the 5002 to be associated with the paper folder.

Earnings Clearly ARE SGA

DI 10505.003 C

When a completed Work Activity Report (SSA-821) shows the claimant's countable earnings are clearly SGA and the individual does not allege any Subsidy, IRWE or special work conditions (discussed in detail in this objective), then you do not need to develop and determine the exact amount of monthly earnings. There is also no need to re-contact the claimant regarding their work activity if you have no reason to question the accuracy of the statements.

EXAMPLE:

Elaine Sigmund states on the SSA-821 that she was earning $2,500 per month until June of last year. She alleges her disability began in February of last year. These earnings are clearly over the SGA limits, and she does not allege any subsidy, IRWE, or special conditions. No further development is necessary. Document the SSA-823 indicating the earnings are SGA without obtaining verification.

DOCUMENTATION:

1. Determine the work activity is SGA, as it is clearly above the SGA level; and no special considerations could reduce the countable earnings.

2. Document your findings on an SSA-823 (Report of SGA Determination).

Verifying Earnings

DI 10505.005 D; **GN 00204.150**

In an initial claim, when it is not clear whether the individual's earnings are above or below the SGA limit, you must develop and verify the earnings. Per the Bipartisan Budget Act of 2015 (BBA), you must request authorization to obtain earnings information. You will record the authorization by completing the Wage and Employment Information Authorization (WEIA) pages in the MCS claims path.

Obtain evidence of earnings during an initial claim using this order of priority:

1. Third party payroll provider that reports wages <u>when earned</u> such as The Work Number or Verify Advantage
2. Paystubs
3. Shared process screen and Paystubs feature in eWork
4. SSA-L725 (SSA's request to employer for wage verification)
5. Third-party payroll provider documents that report wages <u>when paid</u>
6. SSI verified wages
7. National Directory of New Hires (NDNH)
8. IRS earnings on the SEQY/DEQY

Determining Earnings from Self-Employment

DI 10510.012

Use the individual's tax return to determine the Net Earnings from Self-Employment (NESE) for any year in which the actual net income is pertinent.

Countable Monthly Earnings

DI 10505.000ff, **DI 10520.000ff**

Definition of Countable Earnings

DI 10505.010; **DI 10505.001B.1**

SSA defines countable earnings as the portion of an individual's earnings, which show the actual value of work done.

To determine an employee's "countable earnings," we first determine the total earnings reported for work activity using gross wages. Total earnings may also include in-kind (non-monetary) payments, i.e. employer provides room and board or free rent. Count in-kind payments if they are paid based on the employee's own productivity.

Determining Countable Earnings

Once gross wages are determined, you will deduct (in this order) the amounts of:

1. **Subsidies** provided by the employer; and

2. **Impairment-related work expenses (IRWEs)** paid by the employee.

3. After, you apply the rules of **averaging**, if appropriate.

4. If there are still periods of SGA, you will consider **Unsuccessful Work Attempts (UWA)**.

5. **Finally**, you will make an **SGA determination**.

Please refer to EXHIBIT 3: SGA DEVELOPMENT GUIDE – EMPLOYMENT for a SGA Development Guide.

Subsidy

DI 10505.010

Definition of Subsidy

A subsidy is a payment of wages made to an employee above the reasonable value of the actual work they perform. Subtract subsidies from gross earnings to determine the value of countable earnings.

An employer may subsidize the employee's earnings because they have a charitable attitude toward the individual. In this case, the excess is a subsidy rather than earnings. The SSA-3033 Employee Work Activity Questionnaire can be used to obtain subsidy and/or unsuccessful work attempt information from employers.

Strong Possibilities of Subsidy

The following situations indicate a possibility of subsidy:

- Work in sheltered workshop

- Childhood disability involved

- Mental impairment involved

- Discrepancy between pay and value of service

- Receive unusual help from others

- Involved in government-sponsored job training

A subsidy can be specific or non-specific.

Specific Subsidy

DI 10505.010 A

A specific subsidy occurs when the employer can furnish a specific dollar amount or percent of income considered a subsidy paid to an impaired person.

First, the employer will determine the reasonable monetary value of the services performed by the employee. Subtract this dollar amount from the employee's gross wages. The remainder is the subsidized wages. The employer's logical explanation of how the amount of subsidy was determined will be sufficient without additional development.

Specific Subsidy Example:

Art Major is employed by a local paint store. He has worked there 4 years. Due to his alleged disability, he is only able to work 25 hours each week. He continues to receive his usual wage of $12.00/hour. You contacted his employer who told you if he hires someone else to do the exact work duties Art is now performing, he would pay the new person only $8.00/hour. Due to his illness, Art is not able to perform all of his usual job duties. Art continues to receive his usual hourly wage because the employer is sympathetic to Art's situation.

25 hrs/wk	$300	25 hrs/wk	$200
x $12/hr	x 13/3**	x $8/hr	x 13/3**
$300 gross wages/wk	$1300 paid to Art	$200 gross wages/wk	$866.67 actual value of services

** Remember, when doing manual computations converting weekly earnings to monthly earnings, SSA multiplies a factor of 13/3 to determine the monthly amount.

$1,300.00
-   866.67
$ 433.33 (specific subsidy amount = $433.33/mo)

Nonspecific Subsidy

A nonspecific subsidy occurs when the employer cannot furnish a satisfactory explanation identifying a specific amount of income or percentage of pay as a subsidy.

When there appears to be a non-specific subsidy, you establish a reasonable dollar amount to deduct from gross wages.

To develop the non-specific subsidy, contact the employer to determine the approximate extent of a subsidy based on the individual's:

    1. Lack of productivity; or

2. Unusual supervision or assistance required to perform simple tasks; or

3. The employee is extremely inefficient or otherwise unproductive.

Exhibit 4 lists a number of questions you can ask to help with your decision to determine the amount of the non-specific subsidy. (A complete list is in **DI 10505.010 A.3**)

Nonspecific Subsidy Example – Paige Turner works at the City Herald, which prints and distributes the local daily newspaper. Her job is to fold and insert local shopping ads into the daily paper. Her disability is a rare inflammation of her fingernails, which is a result of overexposure to newsprint. She claims she is not working as much as she did before her condition began bothering her. When you contact her employer, you are told she is being paid a salary of $1,400.00 per month. Other employees working at a job similar to hers also earn a salary of $1,400.00 per month. Employees work 20 days in a month. If they miss work, their salary is reduced $70.00 for each day they miss.

Paige has exhausted all of her sick leave and misses an average of 5 workdays per month due to illness, and still receives her full salary. Her employer says he has kept Paige on the payroll in spite of her lower productivity because of her years of loyal service. He knows Paige and her five children need the money to survive because Paige is a widow and has no friends or family to rely on.

Question 1: How much subsidy is provided to Paige each month?

Answer: $350.00

Rationale: $70.00/day in sick leave x 5 sick days/month = $350.00

Question 2: How much does Paige have in monthly countable income?

Answer: $1,050.00

Rationale: $1,400.00 (salary)
- 350.00 (subsidy)
$1,050.00 (countable wages)

Special Employment Situations

Sheltered Employment

DI 10505.025 D

Sheltered employment consists of work provided for disabled individuals in a protected environment under an institutional program. Typically, individuals participating in sheltered employment have severe impairments. The most common types of sheltered employment are:

- Sheltered workshops

- Hospitals, VA facilities and long-term care institutions

- Homebound employment

Sheltered work is ordinarily NOT considered SGA if earnings do not exceed the primary SGA amount. If earnings exceed the primary SGA amount, develop for subsidy, IRWE, and consider averaging.

If, after your development, the earnings are still above the SGA limit, consider the tests of Comparability and Worth of Work. **DI 10505.020 C**

Many FOs have precedent files on sheltered workshops in their area. These files may already explain the specific subsidy percentages associated with each workshop.

Supported Employment

The Employment Opportunities Act of 1986 brought about supported employment. Many disabled individuals receive training and actual work experience in sheltered workshops. In addition, other special work environments exist. These new environments are commonly referred to as supported employment.

Instructions for evaluating supported employment situations are found in **DI 10505.001** through **DI 10505.020.**

Supported employment is an indication of subsidy. Such employment begins with one or more of the following during the initial phases of employment:

- Wage subsidy

- Additional supervision

- Job coach

- Special counselor

These subsidies phase out as the beneficiary gains job skills and proficiency. During this period, the productivity of the beneficiary should be calculated and compared with the productivity of an unimpaired worker doing the same or similar work. Calculate the reasonable value of countable earnings by subtracting the wage subsidy and/or the worth of additional job assistance given by the supervisor, job coach, or special counselor from the beneficiary's wages.

Calculate the worth of the job assistance by multiplying the number of extra hours spent by the supervisor, job coach, and/or counselor times the hourly wage paid to the beneficiary. Subtract this subsidy amount from the beneficiary's wages to determine if the beneficiary is performing SGA. Here are two examples:

Example 1 Job Coach (wages are given at a weekly rate):

Joe works 32 hours per week. He is paid $9 an hour. His job coach comes in for 15 hours each week and works with him. The job coach is paid $20 an hour. During the 15 hours spent with Joe, the job coach performs all of Joe's duties while Joe observes and practices. The following is how we compute Joe's subsidy:

$9 x 32 hours x 13/3 = $1,248 (Joe's monthly wages)

$9 x 15 hours x 13/3 = $585 (Monthly subsidy provided by job coach)

$1,248 - $585 = $663 (Joe's monthly wages less subsidy amount)

We convert Joe's weekly wages and weekly subsidy into a monthly figure first, then we subtract the monthly figures; $1,248 in wages deducted by the monthly subsidy $585 to get his monthly countable income of $663.

Caution: Do not deduct the amount of pay the job coach receives. You only subtract the value of the monthly subsidy provided by Joe's coach, which is $9 per hour x 15 hours per week x 13/3.

Example 2 Job Coach (wages are already given at a monthly rate):

Jane works 130 hours per month and is paid $1,235 a month ($9.50 an hour). Her job coach is with her 40 hours a month but directly assists her only 10 of those hours. The remaining 30 hours the job coach observes and checks her work. Jane is already paid in a monthly wage, so there is no need to multiply by 13/3. The following shows our subsidy calculation:

$9.50 x 10 hours = $95 (value of monthly subsidy provided by Jane's job coach)

$1235 - $95 = $1140 (Jane's monthly wages less subsidy amount)

The $1140 is the amount of earnings we would attribute (her countable earnings) to Jane's own productivity.

IRWE

DI 10520.000ff

An impairment-related work expense (IRWE) is the cost an individual pays for an item or service, which is needed to enable him/her to work, and is directly related to a physical or mental impairment. The IRWE must be needed because of the medical basis for disability established by the DDS or another impairment being treated by a physician or health care provider.

The law provides we deduct the cost of certain items and services the disabled person needs in order to work. The cost can be deducted from earnings in SGA determinations even though the items and services are also used for non-work activities.

The amount of IRWE, which may be deducted, is subject to reasonable limits. Deductions for needed items and services will be made only if the impaired individual pays the cost, not an insurance company, social agency, or other reimbursement.

Example of IRWEs

Attendant care services:

This includes forms of personal assistance to help an individual meet his or her essential needs at home or at work. Personal assistance includes bathing, dressing, cooking, eating, communicating and traveling to and from work.

Medical Devices:

This includes durable medical equipment that can withstand repeated use and primarily serves a medical purpose. These items are generally not useful to a person in the absence of an illness or injury. Examples of medical devices include wheelchairs, respirators, pacemakers, leg/arm/back braces, and similar items.

Prostheses:

Items included in this category are devices used to replace internal body organs or external body parts such as artificial hips, limbs or other body parts. If the replacement is purely cosmetic, the cost is usually not deductible.

Work related equipment:

This category includes equipment, which is impairment-related and necessary for the impaired individual to do his or her job. Examples include vision and sensory aids for the blind and telecommunications devices for the deaf.

Residential Modifications:

This category includes changes made to alter the physical structure or operation of a person's home in order to accommodate his or her functional limitations.

If the person works **away** from their home, modifications, which permit access to the street, such as a ramp or handrails, are deductible.

If the individual works **at home**, the costs to modify the interior of the home in order to create a working space compatible to the person's impairment, would be deductible to the extent the modifications pertain specifically to the workspace. An example of this would be the enlargement of a doorway leading into an office.

Routine Drugs and Services:

Routine drugs and medical services are deductible if needed to control the disability, thus permitting the person to work.

Transportation Costs:

A disabled person may have deductible transportation costs if he or she requires structural or operational modifications to a vehicle in order to drive, or be driven, to work.

The cost of the automobile is not deductible, but the modifications are.

A disabled person might also need to pay for a taxi or an independent driver. Exclude these expenses if the individual is unable to use available public transportation.

Other Costs:

Similar items or services may also be deductible if they meet the criteria listed above. Examples include:

- Expendable medical supplies such as ace bandages, elastic stockings, and facemasks.

- Expenses relating to a guide dog or other service animal. These expenses may include the purchasing of dog food, licenses, and veterinary services.

NOTE: If the cost of equipment or home modifications is deductible by a self-employed individual on their tax return as a business expense this same cost is **not** deductible as an IRWE. **DI 10520.010 E.2**

When to Develop IRWEs

DI 10520.015

Whether IRWE should be developed depends on the amount of the alleged IRWE and its effect on the claimant's SGA level.

When the claimant has reported earnings already below the SGA level, you do not need to develop any allegations of IRWE because they will have no effect on their non-medical factors of entitlement.

When reported earnings are at or above the SGA level, determine first whether the deduction of alleged IRWE would reduce their earnings below the SGA level.

- If the alleged IRWE does not reduce their earnings below the SGA level, you will STOP development.

- If the alleged IRWE reduces earnings below the SGA level, you will evaluate the correlation of the individual's alleged IRWE with the person's disability. This is discussed below.

NOTE: IRWE development is different for Title II than it is for Title XVI.

Correlating Alleged IRWE with a Person's Disability

DI 10520.020

When a determination of SGA or SSI countable earned income depends on the deduction of alleged IRWE, you must confirm the IRWE items or services correlate with the DDS established medical basis of disability or with any medically established impairment(s) treated by a physician or health care provider. In addition, the IRWE must be needed to enable a person to work.

At the initial claim level, a medical determination has not been made yet, so when deduction of IRWE will affect the determination of SGA countable earnings, follow these procedures:

1. Record the alleged IRWE on SSA-821 or SSA-820.

2. Check IRWE in Question 1 of the Initial Claim section of the SSA-823. In the remarks of this same section, record the following items:

   - The item or service alleged as IRWE;

   - The alleged impairment(s) to which each item or service applies; and;

   - The cost of each alleged item or service.

3. Enter "IRWE Case" as a message in EDCS (Flags and Messages) screen. Forward the case to the DDS for a disability determination and do not input a non-medical completion. Your upcoming disability adjudication lesson will go over non-medical completions.

Verification of IRWE

DI 10520.025

After DDS finds the person disabled and returns the case to the FO, initiate development and verification of the IRWE. Compare the alleged IRWE item or service with the diagnosis(es) entered by the DDS on the SSA-831-U5.

If the alleged IRWE correlates with the DDS diagnosis(es), establish the need for the item or service and obtain proof of payment.

If the alleged IRWE does not correlate with DDS established diagnosis(es), determine if the person has another impairment treated by a physician or health care provider. A correlation issue can still be established if:

- The medical file has medical records or statements from a treating physician or health care provider which confirm the existence of the alleged impairment; and

- The person is being treated by a physician or health care provider for the impairment; and

- Confirms the identity of the physician or care provider.

If no correlation can be established with the alleged diagnosis or the medical records in the medical file, ask the beneficiary to provide medical records or statement from the treating physician or health care provider establishing the correlation.

In cases where the beneficiary is unable to provide documentation, contact the physician or health care provider directly to determine if the person is treated for the alleged impairment and the alleged IRWE is needed due to the impairment.

- Obtain a signed SSA-827 from the beneficiary.

- Use Form SSA-L732 to request information. The SSA-L732 should list the claimant's impairment, a brief description of the claimant's job, and the alleged IRWE. Ask the health care provider if the IRWE listed is necessary for the claimant to do the job as described.

- Include customized language that fits the person's case. (See **DI 10520.020 E.2** for an example).

Need for an Item or Service

DI 10520.025 A

Often, it may be obvious to the FO interviewer, based on the person's impairment(s), an item or service is impairment-related and needed to enable the claimant to work. For example, if a person's disability is paraplegia their need for a wheelchair in order to work is obvious. When the need is established, record the justification on the RPOC (Report of Contact Screen). If unable to determine

an item or service is related to the disability and needed to work, send an SSA-L732, Social Security Request for information with a signed and dated SSA-827, to the treating physician or health care provider.

When after all efforts, the question regarding need is still unresolved, consult with your regional office work incentives contact before disallowing the IRWE.

Payment for Item or Service

If SSA receives confirmation the item is related to the impairment and needed for work, obtain proof of payment. A verifying statement signed by the person (SSA-795) and copies of canceled check(s), or paid receipt(s) would be adequate to prove payment. The SSA-795 should include a statement no reimbursement was or will be received for the IRWE and no agency or other source is underwriting the expense for the person.

When the disabled individual does not have proof of payment, contact the prescribing source or supplier of the item or service and verify payment.

Whenever services (attendant care, transportation) are involved, document the file if the provider is a family member. See **DI 10520.025 C.3** for detailed instructions.

IRWEs will not be deducted if the claimant has been, could be, or will be, reimbursed for the expenses. Deduct the actual amount paid for the IRWE unless the amount is unreasonable. See **DI 10520.025 D** for detailed instructions.

When Both Subsidy and IRWE Apply

DI 10520.030 A.3

If an individual has both subsidy and IRWE, it is very important you apply them in the proper order. In these situations, apply Subsidy first and then deduct the IRWE. This can have an effect on the outcome of your SGA determination.

Apply Subsidy first, then IRWE

EXAMPLE:

Mr. Smith is working and earning $1,800.00 per month. His employer indicates he receives 25% subsidy. He has provided proof showing he pays $200.00 a month in IRWE.

In this situation you should apply the subsidy first and then the IRWE:

Apply the Subsidy first:

$1,800.00 x 75% = $1,350

Then apply the IRWE:

$1,350 – $200.00 = $1,150

By applying the Subsidy first and then the IRWE, the individual's countable earnings are below SGA.

Now let's see what would happen if you were to **INCORRECTLY** apply the IRWE first.

INCORRECT: Apply the IRWE first:

$1,800.00 – $200.00 = $1,600

INCORRECT: Then apply the Subsidy:

$1,600 x 75% = $1,200.00

By applying the work incentives incorrectly, you would make an improper determination the individual's countable earnings are over SGA.

Remember: ALWAYS apply Subsidy before IRWE.

Averaging Earnings

DI 10505.015

After considering subsidy and IRWE, we will average the individual's countable earnings. We do this to determine SGA in any situation, whether it is advantageous to the claimant or not, when a person has:

- continuous work, **and**

- does not have a significant change in work patterns, **and**

- monthly earnings fluctuate from above to below the SGA thresholds.

After averaging in these situations, we compare the averaged amount with the appropriate SGA level.

Generally, average countable earnings over the entire period that requires evaluation for the application. If the place of employment and the type of work is the same, then you average the total earnings over the entire work period. To average earnings, add up all countable income earned within a specific period and divide the total amount by the number of months used in the computation.

EXAMPLE:

Mrs. Summers filed a DIB claim 01/03/19 alleging a DOO of 12/25/17 when she stopped working due to her disability. She was earning $27,000 annually. She returned to work part time as a server from 07/05/2018 – 12/30/2018. Her earnings during those months were as follows:

07/18 - $1,185	10/18 - $1,060
08/18 - $1,060	11/18 - $1,185
09/18 - $1,185	12/18 - $1,060

To determine Mrs. Summers' average earnings, add the earnings in all months and divide by the number of months worked.

Total earnings $6,735 / 6 months worked = $1,122.50 average earnings per month.

The average earnings are below the 2018 SGA limit of $1,180. The POD is 12/25/2017. This is the date she last performed SGA level work activity.

Averaging Determination

A determination the individual is engaging in SGA, based on averaged earnings, can usually be made by comparing the person's monthly countable earnings with the monthly amount shown in the Earnings Guidelines. If when the person's countable earnings are averaged, indicate SGA, the individual is considered to have engaged continuously in SGA during the entire period of work activity.

Special Considerations to Consider when Averaging

Changing Types of Work at the Same Employer

If the place of employment remains the same, but the NH switches to a different type of work, you must average the periods of work separately.

EXAMPLE:

John worked for Anderson Manufacturing from 01/2018 – 12/2018. From 01/2018 – 06/2018 he was an assembly-person. Due to changes in his medical condition, he was unable to continue as an assembly-person, so from 07/2018 – 12/2018 he worked as a janitor in the same company.

His earnings in 01/2018 – 06/2018 must be averaged separately from his earnings in 07/2018 – 12/2018 because he was performing different types of work.

Averaging when there are Changes in the Yearly SGA Limit

If there is a change in the SGA limit, you must average the periods of work under each limit separately.

EXAMPLE:

Greg filed for DIB on 07/09/18. He says he became disabled 07/04/17 and could no longer work at a substantial level. He worked from 09/05/17 – 04/25/18 as a cook in a local restaurant. His earnings were as follows:

09/17	$1,108	01/18	$1,210
10/17	$1,340	02/18	$1,010
11/17	$1,092	03/18	$1,190
12/17	$1,276	04/18	$1,170

The SGA level in **2017 was $1,170**. The SGA level in **2018 is $1,180**. We cannot average the earnings in 2017 with the earnings in 2018.

2017 total earnings $4,816 / 4 months of work activity = $1,204 average earnings. This is **above** the $1,170 SGA limit.

2018 total earnings $4,580 / 4 months of work activity = $1,145 average earnings. This is **below** the $1,180 SGA limit.

Greg's earnings are above the SGA levels in 2017 and below in 2018. His POD will not be the same as his AOD of 07/04/2017. Based on his averaged earnings being above SGA in 2017, his POD is 12/31/2017. This was the day he last performed SGA level work activity.

Averaging Non-Work Months

Do not average earnings for months the person was not working. When an individual has periods of non-work mixed in with periods of work, determine if you need to average over the entire period or average each period separately by looking at the type of work performed before and after the interruption of work activity.

EXAMPLE:

Professor B earns a yearly salary of $10,800 teaching at a local college. He receives $900 every month, but he only performs services in January – May and September – December. To determine his average monthly earnings, we must divide the $10,800 annual salary by the number of months he is actually performing services.

$10,800 / 9 = $1,200.00 average earnings per month. This is over the SGA limit for 2018. We would determine Professor B is performing SGA for the months he was performing services.

Averaging Partial Work Months

DI 10505.015 B

When a person worked for a continuous period of time, but is no longer working, average the earnings over the actual period of time he or she was actively engaged in work activity <u>if</u> there are no significant changes in the earnings or work pattern. This completed period of work may contain two partial months of work activity--the month work began and the month work stopped. To determine if these partial months should be included in the averaged period depends on whether there was a significant change in either the earnings or the pattern of work activity when compared to the rest of the period of employment.

Consider all the facts when comparing the work activity in the first and last months with the rest of the period of employment. Some factors to consider include:

- Amount of Earnings

- Number of days worked

- Job duties and responsibilities

If, after considering all of the factors, you determine the partial months do not represent a significant change, include them in the period to be averaged. If you determine they represent a significant change in the work pattern or earnings, do not include those months.

We do not want to lower the average monthly earnings artificially by including months that are not representative of the rest of the period of employment. This is the reason we do not include partial work months with significantly lower earnings.

EXAMPLE:

Paul Davis filed for DIB 12/13/2018 with an AOD of 06/01/2018. He had worked from 01/05/2018 – 07/04/2018. His earnings were as follows:

01/18	$1,240	05/18	$1,290
02/18	$1,140	06/18	$1,130
03/18	$1,230	07/18	$ 375
04/18	$1,130		

First, determine if the partial months should be included in the average.

- The month of January does not represent a significant change in the earnings, so we will include it in the average.

- The earnings in July are significantly lower than the other work months, so we will NOT include it in the average.

Second, determine the average monthly earnings for the period of work activity that represent his earnings.

Third, add the earnings included in the average period: 01/18 through 06/18 = $7,160 / 6 months = $1,193.33

Paul performed SGA because his average earnings are more than the 2018 SGA limit of $1,180.

Fourth, determine the Potential Onset Date to provide to DDS.

- The averaging determination applies to the entire period of work activity. For Paul, this period runs from 01/05/2018 – 07/04/2018. Even though we exclude July when we average, we do not exclude it when we figure out the POD, because he was still engaging in SGA in January. Based on his entire work period, we will alert DDS to a POD of 07/04/2018. This is the last day he was performing SGA level work activity.

Refer to **DI 25501.220 A** for information on using the last day of the period of work activity as the POD for DDS.

Refer to **DI 10505.015** for a complete explanation of when averaging is appropriate.

Unsuccessful Work Attempt

Definition

DI 10501.055

An unsuccessful work attempt (UWA) is an effort to do substantial work (SGA) in employment or self-employment which stopped or was discontinued or reduced to a non-SGA level after a short time (no more than 6 months) because of the

individual's impairment or due to the removal of special conditions given at the workplace.

NOTE: In order to consider an unsuccessful work attempt (UWA), the claimant's earnings must be over the SGA limit. If earnings are below SGA, UWA is not applicable.

Events which Must Precede and Follow a UWA

DI 11010.145 & DI 24005.001

There must be a significant break in the work before the person can be considered to have started a work attempt that later proves unsuccessful. A significant break occurs when the person:

- Discontinued or reduced their work to a non-SGA level because of the impairment, or the removal of special conditions related to the impairment; or
- Discontinued or reduced work to a non-SGA level prior to the alleged onset date for reasons unrelated to the impairment; or

- The person never previously engaged in work activity.

Work may also stop, or be reduced to a non-SGA level, because the special work conditions which once helped a person keep the job, despite their limitations, are now gone. A significant break would exist if the person were:

- Out of work, or has earnings reduced to a non-SGA level, for at least 30 consecutive days; or

- Forced to change to another type of work or go to another employer

NOTE: On rare occasions, a break lasting less than 30 days may satisfy this requirement if the subsequent work episode was brief and clearly not successful because of the impairment. **DI 11010.145 C.2**

UWA Requirements

DI 11010.145

Work Effort Lasting Under 6 Months:

To qualify as a UWA, the work must have ended or the earnings were reduced to non-SGA levels within 6 months; **and** the work needs to have ended due to the:

- Disability, or

- The removal of special work conditions which would have helped the person to continue working.

FO Documentation for UWA

Verification is not required when the work effort lasted six months or less, the alleged reason for the stoppage or reduction of work is the impairment or removal of special conditions that took into account the impairment and permitted the individual to work. Remember to document the claimant's allegation on the appropriate work activity report.

Work Effort Lasting Over 6 Months:

Work at SGA level, which lasts longer than 6 months, cannot be a UWA regardless of why it ended or why income dropped below SGA levels.

NOTE: Seasonal or recurring work should not be regarded as a series of UWAs since each period of work ended due to reasons unrelated to the impairment.

EXAMPLE 1:

Beau Archer is filing for disability benefits. He says he has been unable to work after he was diagnosed with cancer on 06/05/18.   He tried to return to work 08/15/18 and continued until 12/15/18 when his condition worsened. During that time, he received a gross salary of $1,510.00/month.

Question: Does this qualify as a UWA?

Answer: Yes, because Beau had a break in employment of more than 30 days prior to his return to work. He worked above SGA for less than six months and alleged his work stopped due to his condition.

EXAMPLE 2:

Ann Teak is filing for disability benefits based on a heart condition. She left her full time job at a large manufacturing plant on 05/10/18. After undergoing a series of treatments, Ann felt well enough to go back to work. She worked full time again from 09/15/18 through 12/09/18 and earned $1,260/month. She has not worked since 12/10/18 because of her disability.

Question: Does this qualify as a UWA?

Answer: Yes. Even though Ann worked at SGA levels for almost three months, her work ended due to her disability and there was a significant break in employment before her return to work.

EXAMPLE 3:

Kelly is filing for disability benefits. She stopped working due to her disability on 10/23/17. This is her alleged onset date. She returned to part-time work earning $1,450 a month from 03/03/18 through 05/30/18. She states her job ended because her husband's job relocated them to another state.

Question: Does this qualify as a UWA?

Answer: No. Although the job lasted less than six months, the job did not end because of her disability. It ended because her husband's job required them to move.

EXAMPLE 4:

Jack is filing for disability benefits. He stopped work 08/28/18 because of his disability. He returned to work 11/05/18 and earned $990 a month. This job ended 01/01/19 due to his disability.

Question: Does this qualify as an UWA?

Answer: No. His monthly earnings are below the SGA amount. UWA applies only when earnings are above SGA.

EXAMPLE 5:

Doris works only 30 hours per week for a large retail store due to a back injury. She earns $940 per month. She was asked to work more hours (due to staff shortages) and reluctantly agreed. From 10/02/18 to 12/18/18, she worked 40 hours per week and earned $1,243.33 per month. The extra hours

adversely affected her back condition and she was given permission to return to her old 30-hour workweek.

Question: Does this qualify as an UWA?

Answer: Yes. A significant break exists because Doris was working at a non-SGA level due to her impairment and the non-SGA level work lasted at least 30 days. Her subsequent SGA level work lasted less than 6 months and ended due to her disability.

DDS/FO Role

DI 11010.140

The FO documents and makes a recommendation regarding the existence of a UWA on the last page of the SSA-823. DDS has the final authority regarding the existence of a UWA in initial disability determinations.

Return to Work After Disability Claim Initiated

DI 13010.105

Processing Title II Claims Involving Work Activity

If a person is working or returns to work while he or she has an initial application pending in the FO or at DDS, you will need to undertake SGA development. You may need to complete Form SSA-821 or SSA-820 with the individual and prepare an SGA determination on the SSA-823 if the earnings do not meet the requirements for a clearly not SGA determination.

If the individual meets the requirements for a "clearly not SGA" determination, simply annotate your determination by notifying DDS of the work activity via an Update After Transfer (UAT) action in EDCS. If the individual is performing SGA, your action will depend on when the person returned to SGA level activity.

Return to Work in the Waiting Period

When an individual returns to work at the SGA level while in the waiting period and continues to perform SGA, deny the claim and complete Form SSA-831. If

the claim is awarded, reopen the determination and revise the allowance to a denial by completing an SSA-831.

Work is Fewer Than 12 Months from Onset Date but <u>Prior</u> to Final Determination

If an individual returns to work at SGA levels in fewer than 12 months from the date of onset and before SSA processes the final determination, the application will be denied.

Procedure: contact the DDS and let them know of the revised determination about work due to new information. You can do this by notifying DDS electronically through a message in eView or calling the examiner directly. They will transfer the folder back to you, and you can prepare an SSA-831, if applicable.

You will learn how to process an SGA denial in the DIB Adjudication lesson.

The person will **not** be protected from denial by the Trial Work Period (TWP) provisions. (The TWP will be covered in the Advanced CDR Training.) **DI 13010.035** has additional information regarding the TWP.

NOTE: If after returning to work at the SGA level, the individual subsequently stops SGA work prior to the final determination, you will develop the work activity for the earliest possible onset and notify DDS of the work attempt.

Work is Fewer than 12 Months from Established Onset Date but <u>After</u> Final Determination

If an individual returns to work after the end of their waiting period and after the final medical determination is made by DDS, they could be protected from a denial by the TWP provisions or their case could be subject to a medical recovery review if there is a Medical Improvement Expected (MIE) diary on the claim. These issues are taught in detail in your advanced training lessons. **DI 13005.055 expands on Medical Improvement diaries.**

Work is More than 12 Months from Established Onset Date

When an individual returns to work at an SGA level more than 12 months from the date of onset, we will apply the Trial Work Period (TWP) provisions. This is

the procedure regardless of whether the work was before or after the final DDS determination. If the folder is still at the DDS pending a decision, send the SSA-821/820 along with the SSA-823 to DDS to verify and document the work took place more than 12 months from the established onset date.

NOTE: The procedure is different if the person meets the requirements for a "clearly not SGA" determination; it is important to notify DDS and document all work activity.

OBJECTIVE 3:

Identify situations in which self-employment represents SGA.

Evaluation of Self-Employment

DI 10510.000ff

Individual's Activities

When self-employment is involved, you must consider the person's activities and their value to a business. The earnings level alone in self-employment is not a reliable factor in determining SGA.

A person may receive substantial income from a business while performing little or no work. On the other hand, the individual may do a great deal of work and receive very little income.

You need to base SGA decisions for self-employed individuals on three tests. Consider all three tests before you make a determination the work is not SGA.

Please refer to **Exhibit 5** at the end of this chapter for an SGA Decision Guide for Self-Employment work activity. There are many guides to help you determine if a self-employed individual is engaging in SGA. **Exhibit 5** is a thorough systematic guide. Two other resources available online are the (b) (2)(b) (2)(b) (2)   and the (b) (2)(b) (2)(b) (2)

Test One: Significant Services and Substantial Income

Part One of Test One: Significant Services

DI 10510.015

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

- **One-Person Business** – In a one-person business, farm, or operation, services are always significant. Examples: carpenter, repairperson, bookkeeper, consultant, etc.

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

- **Two or More Person Business** – In businesses which 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 café. Larry had a stroke and was not able to come to the restaurant at all. Marilyn occasionally consults with Larry regarding suppliers and vendors, but no more than 5 hours a month. Marilyn estimates she spends about 45 hours per month on management tasks.

  Larry's services do not comprise more than half of the total management time needed to operate the restaurant and he works fewer than 45 hours per month for the business. His services are not significant for the business.

- **Farm Rental** – A farm property owner rents land to another farmer. If the property owner is contributing enough time and labor in the farm operation to be "materially participating" in the farm activities, we can determine he is performing significant services. See **RS 01803.700** for a complete definition of Material Participation.

Part Two of Test One: Substantial Income

We also need to evaluate the income from the self-employment business activity.

Income is considered substantial if:

- The countable income from the business averages more than the SGA amount ($1,180.00/month in 2018), or

- The countable income is less than the SGA amount, but the livelihood derived from the business is:

  - Comparable to the income which he or she had before the disability onset, or

- Comparable to unimpaired self-employed individuals in the community who are working at the same or similar business as their means of livelihood.

If both parts of Test One are met, then the person is found to be working SGA and we do not proceed to the next test. If either or both are not met, we need to proceed to Test Two.

Test Two: Comparability of Work Activity

DI 10510.020

If countable income does not average more than the SGA amount, consider it SGA if:

- The person's **work activity** is comparable to work by an unimpaired individual within the community who is operating a similar business as means of livelihood.

If we find the person's comparability of work activity to be SGA, we stop and make the determination of SGA. If we determine the comparability of work activity is not SGA, we proceed to Test 3.

Test Three: Worth of Work

DI 10510.020

Even though self-employment activity may not be Substantial Gainful Activity (SGA) under the Significant Services and Substantial Income tests or under the Comparability of Work rules, it still may represent SGA if it is still clearly <u>worth</u> more than the SGA amount.

You can determine the Worth of the Work activity by considering:

- Its value to the business, or

- The salary the owner would pay to an employee to perform similar services.

Determining SEI Countable Income

DI 10510.012

Work Activity Evaluated

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

NOTE: The "countable income" referred to in this module is computed by subtracting the items listed below from the net income shown on an individual's tax return.

Unpaid Help

We need to determine a reasonable monetary value of any significant unpaid help. This help does not represent regular, daily activities a member of the household performs for the individual. It would be the type of help to which a monetary value could be assigned.

EXAMPLE:

In 2018, Mary Ann Lowe operated a small bookstore by herself. After an accident, she required help unloading boxes of books and stocking the shelves. During this time, her nephew helped 10 hours per week without pay. Such part-time help would normally cost $9.00 per hour. Mary receives $90.00 worth of unpaid help per week.

Mary estimates her net income for the year 2018 will be $16,320.00. After deducting the value of the unpaid help, her countable income is $970.00/month throughout the 12-month period. How is this determined?

$16,320 /12 = $1,360.00   She has $1,350 net profit/month

$90 x 13/3   = $ 390.00   Monthly Amount of Unpaid Help

$1,360.00	Net Monthly Income
- 390.00	Monthly Unpaid Help
$ 970.00	Monthly Countable Income

Deduct IRWEs

IRWEs can be used to reduce countable income further if they are not deducted as a business expense on the individual's tax return. The entire amount paid for a particular item or service can usually be deducted from the net income. Follow the policy in **DI 10520.030** for determining how to deduct IRWEs.

Expenses Paid by Others

Certain business expenses or items of value paid for or provided by another person or agency, can also be deducted from net income. They are called un-incurred business expenses. An example is if the self-employed individual was provided space rent-free.

Soil Bank

Soil Bank payments are made to farmers for certain types of farming operations. The individual requesting deductions for Soil Bank payments should be able to submit evidence of their receipt of such payments.

Average Income

In order to average income, you first need to figure the amount of countable income that pertains to the period in question. Then, divide the income by the number of months in the period.

Averaging of earnings can only be carried out for periods in which similar SGA limits apply. When there has been a change in the SGA earnings limit, a new period of averaged earnings must begin. This is the same procedure used for employees.

Determine Countable Income for SEI

DI 10510.012 B

- Start with the Net Income from Self Employment (NESE)
- Deduct Unpaid Help (this is SE's form of subsidy)
- Deduct any IRWE
- Deduct any un-incurred business expenses
- Deduct Soil Bank Payments

- Average if needed

OBJECTIVE 4:

Complete the SSA-821-BK, SSA-820-F4, and the SSA-823.

Completion of Work Activity Forms

The SSA-821 for employees and the SSA-820 for self-employed persons are forms used to develop work and document:

- UWAs,

- Work issues,

- Countable earnings/subsidies/IRWEs.

Use the SSA-823 to document the SGA determination based on the above considerations.

Use the forms in initial claims, continuing disability cases (CDR), and appeals. They are designed to obtain information regarding a person's work activities. The SSA-821, SSA-820, and SSA-823 are found in EDCS, the eWork program and (b) (2)(b) (2)   In initial claims cases, we can use signature proxy to complete the forms. It is not necessary to restate the attestation script specifically for the SSA-821/820.

When completing the forms during an initial claim, it is preferred to use EDCS because the system will allow you to add the form directly to the claimant's electronic disability folder without printing the form or a barcode. When the SSA-821/820 is needed post-adjudicative, you can access them in electronic format through (b) (2)(b) (2). Then you can print the form for the individual to sign, if necessary. eWork is another option for initial and post-entitlement cases. It will pre-fill the claimant's past employers for you, but you will have to print out the document and generate a barcode to fax it into the claimant's electronic folder.

You can utilize many queries to obtain the necessary information to fill out the SSA-821/820 with the claimant. The (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)   ! (WHAT) query is a preferred process because it pulls all of the necessary queries into one online collection used to evaluate a claimant's work history.

SSA-821 Work Activity Report – Employee

DI 10505.035; **SSA-821**

Identification

The identification section contains personal data. SSA completes it prior to giving or sending the form to the applicant. It includes name, claim number, and the date the disability began. This date is the alleged onset date from the SSA-3368 and is the earliest possible date of onset.

Information – To Be Completed by Person Applying for or Receiving Benefits

Question 1

Ask if the individual has any employment income or wages since the date shown in the Identification section.

Question 2

Request additional information on any reported income that is not a result of the person's work activity. For example, vacation pay, sick pay, Worker's Compensation, etc.

Question 3

Request information about the NH's employers since the date shown in the Identification section. Enter the name, address, and telephone number for each employer and the job title or type of work. Show the dates of work, rate of pay, and average number of hours worked per week. There is also a place to record if the NH has pay stubs to submit, and if not, use the section below it to record an estimated monthly breakdown of earnings. Include any additional information in the Remarks section starting on page 6 of the form.

Question 4

Ask if the NH received any special payments from any employer in addition to their regular pay and list several examples. If the question is yes, then list the type of pay and details.

Question 5

Request information about special conditions on the job, which helps identify UWAs and possible subsidy. Ensure you ask the Employer Name and dates of the special conditions along with a brief description. Use this information to help determine needed development, if any, for your SGA decision.

Question 6

Use the information in Question 6 to develop for potential UWAs. List the type of change, the employer, the date, and the reason for change in Question 6A. Use Question 6B to record additional information about the work changes.

Question 7

Ask information about possible Impairment Related Work Expenses (IRWE) deductions.

Remarks

This is a space for any additional information at the end of the form. If there is not enough space to record the details of the work activity in any prior section, use the Remarks section to complete the information.

Signature

The person reviews the form and signs/attests where marked.

NOTE: Use Signature Proxy for the SSA-821. See **DI 81010.120** for full instructions.

SSA-820 Work Activity Report – Self-Employed

DI 10510.025; **SSA-820**

Identification

The identification section contains personal data. SSA completes it prior to giving or sending the form to the applicant. It includes name, claim number, and the date the disability began. This date is the alleged onset date from the SSA-3368 and is the earliest possible date of onset.

Information – To Be Completed by Person Applying for or Receiving Benefits

Question 1

Ask if the NH has any self-employment income since the date shown in the Identification section.

Question 2

Provides an opportunity for the NH to explain any income reported not based on work activity.

Question 3

Capture information about the business; i.e., name, address, primary service, dates of work, average number of hours, and type of ownership arrangement

Question 4

Provides space for the NH to record the net earnings for every month he/she worked and whether the NH worked more than 45 hours per month.

Question 5

Request all self-employment tax returns (including Schedule C & SE) since the date shown in the Identification section.

Question 6

Document if any other person, besides the NH, has any management responsibilities in the business. If so, request the specific number of hours spent in managerial activities for the NH and other person(s) along with a description of the duties.

Question 7

Document information to assist in making a UWA determination.

Question 8

Request information regarding potential subsidy for self-employment situations. This includes un-incurred business expenses, extra help, etc.

Question 9

Allows the NH to document any Impairment Related Work Expenses (IRWEs).

Remarks

A space for any additional information at the end of the form. If there was not enough space to record the details of the work activity in any prior section, use the Remarks section to complete the information.

Signature

Have the individual review the form, answer any questions he or she may have and then obtain his or her signature or the signature of the applicant on the form.

NOTE: Use Signature Proxy for the SSA-820 in initial claims situations. See **DI 81010.120** for full instructions.

SSA-823 Report of SGA Determination

DI 10505.035; **SSA-823**

In initial claims where you are required to complete an SSA-820 or SSA-821, you must complete the SSA-823, Report of SGA Determination. This form documents your SGA determination and alerts DDS to the best Potential Onset Date (POD).

Identification

The top of this form requests information on the claimant. Complete the claimant's name, SSN, and the claim number, if different.

Instructions

For an initial claim, complete the following sections:

1. Initial Claim section for initial Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) claims (page 1 – top of page 2).

2. Complete the Signature and Date section (bottom of page 3).

Initial Claim Section

Question 1

This section is divided into two parts. The top part is for SSDI claim considerations. Check all that apply to your case. The bottom part of Question 1 is for SSI Initial claim considerations, if you are a taking a concurrent application. Again, check any item that apply to your claim.

Question 2

This section is where you complete your determination and divides into three parts.

If the individual is clearly not engaging in SGA based on the three bullet points shown, check option A.

If the individual is clearly engaging in SGA based on the three bullet points shown, check option B.

Use option C to record your evaluation of work and potential onset date when further development is needed. For example:

- IRWE
- subsidy
- UWA
- Evaluation of the 3 tests for self-employment income – significant services, comparability and worth of work

Continuing Disability Review/Post Entitlement (CDR/PE)

Complete this section for SSDI Continuing Disability Review (CDR) and post-entitlement determinations. These questions are similar to the ones in the Initial Claim section. You will learn more about CDRs in Advanced Training.

Signature and Date

In every case, you must complete the Signature and Date section. The top part of this section records the evidence you used to make your SGA determination. Then sign the form electronically and record the date, FO code, and your phone number.

SSA-3033 Employee Work Activity Questionnaire

(b) (2)(b) (2)   **& DI 10505.010**

The SSA-3033 Employee Work Activity Questionnaire's is sent to the direct supervisor of the claimant. Its purpose is to help SSA establish the type and value of the subsidy provided and whether work is an unsuccessful work attempt. The form has 2 main sections:

- Section 1 asks about the existence of a subsidized work situation.
- Section 2 asks about the existence of an unsuccessful work attempt.

Cover page:

- Identifies the employer the forms are sent to
- Date the form is sent
- Worker's name and SSN
- Asks the form be filled by the direct supervisor of the claimant
- Basic Subsidy and Unsuccessful Work Attempt explanation
- Name and contact info of CS sending the form

Identification

Complete this area with the basic information the claimant has given you about their position and time spent at work.

Section 1 - Subsidy Questions

Question 1 & 2

Requests information about the person's ability to complete their usual work duties.

Question 3

Asks about the person's work attendance.

Question 4

Requests information about the person's ability to complete work timely as other employees.

Question 5

Requests information about any special assistance the person receives not given to other employees. The question gives a list that include existence of:

- fewer or easier duties,
- special transportation,
- extra help or supervision,
- special equipment and others.

Question 6

Asks about the person's productivity percentage rate when compared to other employees in a similar position.

Question 7

Asks whether the employer pays the person more than other employees in a similar position.

Section 2 Unsuccessful Work Attempt Questions

Question 1

Asks whether the person is frequently absent from work.

Question 2

Requests information about any special conditions such as extra help or supervision to do the work.

Question 3

Requests information on the person's work quality in comparison to other employers in a similar position.

Section 3 - Signature

Asks for the direct supervisor signature, date the form was filled and telephone number.

EXHIBIT 1: TABLE OF SGA EARNINGS

DI 10501.015

Effective Dates	SGA
2019	TBD
2018	Over $1,180 / month
2017	Over $1,170 / month
2016	Over $1,130 / month
2015	Over $1,090 / month
2014	Over $1,070 / month
2013	Over $1,040 / month
2012	Over $1,010 / month
2010 - 2011	Over $1,000 / month
2009	Over $980 / month
2008	Over $940 / month
2007	Over $900 / month
2006	Over $860 / month
2005	Over $830 / month
2004	Over $810 / month
2003	Over $800 / month
2002	Over $780 / month

EXHIBIT 2: TABLE OF BLIND SGA EARNINGS

DI 10501.015

Effective Dates	SGA
2019	TBD
2018	Over $1,970 / month
2017	Over $1,950 / month
2016	Over $1,820 / month
2015	Over $1,820 / month
2014	Over $1,800 / month
2013	Over $1,740 / month
2012	Over $1,690 / month
2011	Over $1,640 / month
2010	Over $1,640 / month
2009	Over $1,640 / month
2008	Over $1,570 / month
2007	Over $1,500 / month
2006	Over $1,450 / month
2005	Over $1,380 / month
2004	Over $1,350 / month
2003	Over $1,330 / month
2002	Over $1,300 / month

EXHIBIT 3: SGA DEVELOPMENT GUIDE – EMPLOYMENT

STEP 1:   Determine monthly countable income.

Start with gross wages—subtract:

- Subsidies first, then;
- Any IRWEs

STEP 2:   Compare monthly countable income to SGA amount. Use Averaging, if appropriate.

A. When countable Income exceeds the allowable limit, explore the possibility of a UWA. If a UWA is not possible, **STOP—**determine SGA exists.

B. If Countable Income is equal to or below the SGA amount or a UWA is possible, go to Step 3.

STEP 3:   Is there evidence indicating the individual may be engaging in SGA or the individual is able to control income (e.g. corporate officer, self-employed)?

- If no, omit comparability and worth tests and determine SGA does <u>not</u> exist (without evidence to the contrary work is SGA).
- If yes, go to comparability test.

When comparability test is met (work activity is comparable to the unimpaired worker doing the same job),

STOP—determine SGA exists*.

If comparability test is <u>not</u> met, then go to the worth test.

If the worth test is met (the worker's work activity is clearly worth more than the SGA amount),

STOP—determine SGA exists*.

*Whenever you determine SGA exists, you must explore the possibility of an unsuccessful work attempt (UWA).

EXHIBIT 4: NON-SPECIFIC SUBSIDY

DI 10505.010

Questions Used to Determine Amount of Subsidy

1. Why was the individual hired?

2. How are the person's total earnings computed?

3. What are the person's duties?

4. How much time does the individual spend on those duties?

5. Who did the job before the person was hired; and how much time did the person spend on the job duties?

6. If the individual no longer worked at the particular job, would he or she be replaced? If so, how much time would the replacement spend on the individual's tasks?

7. How often is the person absent from work?

8. Does someone else do the work when he or she is absent; and how much time does this worker take to do the individual's job?

9. Is the person's pay reduced proportionately when he or she is absent from work?

10. Does the individual receive any unusual assistance or supervision? Describe

11. Does the employer consider the work to be worth substantially less than what was paid? If so, what are the reasons for this view? Document the employer's estimate of the value and explain how the estimate is calculated.

12. Is the individual still on the payroll despite unsatisfactory work? If so, why?

13. If the person is no longer employed, why were they terminated?

EXHIBIT 5: SGA DEVELOPMENT GUIDE: SELF-EMPLOYMENT

TEST 1: BOTH Significant Services and Substantial Income

A. Significant Services

1. Is the business a one-person operation?

    If yes, significant services exist; go to 4. If no, go to 2.

2. If others are involved, does the claimant make more than half the management decisions or render management services for more than 45 hours/month?

    If yes, significant services exist; go to 4. If no, go to 3.

3. If the claimant's income is farm rental income, does the claimant materially participate?

    If yes, significant services exist; go to 4.

4. Do significant services exist?

    If yes, go to B. If no, go to TEST 2 below.

B. Substantial Income

1. Is the claimant's **monthly countable income** at the SGA level? To determine if it is:

    a. Divide the annual net SEI by the number of months the business was in operation. This yields the monthly net SEI.

    b. Deduct unpaid help.

    c. Deduct IRWE if not already deducted from gross earnings as a business expense.

    d. Deduct un-incurred business expenses.

    e. Deduct soil bank payments.

    f. Is the remaining monthly countable income at the SGA level?

If A.4 and B.1.f are both yes, claimant is engaging in SGA. If B.1.f is no, go to 2.

2. Is the claimant's **livelihood*** comparable to one they had before becoming disabled?

    If the self-employment activity started after the alleged onset date, go to 3 below.

    If the business existed prior to alleged onset date time, request tax returns for all years the business existed within the 5-year period prior to the alleged onset date. With the tax returns:

    a. Compare the gross income and expenses for the period prior to and following the alleged onset date. Use this as an indicator of any changes in the volume of sales and services, scope of the operation and employee salaries.

    b. Compare the claimant's services and duties for the period prior to and following the alleged onset date.

    c. Compare the number of employees/helpers and their duties for the period prior to and following the alleged onset date.

    d. Are there substantial differences in gross income, expenses, or the operation of the business for the period prior to and following the alleged onset date?

        If 2.d is no, the claimant's livelihood is comparable to his livelihood prior to becoming disabled and he is engaging in SGA.

        If 2.d is yes, go to 3 below.

3. Is the claimant's **livelihood*** comparable to that of an unimpaired self-employed person in the community engaged in the same or similar businesses as their means of livelihood?

    If yes, claimant is engaging in SGA. If no, go to TEST 2 below.

TEST 2: Comparability

Is the claimant's **work activity**, when considering all the relevant factors such as hours, skills, energy output, efficiency, duties, and responsibilities, comparable to the work of unimpaired individuals in the same community engaged in the same or similar businesses as their means of livelihood? Explain.

If yes, claimant is engaging in SGA. If no, go to TEST 3 below.

TEST 3: Worth of Work

Is the claimant's **work activity** clearly worth more than the SGA primary amount when considered in terms of its value to the business or the salary an owner would pay an employee for such duties in that business setting?

    a. Consider the average hours worked per month**

    b. Multiply by the hourly rate of pay***

    c. Determine the worth of work

    d. Is c. above the SGA level?

        If yes, claimant is engaged in SGA. If no, see below.

If final answer on all 3 tests is no, claimant is not engaged in SGA.

* Livelihood is the means of support or subsistence, the economic value of a claimant's situation. This would include countable income plus anything else of economic value. See **DI 10510.015.**

** Consider only the months that the business is in operation. Do not average in zero hours for the months the business was not in operation.

*** If the job is other than unskilled labor, call the state employment service or a company or self-employed individual in the same business. Ask what they would pay someone to do this kind of work. They may ask how many years of experience, what training, and what skills the person has before they can give you an hourly wage. Be prepared. An apprentice gets less than a journeyman and different skill levels are paid differently. The economy will also affect wages and worth.

OFF AIR ACTIVITIES

Activity #1: Provide the word that matches the following definition. (A list of all possible answers is listed below.)

1. A person's job or career _____

2. Hourly pay or income (not self-employment income) _____

3. A person who doesn't work for wages; a person who has his or her own business is considered to be _____

4. Word to describe earnings over the primary amount level _____

5. A type of SSA benefit a person may file for if they become ill and are unable to work _____

6. The agency which makes medical decisions on initial disability claims and medical Continuing Disability Reviews (CDRs) _____

7. A payment made to an employee above the reasonable value of the work being performed _____

8. The expense of this item occurs because an item or service is needed to enable a person to work _____

9. The actual value/earnings of the work being done by an individual after allowable work expenses and incentives are deducted _____

10. A method of computation to determine the regular amount of monthly earnings attributable to a certain length of time in which a person's income fluctuates _____

11. Changes in policies which affect certain parts of the country and address the manner in which SSA applies the law to applications and claims reviews _____

Word List:

Subsidy	Acquiescence Rulings	Vocation	Countable Earnings
Averaging	Self-Employed	DDS	Wages
IRWE	Disability	SGA	

Activity #2: If there are any sheltered workshops in your area, discuss them with your mentor. Explain how wages earned there by beneficiaries are handled by your FO.

Explain any subsidies or IRWEs involved.

Also, look up and read any precedents written about the workshops.

Activity #3: Sit in and observe a T2 disability interview conducted by your mentor or another CS.

Activity #4: Review at least two completed SSA-821s AND SSA-820s (if possible) along with their completed SSA-823 determinations. Discuss the documentation process with your mentor.

Activity #5: Review **DI 10505.005 D** with your mentor. Then examine each type of earning verifications listed in the hierarchy (if possible). Discuss how to request and interpret them.

OFF AIR ACTIVITIES – ANSWERS

Activity #1

1. A person's job or career – **Vocation**

2. Hourly pay or income (not self-employment income) – **Wages**

3. A person who doesn't work for wages; a person who has their own business is considered to be – **Self-Employed**

4. Word to describe earnings over the primary amount level – **SGA**

5. A type of SSA benefit a person may file for if they become ill and are unable to work – **Disability**

6. The agency which makes medical decisions on initial disability claims and medical CDRs – **DDS**

7. A payment made to an employee above the reasonable value of the work being performed – **Subsidy**

8. The expense of this item occurs because an item or service is needed to enable a person to work – **IRWE**

9. The actual value/earnings of the work being done by an individual after allowable work expenses and incentives are deducted – **Countable Earnings**

10. A method of computation to determine the regular amount of monthly earnings attributable to a certain length of time in which a person's income fluctuates – **Averaging**

11. Changes in policies which affect certain parts of the country and address the manner in which SSA applies the law to applications and claims reviews – **Acquiescence Rulings**

EXERCISE #1

OBJECTIVE 1: Substantial gainful activity and Verification of Earnings.

1. In your own words, give a brief description of substantial gainful activity (SGA).

2. What is the SGA Amount for a non-blind wage-earning person in 2018 and 2019?

3. Ursula R. Welcome worked for B&C Farms as a Receptionist and Accountant until December of last year. She filed for disability in January. Because she was the accountant, she is able to tell you what her earnings were from the period her disability began until she stopped working. Based on her allegations, some months were over SGA while others were under SGA. Because she has such accurate recall of her earnings, you do not contact her employer to obtain proof.

    True or False.

4. When verifying wages, use whatever evidence is the easiest to obtain.

    True or False.

EXERCISE #2

OBJECTIVE 2: Identify situations in which wages represent SGA.

Part 1

1. Mr. Douglas has an initial application for disability pending at DDS. The FO determines Mr. Douglas has just returned to work and is performing at SGA levels. He stated on the application that his disability began four months ago and he worked SGA up until that point. What effect, if any, does this have on how SSA will process his disability application?

2. In 2018, Park A. Studebaker worked for a small automobile tune-up business owned by his friend. He was working 40 hours a week until he hurt his back in June. Since then, he has continued to be paid for 40 hours of work per week, but because of his back ailment, he alleges he has physically only been able to put in 20 hours of work a week. Contact with the employer verifies this reduction in work activity and verifies he is continuing to pay Mr. Studebaker his full salary. His gross wages are $420 per week. Is Mr. Studebaker performing SGA?

3. Bonnie Robbins was employed as a floral designer earning gross wages of $1,210 a month in 2018, which was the usual wage for a part-time worker in her area. She lost the use of her legs, stopped work in 08/2018 and has used a wheelchair since then. She bought the wheelchair in 08/2018 and started paying $110 a month out of her own pocket to purchase it. The wheelchair will be completely paid for in 12/2019. She returns to work in 11/2018 and continues to work at the same rate of pay. Since returning to work, has Bonnie been performing SGA? Please explain your answer.

Part 2

Referring to the chart in **Exhibit 3** and what you have learned in this module, analyze the two following scenarios and provide answers and rationales for each.

4. Last year, Betty Dwyer worked 15 hours a week at a local dry cleaner. Her wage was $19 per hour. She paid $70.00/month for her medications. Without them, she would not have been able to work. She paid this expense herself. She has no medical insurance coverage. Was her work at SGA levels?

5. The same information applies here as it did in Question 4, except Betty works 18 hours a week and pays $90.00 each month for her medications. After talking with her employer, you learn Betty is assigned fewer duties and takes more breaks than other employees due to her condition. In addition, one of Betty's friends is employed at the dry cleaners. When Betty falls behind on her work, her friend will provide extra help to keep her caught up. The employer estimates Betty is only at about 90% of other employees' productivity. Is Betty's work at SGA levels?

Part 3

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

6. John Miller files for disability today. He is a resident of the City Vocational Training Center. He is also an employee in the center's workshop. It has been determined the workshop provides sheltered employment for its residents and other handicapped individuals. Mr. Miller is currently earning $40 per day and works 21 days a month. His work involves simple assembly of household products marketed by the workshop.

7. Chris P. Bacon files a claim in July 2018. He alleged his disability onset was June 15, 2017 when he was involved in a serious vehicle accident and stopped working. Prior to the accident, he had been earning $25,000.00 per year at a local meat processing plant. He attempted to return to work February 25, 2018. His countable earnings were as follows:

    February 2018 $315.00

    March 2018 $1,180.00

    April 2018 $1,170.00

    May 2018 $1,125.00

    June 2018 $460.00

    During this period of work, he was frequently absent due to his condition. He finally quit work June 10, 2018, because he was in too much pain to continue working.

8. Cheri Pitts has filed an application for disability benefits alleging an onset date of June 2018. She continues to work 35 hours/week at a local grocery store. Her

earnings are $1,200.00 per month with no change. Her employer says Cheri does about the same work, at the same level and for the same number of hours as other employees do for the store.

9. Penny Dollar works as a bank teller and earns a fixed salary of $1,290 per month. She says she is too ill to work, but needs the money to survive until she can secure some other financial assistance. She says she misses many days due to illness and her employer gives her a "break."

    When you contact the employer, you are told Penny uses more sick leave than other employees do. Penny's work is not as good as it has been and it takes her longer to finish routine projects. She is kept on the payroll because of her past loyalty. The employer also knows Penny is struggling with a serious illness.

    When asked to be specific, the employer states Penny is doing about 75 percent of the quality and quantity of what is normally expected of an employee. In arriving at this figure, the employer considers Penny's increase absences and her decreased speed and accuracy.

10. Derrick West sorts parts in a factory. He states he is blind since birth but has no other physical impairment. He earns $390 per week. His employer claims his work is fully satisfactory. He needs some special assistance on occasion, but more than compensates by being so prompt and dependable.

EXERCISE #3

OBJECTIVE 3: Identifying situations in which self-employment represents SGA.

Decide if the work represents SGA or need further development to reach a decision.
Give a brief rationale of your decision.

1. Xavier Benedict filed for disability benefits December 2018. He was a self-employed
    carpenter, but he stopped working four months ago when he had a heart attack.
    Today he calls you to report he began working again last week. He is now self-
    employed as a maintenance man in the apartment building where he lives. He
    works 3 hours a day, 5 days a week, and for this, the building manager gives him
    $10 an hour. He does not receive any other compensation. He is the only person in
    the business, but he does not make the decisions as to what he will work on or
    where he will work. Is Xavier working at SGA levels? Why or why not?

2. Gail Storm owns a tavern. She is physically unable to be on the premises of the
    business because she has severe emphysema and cannot tolerate smoke. Her
    daughter has taken over all day-to-day management activities, spending 22 hours a
    week performing these activities without pay. It is estimated in order to hire a
    manager; Gail would have to pay someone $10 an hour for comparable activities.
    Her net profit last year was $14,400 and she expects the same this year. Is her
    work activity considered at SGA levels? Explain why it is or is not considered SGA
    by SSA.

EXERCISE #4

With the assistance of your mentor, complete an SSA-821 using the following information:

John Jacobson is filing for disability benefits today. It has already been determined he is insured. He is not blind.

- His alleged onset date (AOD) is 10 months ago.

- Prior to the AOD, he was working full-time (40 hours per week) at The Fir Tree Factory, 1967 Stonewood Way, Duluth, Minnesota 55802. Phone number: 218-555-1234. He worked as a log cabin builder and earned $25.00 per hour.

- His alleged disability is a back injury.

- Mr. Jacobson's doctor feels he will never be able to return to full-time work, but did release him to return to his job part-time.

- Mr. Jacobson returned to work 6 months ago for the same employer for the same rate of pay.

- He worked 3 days a week, 8 hours a day.

- Mr. Jacobson no longer did heavy lifting, but he performed all other normal duties of the job (i.e., building scaffolding, positioning and securing the logs, hammering, etc.). He rested frequently.

- Mr. Jacobson was "let go" 2 months ago because of his inability to perform the job satisfactorily due to his disability.

EXERCISE ANSWERS

Exercise #1

1. It is the performance of significant physical and/or mental work activities for pay or profit.

2. In 2018, $1,180.00 per month in countable wages.

3. False. Verification of an individual's earnings from employment is always required unless the earnings are clearly above or below SGA. **DI 10505.003** and **DI 10505.005**

4. False. To determine monthly countable income when a beneficiary alleges earnings above SGA, request verification using the order of priority set forth in **DI 10505.005 D** which is as follows:

   - Third-party payroll provider documents earnings when earned

   - Paystubs

   - Shared process screen and Paystub feature in eWork

   - SSA-L725

   - Third-party payroll provider documents when paid

   - SSI verified wages

   - National Directory of New Hires (NDNH)

   - IRS earnings on the SEQY/DEQY

   -

Exercise #2

Part 1

1. Because Mr. Douglas has demonstrated the ability to engage in SGA within the waiting period, he cannot be found disabled for Social Security purposes. The FO

should request that DDS return the folder and process an SGA denial. Mr. Douglas cannot be disabled regardless of how severe his impairment is.

2. A subsidy applies in this case and work is not SGA. Because of the personal friendship between the employer and employee, Park continues to be paid a full-time salary for working part-time hours. Gross wages of $420 per week generates monthly earnings of $1,820 ($420 x 13/3). Park is 50 percent subsidized.

    $1,820 x 50 percent = $910 subsidy

    Unsubsidized wages are $910/month. These are not at SGA levels
    DI 10505.010.

3. An IRWE applies in this case. Bonnie earns $1,210 a month, but since her wheelchair is necessary for her to work and she has been making the payments for it herself, we can subtract the $110 a month she pays, making her countable earnings $1,100 month. This amount is not **more than** the SGA level for 2018 <u>or</u> 2019. (**DI 10501.015** and **DI 105200.00**)

Part 2

4. No

    <u>Rationale</u>:

15 hours/week	$285/week
x $19/hour	x 13/3
$285/week	$1,235 monthly wages

    $1,235 monthly wages
    <u>- $70 monthly IRWE</u>
    $1,165 countable income (which is not SGA in 2018)

5. Yes

    <u>Rationale</u>:

18 hours/week	$342/week
x $19/hour	x 13/3
$342/week	$1,482 monthly wages

    Remember, when you are finding countable earnings **you must subtract subsidy first,** and then apply any applicable IRWE.

    $1,482 monthly wages

x   .10 subsidy %
    $148.20 monthly subsidy

$1,482.00 monthly wages
-   148.20 monthly subsidy
-    90.00 monthly IRWE
$1,243.80 countable income (which is SGA for 2018)

Part 3

6. <u>Not SGA</u> - Mr. Miller's monthly earnings average $840 which is not more than the SGA earnings amount and there is no evidence to suggest he may be engaging in SGA. **DI 10505.020**

7. <u>Not SGA</u> - In this situation, SSA could still use 06/15/2017 as the alleged onset date. The months of work in question can be identified as an UWA since he had a significant break in work, it was less than six months, and his work ended due to his condition. **DI 11010.145**

8. Work is SGA. There is no evidence of subsidy. **DI 10501.015**

9. Work is not SGA. The employer alleges a subsidy of 25 percent per month. This reduces the average monthly earnings to $967.50, which is below the earnings limit. **DI 10501.015**

10. Blind individuals have a higher SGA limit than other disabled individuals under the Title II program. The SGA limit for blind individuals for Title II in 2018 is $1,970 per month. Mr. West's earned income of $1,690 is below the blind SGA limit without considering reductions in gross earned income such as IRWEs and Subsidies. **DI 10501.015**

$390.00/week
X   13/3
$1,690 monthly earnings

Exercise #3

1. Work is <u>not</u> SGA. The earnings are not substantial though the services are significant as a one-person business. There is no indication the work is comparable to that of an unimpaired person or the work is worth over the SGA level. **DI 10510.015** - **DI 10510.020** (Also refer to **Exhibit 3**)

Rationale: 15 hours/week x $10/hour = $150/week.

$150/week x 13/3 = $650.00/month in income

2. The value of unpaid assistance is $220/week or $953.33/month.

22 hours/week x $10.00/hour = $220.00/week x 13/3 = $953.33/month.

Gail's income is $14,400 divided by 12 months = $1,200/month.

$1,200 - $953.33 = $246.67/month in countable income. The countable income is NOT SGA.

The larger issue is whether she is performing any services. If she is performing any services, then she may meet Test 2 or 3, depending on what work activity she actually performs. She could be doing all of the bookkeeping and taxes from home or other administrative functions which do not require being present in the tavern. We need more information to evaluate her work activity. **DI 10510.000**

Exercise #4

This is a hands-on activity with the assistance of the mentor. Review the completed SSA-821 together and discuss any questions you have regarding how the form should be completed. You should also take a few minutes to discuss Mr. Jacobson's date of onset and possible unsuccessful work attempt (UWA).

TABLE OF CONTENTS

LESSON PLAN

Module Objectives

At the completion of this module, the students will be able to:

1. Understand DIB Insured Status.

2. Understand Date Last Insured (DLI), Date First Insured (DFI), and How to Document Insured Status.

3. Verify Insured Status.

Length of Chapter

8 hours

BACKGROUND AND RATIONALE

Insured Status

Insured status requirements under disability are different from RSI requirements. In addition to being fully insured, a worker must have worked in covered employment for at least 5 of the 10 years (20 out of 40 quarters) before the onset of disability.

A less restrictive insured status requirement applies to persons who are disabled before the quarter of attainment of age 31 or who are determined to be statutorily blind.

Quarter vs. QC

A Quarter is a period of time.

- 01/01 through 03/31 is the March Quarter or the 1st Quarter.
- 04/01 through 06/30 is the June Quarter or the 2nd Quarter.
- 07/01 through 09/30 is the September Quarter or the 3rd Quarter.
- 10/01 through 12/31 is the December Quarter or the 4th Quarter.

Since 1978, a QC (Quarter of Coverage) can be assigned to any quarter in the calendar year, if an individual's earnings allow assignment. Up to four QCs can be applied yearly.

OBJECTIVE 1:

Understand DIB Insured Status

DIB Insured Status

RS 00301.120ff

DIB Insured Status

> To be insured for DIB, a NH must be **BOTH** fully insured <u>and</u> meet 20/40 <u>or</u> special insured status in the quarter of onset.

> If the NH is not insured in the calendar quarter of onset but meets insured status at a later point, the ending period for computing insured status is extended to the quarter when insured status is met.

> The process to determine DIB Insured Status depends on whether the NH had a prior period of DIB.

Determining DIB Insured Status

Age 31 or Over

> ### <u>Fully Insured</u>
>
> **RS 00301.105** & **RS 00301.120B.2**
>
> To determine fully insured status for DIB we take the year of disability onset minus the year of attainment of age 22.
>
> This is the number of QCs the NH must have on their earnings record. These QCs can be anywhere on the earnings record. The minimum number of QCs needed for fully insured status is 6 and the maximum is 40.

EXAMPLE: Mr. Clay

DOB: 11/22/83; Date of Onset 11/12/18

Start by determining if Mr. Clay meets fully insured status.

We take the year of onset minus the year of attainment of age 22.

The year of onset is 2018.

The year of attainment of age 22 is figured by:

1983 + 22 years = 2005

Mr. Clay attained age 22 in 2005.

2018(year of onset) – 2005 (year of attainment of age 22) = 13 QCs

Mr. Clay needs 13 QCs to be fully insured.

Mr. Clay has 30 QCs on his earnings record and is fully insured.

20/40 Insured Status

RS 00301.120

The 20/40 QC requirement is in addition to the fully insured status requirement. A NH must have 20 QCs during the 40 quarter period ending with the quarter of onset. The QCs counted for 20/40 must be within a certain timeframe.

Now we must determine if Mr. Clay meets 20/40. Let's look at Mr. Clay's earnings record.

2007—CCCC	2011—NNNN	2015—NNNN
2008—CCCC	2012—CCNN	2016—CCCC
2009—{CCCC	2013—CCCC	2017—CCCC
2010—NNNN	2014—CCCC	2018—NNNN}

We count 40 calendar quarters beginning with the 12/18 quarter, the quarter of onset back to the 03/09 quarter. There must be 20 QCs within this period. Mr. Clay has 22 QCs within this period. He meets 20/40 Insured status.

NOTE: It's important to remember Quarters of Coverage are flexible which means they can be moved within a calendar year if they are needed to meet insured status. **RS 00301.230B**

After age 24 to 31 Requirements

Fully Insured

Younger individuals must meet the rules for fully insured status as previously stated. We take the year of onset minus the year of attainment of age 22 to figure the number of QCs required for fully insured status. Remember, the minimum number of QCs for fully insured status is 6.

EXAMPLE: Mrs. Crawford

DOB 06/14/89; Date of Onset 01/10/19

2019 (year of onset) – 2011 (year of attainment of age 22) = 8 QCs anywhere on the earnings record.

Mrs. Crawford has 17 QCs on her entire earnings record, so she is fully insured.

The One for Two Rule

RS 00301.140

Individuals disabled after the quarter of attainment of age 24 and before the quarter of attainment of age 31 are often too young to meet the 20/40 insured status requirement. If the NH does not meet 20/40, we can use the special DIB insured status requirement.

To meet the special DIB insured status requirement, a NH must have 1 QC for every 2 quarters from the period ending with the quarter of disability onset to the quarter after age 21 attainment. Quarters of coverage earned in or before the quarter of attainment of age 21 may **NOT** be used to meet this requirement with the exception of moveable QCs within that year. See **RS 00301.230B** for more information on moveable QCs.

EXAMPLE: Mrs. Crawford

DOB 06/14/89; Date of Onset 01/10/19

2008—NNNN	2012—CNNN	2016—CNNN
2009—NNNN	2013—CCCC	2017—NNNN
2010—NN{NN	2014—CCNN	2018—CCNN
2011—CCCC	2015—CCCN	2019—N}NNN

There are 35 quarters in the period starting with the quarter of onset (03/19) back to the quarter after attainment of age 21 (09/10).

To figure the number of QCs needed in the period, we divide the number of quarters by 2. Because there is an odd number of quarters in the period, we take 35 minus 1 to get 34. 34 divided by 2 equals 17.

17 QCs must be within the 35 quarter period in order for the One-for-Two DIB special insured status to be met. Because Mrs. Crawford has 17 QCs in the period, she meets the requirement.

Age 24 or Younger Requirement

Fully Insured

Fully Insured status for individuals disabled in the quarter of attainment of age 24 or younger is the same as previously described. Remember the minimum number of QCs for fully insured status is 6.

EXAMPLE: Ms. Nelson

DOB 04/05/97; disabled 01/18/19

2019 (year of onset) – 2019 (year of attainment of age 22) = 0.

Remember the minimum QCs required is 6. Ms. Nelson needs 6 QCs anywhere on her earnings record, and she has 6 so she meets fully insured status.

The Six-Out-of-Twelve Rule

Individuals who become disabled in the quarter of attainment of age 24 or younger often do not meet the 20/40 requirement. If they do not meet 20/40, we can use the "six out of twelve rule" which requires 6 quarters of coverage in the 12 quarters ending with the quarter of onset. This method **can** include quarters before age 21 if they occur in the 12 quarter period.

EXAMPLE: Ms. Nelson

DOB 04/05/97; disabled 01/18/19

2016—C{CNN	2018—CNNN
2017—CCNN	2019—C}NNN

Ms. Nelson has 5 QCs in the 12 quarter period from 03/19 back through 06/16, but QCs are flexible. We can move the QC from 03/16 into the 09/16 or 12/16 quarter period in order to provide insured status for Ms. Nelson. (**RS 00301.230 B**)

Earnings Record after moving QCs

2016—N{CNC	2018—CNNN
2017—CCNN	2019—C}NNN

Now, after moving the QC for 03/16, Ms. Nelson has 6 QCs in the 12 quarter period from 03/19 back through 06/16. She does meet the "six out of twelve" DIB special insured status requirement.

Determining DIB Insured Status (Prior Period of DIB)

Age 31 or Over

Fully Insured and has a Prior Period of DIB

To determine fully insured status for DIB we take the year of disability onset minus the year of attainment of age 22.

For cases involving a prior period of disability, the years either wholly or partially within a prior period are not counted when determining the number of QCs needed for fully insured status.

EXAMPLE: Mr. Fulton

DOB: 09/22/1970; Current Onset: 11/22/18

Prior Period of Disability: 02/08/04 – 11/14

We determine the number of QCs required for fully insured status by the year of onset (2018) minus the year of attainment of age 22 (1992).

2018 (year of onset) – 1992 (year of attainment of age 22) = 26 QCs

If there were no prior period of disability, we would review the earnings record and count the number of QCs on the entire record. If Mr. Fulton had 26 QCs or more, he would be fully insured.

Because Mr. Fulton has a prior period of disability we need to complete an extra step. We start by determining the number of years either wholly or partially within the prior period of disability.

The prior period of disability is 02/08/2004 through 11/2014. We count all years either partially or wholly within this prior period of disability, so we count 2004 through 2014, and we get 11 years.

2004   2005   2006   2007   2008

2009   2010   2011   2012   2013   2014

Then we take the number of QCs (26) and subtract the number of years either partially or wholly within the prior period of disability (11).

26 – 11 = 15 QCs

If Mr. Fulton has 15 QCs anywhere on the earnings record, he meets fully insured status. Notice the prior period of disability reduces the number of QCs he needs for fully insured status.

20/40 and Prior Period of DIB

A NH must have 20 QCs during the 40 quarter period ending with the quarter of disability onset. Without a prior period of disability we simply started with the quarter of onset and counted back 40 quarters. We then counted the QCs in that period and if we had 20, the NH met 20/40.

When an individual has a prior period of disability, any QUARTER during a prior period of disability is excluded from the 40 quarter period.*

EXAMPLE: Mr. Fulton

DOB: 09/22/1970; Date of Onset: 11/22/18
Prior Period of Disability: 02/08/04 – 11/14

1995—CCCN	2003—CCCC	2011—NNNN
1996—CCCC	2004—[NNNN	2012—NNNN
1997—NNNN	2005—NNNN	2013—NNNN
1998—{CNNN	2006—NNNN	2014—NNNN]
1999—CCNN	2007—CCNN	2015—CCCN
2000—CCCN	2008—CCCN	2016—NNNN
2001—NNNN	2009—CNNN	2017—CCCC
2002—CCCN	2010—CCNN	2018—CCNN}

To figure 20/40, we begin by distinguishing the prior period of disability. The beginning of the PPD is the first quarter in 2004 and the ending of the PPD is the last quarter in 2014.

We will exclude all quarters beginning with the 1st quarter of 2004 through and including the 4th quarter in 2014. Starting with the quarter of onset, we count back 40 quarters excluding all quarters which fall within the **[PPD]**. This takes us to the first quarter in 1998.

Now count the QCs within the countable 40 quarter period of time (1st quarter of 1998 through 4th quarter of 2003 and 1st quarter of 2015 through 4th quarter of 2018), and we find this individual has 22 QCs in the 40 quarter period.

*QCs in the beginning or end of a PPD

We may count the beginning and ending quarters if they are QCs since this could help the NH meet insured status. Remember QCs are flexible and can be moved within a year to help the claimant attain insured status.

EXAMPLE: Mrs. Santana

DOB 07/18/1975 Date of Onset 01/06/2019
PPD 04/12/2008 – 02/19/2014

1996—CCCN	2004—NNNN	2012—NNNN
1997—CCCC	2005—**CCC**N	2013—NNNN**]**
1998—NNNN	2006—**CCCC**	2014—**C**CNN
1999—CNNN	2007—NNNN	2015—NNNN
2000—CCNN	2008—**C**C[NN	2016—**CCC**N
2001—CCCN	2009—NNNN	2017—**C**NNN
2002—NNNN	2010—NNNN	2018—**CCC**N
2003—CCC**{C**	2011—NNNN	2019—**C}C**NN

When disregarding the PPD we did not disregard the 2nd quarter in 2008 or the 1st quarter in 2014 because they were QCs. When these two quarters are included, Mrs. Santana has 20 QCs in the 40 quarter period.

Period of Disability Disregarded

If the NH's insured status is more advantageous without excluding the PPD, we can include all quarters of the PPD in our decision. When there are two or more prior periods of disability, either all must be disregarded or all must be used when determining insured status and benefit amount.

Special Insured Status - Prior Period of DIB Before Age 31

The requirements to meet the special insured status for NHs who had a prior period of DIB before age 31 are found in **RS 00301.140-.147**. Neither MCS Earnings Computation (EC) screens nor ICERS will correctly calculate this situation.

This provision applies only to disabled NHs who:

- Had a prior period of DIB established before age 31 and met only the special insured status requirement, and

- Do not currently meet the 20/40 requirement.

See **Exhibit 1** for an example on how this is calculated.

DIB Freeze

DI 10105.005

The disability provisions were enacted to preserve the rights of individuals who are under a disability. Under these provisions, a worker's earnings record can be "frozen" at the time they qualify for a period of disability, thereby preserving their insured status and preventing a loss of future retirement or disability benefits which may be computed without considering periods of disability.

Insured Status for Statutory Blindness

RS 00301.150

A NH disabled by reason of statutory blindness needs only to be fully insured in the quarter they become blind. **20/40 or special insured status is not required**.

The number of QCs required for fully insured status will vary depending on onset. Once a blind individual has earned 40 QCs, they will remain fully insured.

Special Freeze Provisions for Blindness

A worker who meets the definition of statutory blindness may be entitled to a "disability freeze" period on the basis of medical findings alone regardless of his or her ability to engage in SGA. This provision allows the protection of a period of disability but denies eligibility for cash benefits. If the blind worker does not have the ability to engage in SGA, they are entitled to a "disability freeze" with the award of cash benefits.

NOTE: When multiple impairments are alleged and one is blindness, you will need to document insured status for statutory blindness as well as determine disability insured status for the other impairment(s) following normal procedure (i.e. fully insured and 20/40 or special insured).

Insured Status for Government Employees

RS 00301.160

Some Federal, state and local government employees (MQGE) pay only the Medicare portion of the FICA tax. These government employment QCs (reflected as F rather than C on an E/R) can be used to meet fully insured status and 20/40 (or alternative) to qualify for Medicare (not cash benefits) if the employee becomes disabled. The same requirements for insured status apply to MQGEs with respect to Medicare as apply for other workers with respect to cash benefits.

OBJECTIVE 2:

Understand Date Last Insured (DLI),
Date First Insured (DFI), and How to
Document Insured Status

Date Last Insured

RS 00301.148

Definition

The Date Last Insured (DLI) is the last day in the last quarter in which DIB insured status (or fully insured status for statutory blindness) is met (both fully insured and 20/40 or an alternative). Date Last Met (DLM) is also used and means the same thing.

Purpose

The FO and Disability Determination Service (DDS) need to know when the Date Last Insured (DLI) for disability is last met because this determines if a particular date of onset is possible and it can also limit the amount of medical development required.

- If onset is traumatic, and claimant is no longer insured as of the onset, do not send the case to DDS for a medical decision. The claim will be technically denied in the field office (technical denials will be addressed in the DIB Adjudication module).

EXAMPLE:

Jackson, files for DIB 02/10/19. He alleges a disability onset of 11/01/18 due to a car accident. His DLI is 06/30/17. Since his DLI is in the past and his onset is traumatic; his claim will be denied due to lack of insured status.

- If onset is non-traumatic, contradictory, or unclear and is within 1 year of the calendar quarter DLI is met, forward the case to DDS for a medical determination.

  EXAMPLE:

  Jacob, files for DIB on 10/10/18. He is alleging he became disabled due to arthritis on 06/05/18. His DLI is 09/30/17. Since Jacob's onset is non-traumatic, contradictory or otherwise unclear **and** his onset is within 1 year of DLI, we will send the claim to DDS for a medical decision.

- If a claim is finally adjudicated as a medical denial after the DLI, a new medical decision will not be made unless the requirements for reopening are met (reopening is discussed in a later module).

- If the NH performed SGA after the AOD but stops before the DLI, forward the claim to DDS. **DI 11055.045**

  EXAMPLE:

  Jesse, filed for DIB on 12/05/18. He alleges he became disabled when he suffered a heart attack on 06/30/18. His DLI is 03/31/19. He also states he returned to work from 08/28/18 – 11/23/18. We determine this work was SGA. Since Jesse did work at or above SGA after his AOD but he stopped working at SGA **before** his DLI, we would send his case to DDS for a medical decision.

Date First Insured

DI 11010.255I & **GN 01010.440**

The date first insured is the first day of the first month of the quarter in which insured status is met. A claimant's alleged onset may occur before insured status is obtained. This is often seen with younger claimants who have been referred by an SSI CS for a T2 claim. With the assignment of QCs based on annual earnings, it is possible to determine insured status prior to the actual start of the insuring quarter and take a claim several months prior to DFI.

If a claimant files a disability claim prior to meeting insured status, but has earnings which indicate insured status will be attained in the current

calendar year, the claim must be sent to the DDS for a disability determination, unless otherwise excluded.

If the claimant has never been insured and will not become insured based on current information, do not send the T2 claim to DDS for a medical determination.

Waiting Period and DFI

DDS needs to know the DFI so if the claimant is found disabled, the onset date can be established as of the DFI.

If DDS makes a favorable disability determination and the onset DDS established (i.e. EOD) is prior to the date first insured, EC is programmed to change the EOD to equal the first day of the quarter insured status is met.

In these cases, the Waiting Period (WP) begins with the DFI.

EXAMPLE:

Jonah

DIB DOF 12/13/18, AOD 07/15/18, DFI 10/01/18. Onset cannot be established prior to DFI. EOD is 10/01/18.

His Waiting Period is: 10/18, 11/18, 12/18, 01/19, 02/19

DOE: 03/19

Documenting Insured Status

DI 11005.045

All information about insured status must be clearly identified for the DDS. This includes information about special insured status, fully insured for blindness, DFI and DLI. Insured status should be included on the 3367. The DLI will propagate from EC to the 3367 in EDCS. All discrepancies must be documented to prevent unnecessary DDS development and follow-ups with the field office. Note before transferring the claim to DDS

the FO must enter the Potential Onset Date (POD) for each Title II disability claim at the initial and reconsideration levels.

OBJECTIVE 3:

Verify Insured Status

MCS Earnings Computation (EC) Screens

MS 03601.001

Online earnings information

Once a claim is established in MCS, the Earnings Computation (EC) screens can be accessed. The EC screens for claims which can be completely processed through MCS will show all earnings and computation data. Even if a claim cannot be fully processed through EC, some data will be available. The EC screens should always be reviewed.

To view the EC screens, enter #2 (Update) in the SELECT field and #21 (Earnings Comp Request) in the SELECT THE DESIRED FUNCTION field on the MCS System Menu:
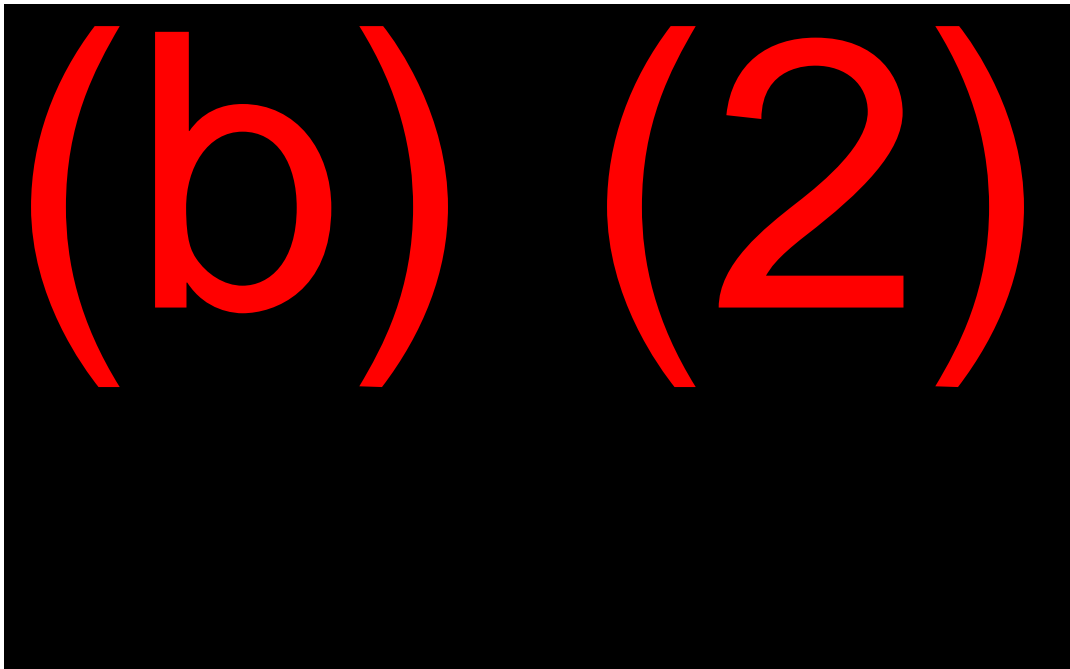
The first two screens, the MREQ and the MECN, allow you to select various options for the system to consider.

The next screen, the MCR1, shows the Date Last Insured (12/18) and the basic benefit computations. Enter #3 (Earnings, I/S) in the CASE DISPLAY field:
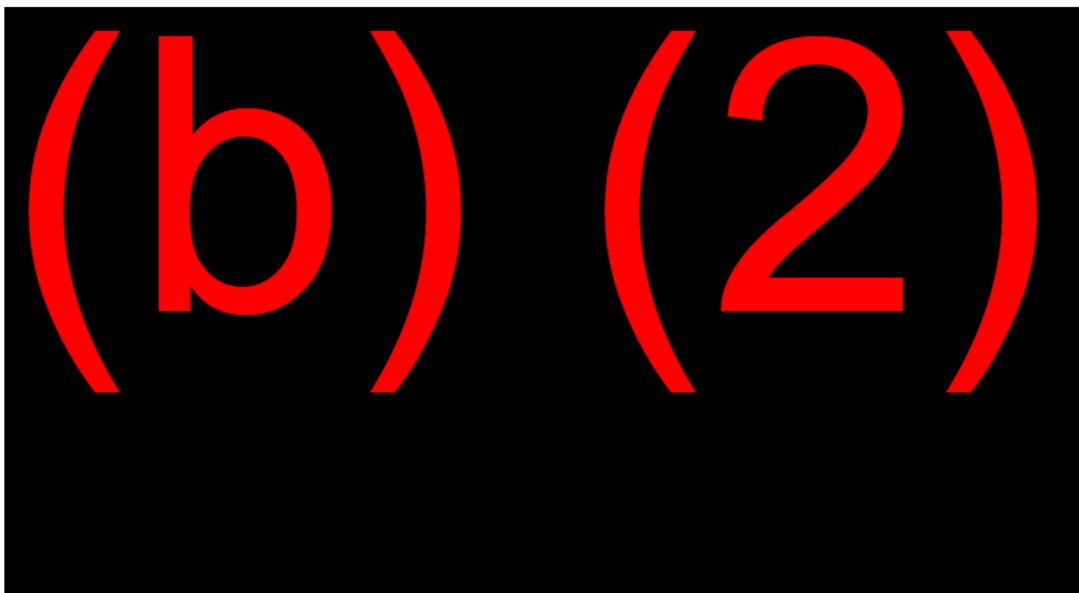
The MEIS screen will appear based on your input on the MCR1. Select #3 (Number Holder Identification, Quarters of Coverage, Date First Insured):
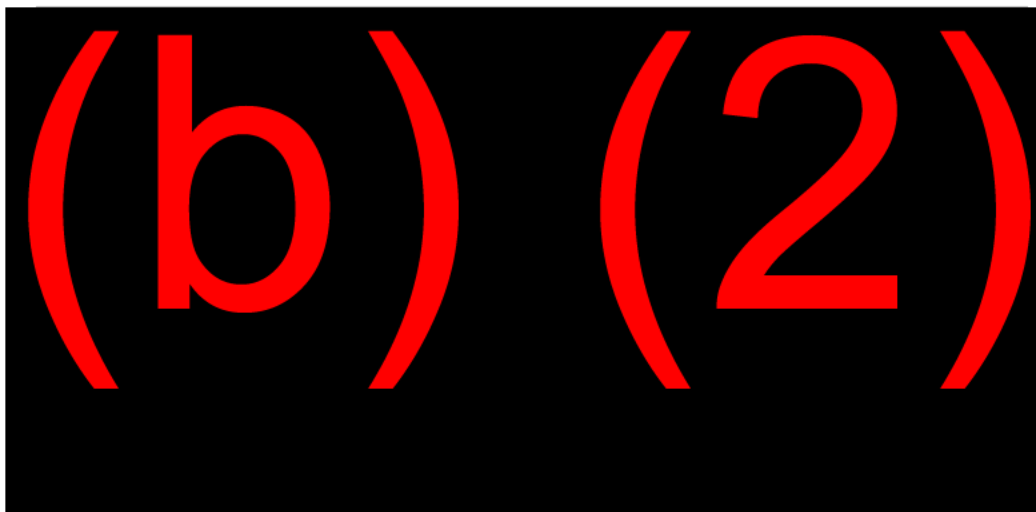
The DEI1 screen will appear and display the Date First Insured (10/12), as well as breakdown the number of QCs required and the number of QCs the NH has.
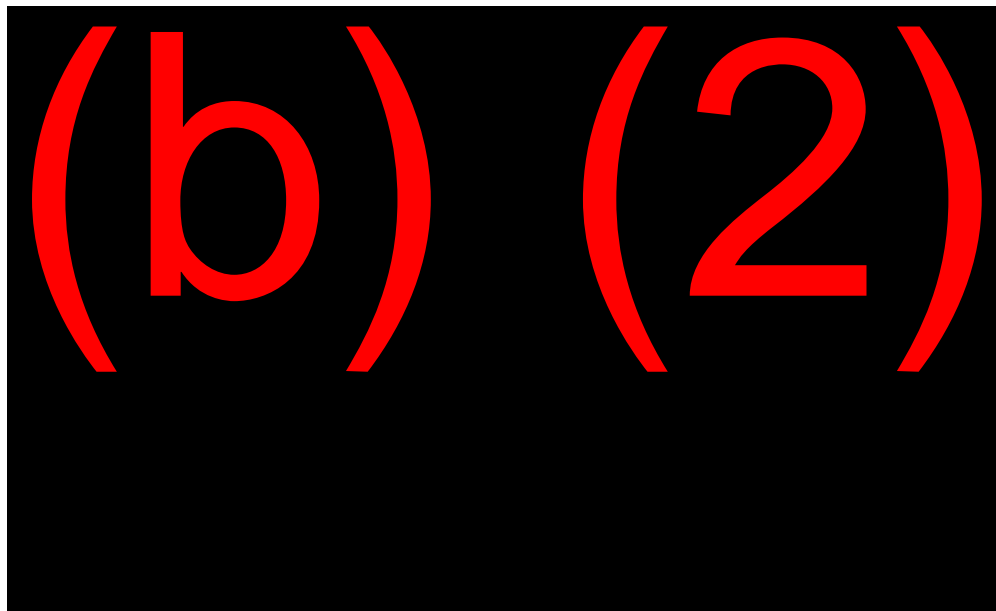
We will go into more detail about EC screens in the Adjudication module.

Informational Certified Earnings Record System (ICERS)

MS 02101.001 & SM 00349.000

When the EC screens cannot be used to obtain the earnings and computational data, request an ICER. ICERS is a "stand-alone" system which does not interface with the MCS claim.

To obtain an ICER, go first to Master File Query (#9 on the SSA Menu), then select #23 – ICERS (Info/Cert Earnings Record) from the Master File Query menu. On the ICERS Menu (ICMN), Select #4 for a Certified Earnings Record.

For a disability claim, enter the onset date and filing date. Provide information regarding lag earnings and/or military service, if applicable. ICERS will also consider prior periods of disability (PPD).

The ICRS (Results Summary) screen provides a lot of information such as DLI (12/2018), insured status, and PIA. $1913.00.
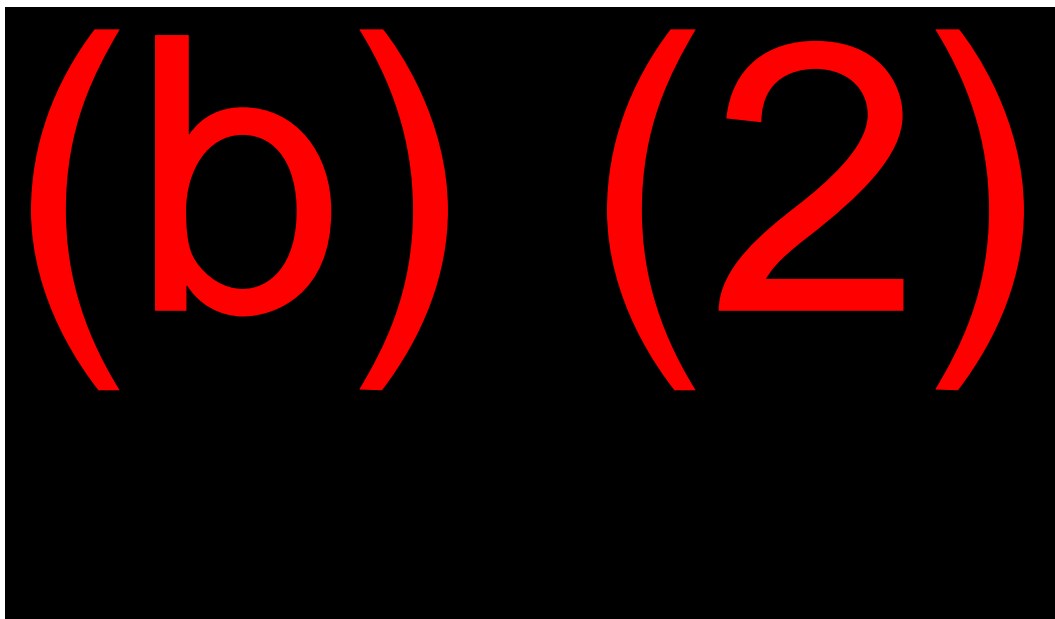
Notice at the bottom of the ICRS screen you have the option to obtain a full ICERS. You can either have it routed to the screen or the printer.

The printout of the ICER is a multi-page document which may also contain:

- Multiple SSNs, along with the combined earnings from those SSNs for the NH;

- Insured status information and PIA determinations;

- Various information which was input on the request; and

- Information from the DRAMS file such as military service and prior periods of disability.

DISCO

DIB Insured Status Calculator Online

This web based program is accessed through your PCOM toolbar. DISCO uses uncertified earnings and is <u>used for informational purposes only</u>; it does a consistently accurate job of computing DIB insured status.

DISCO computes DIB insured status (DFI and DLI for disability and statutory blindness) using earnings from 1951 forward based on the date of birth or the onset you provide. It allows you to manipulate the QC pattern by adding or changing the earnings and posted quarters for computational purposes. It also refigures the insured status and DLI based on the new information.

DISCO does the following:

- Runs the special age 24, special age 31, 20/40 and fully insured status tests, using all displayed earnings

- Tests onset dates beginning with the Date of Birth (or 01/01/61 if earlier)

- Runs the statutory blindness test alongside the regular insured status test

- Allows the user to test scenarios by modifying the QC pattern, prior period of disability, date of onset, or date of birth without re-requesting any queries

- Produces a date first insured (starting with the date of birth) and a date last insured for all insured status periods

- Displays a review sheet containing insured status results, the parameters used, prioritized alerts with hyperlinks to POMS references, and QC pattern data which was used for the calculation

- Creates a PCOM queries tab which displays full queries requested for DISCO calculation

o You can request other common queries (EARQ, FACT, IC94, NUMI, SEQY, and SSID) which can be viewed or sent to the printer.

- Prints or exports the Review Sheet, with or without full queries

Additional features allow users to:

o Open an ICERS computation screen

o Add DDSQ to the list of PCOM queries

o Include MQGE QCs in the computation

o Consider lag earnings and display future QCs

When using DISCO:

- Be sure lag earnings have been considered, including the current year.

- Consider the effect of gaps or incomplete postings.

- Remember QCs after 1977 can be reassigned within a year to the quarter most beneficial to the NH.

Getting Started

You must open a PCOM session and navigate to DISCO. Ensure the DISCO screen matches your PCOM session (Session A or B). Click on the DISCO icon on your PCOM toolbar or navigate to it through the OQP Toolbar in PCOM. If you do not have the OQP Toolbar in PCOM, consult your office SLC.

- Once DISCO is open, enter the NH's SSN.

o Select the check box for "*Get EARQ*" if you want to include EARQ results in the queries tab.

o The check box for "*Use MSSN File*" should be selected if you want to include multi SSNs in the IC94 (Interactive Computation) request.

     o *DISCO will remember your EARQ and MSSN selections the next time you use the tool.*

- Select [Query SSN] button to begin the query process.

- The Calculation Tab will appear which provides preliminary computations.

     o You can change the Date of Onset to the NH's AOD if desired. The NH's DOB is the preselected date of onset.

- To view the final Insured Status Report, click on the Review Sheet tab.

Here is the DISCO request screen.
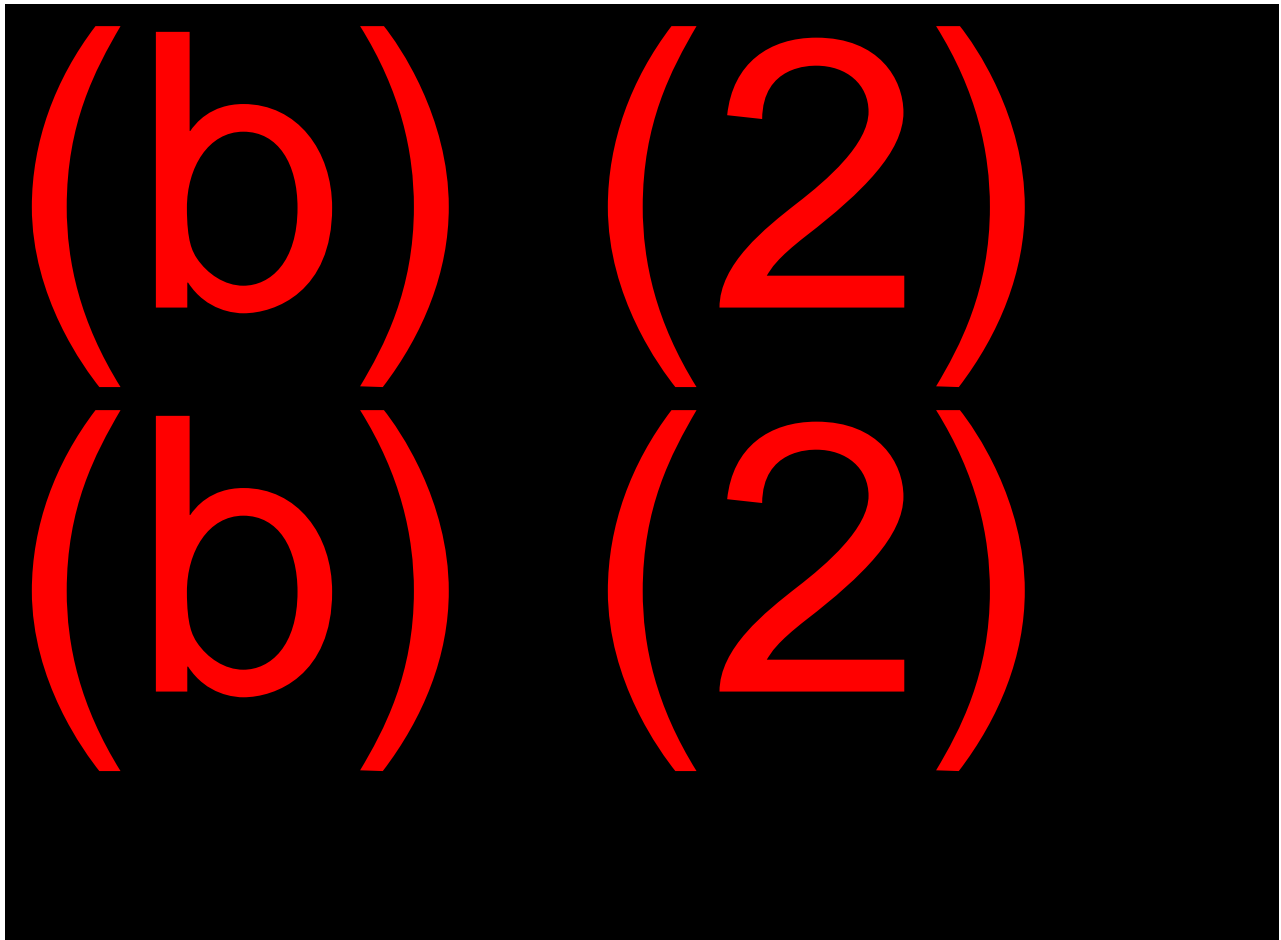
Check the DISCO site for a complete DISCO Guide.

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DIBwiz

OQP Disability Wizard Quality Management Tool

DIBwiz takes a single SSN or list of up to 25 SSNs and obtains up to 19 queries relevant to the disability workload. Once DIBwiz has obtained the queries, two integrated review sheets are produced: a Disability Review Sheet and Special Title II Workload Sheet. These review sheets prioritize and organize the query data so the elements most likely related to a Disability case are easier to identify, allowing proper action(s) to be taken.

DIBwiz also provides an interface in which query data can be easily viewed. In addition, DIBwiz provides the option to navigate to other related tools, web sites, and a version of DIBwiz (DIBwiz AR) where the DIBwiz Analyzer Reports are still available. You can find it on the OQP Toolbar in PCOM.

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The DIBwiz pulls the following queries: FACT, SSID, SEQY, DEQY, DDSQ, NUMI, PCACS, OHAQ, APPT WKSHT, DCF, InternetDIB, NDNH, MCS DW01, MDW, MSSICS DW01, PUPS, WMS, MCS Work/DLI, SSI2.

One of the unique features of the DIBwiz is it includes a Special Title II Worksheet which breaks down the claimant's attainment of critical ages including age 18, 22, 31, 50, 55, 60, 62 and FRA. It also provides open application and reopening information and displays the claimant's FICA earnings with estimated yearly QC and SGA amounts.

NOTE: There is a direct link to DISCO from the DIBwiz. You should still use a DISCO to verify insured status, but the DIBwiz can help you identify prior periods of disability, open applications and possible reopenings.

For more information, the DIBwiz User Guide can be found at
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EXHIBIT 1: SPECIAL INSURED STATUS – PRIOR PERIOD OF DIB BEFORE AGE 31 EXAMPLE

Jason Davis, DOB 04/16/85, became disabled 05/16/10 at age 25. His earnings record showed the following work pattern:

2005 CNNN	2008 **CCNN**
2006 NN**[CC**	2009 **CCNN**
2007 **CCCN**	2010 **NN]**NN

Jason has 6 QCs for fully insured status. These can be earned at any time. For special insured status, 16 Quarters elapsed after the quarter of attaining age 21, starting 3rd Qtr 2006 and up through the quarter of his onset. Jason needs to have earned only half (16 / 2 = 8) of the elapsed quarters to meet the special insured status test. Moving his QCs in 2006 gives him 9 QCs during that period. Jason was approved and his period of disability began 05/16/10. His disability later ceased in 10/13 and his entitlement ended the last day of 12/13.

Jason filed for DIB again in 11/18 alleging a new onset of 06/29/18. An MBR established the dates of the PPD, and the ER shows the following:

2005 CNNN	2012 **NNNN**
2006 NN**[**CC	2013 **CCC)**C
2007 CCCN	2014 CNNN
2008 CCNN	2015 CNNN
2009 CCNN	2016 CNNN
2010 N**(NNN**	2017 CCNN
2011 **CNNN**	2018 CC**]**CN

For Jason to be fully insured, we figure years elapsed since age 22: 2018 (year of new onset) – 2007 (age 22 attainment) = 11 QCs needed. We will exclude years in the PPD; a total of 4 years. After considering the PPD,

Jason needs only 7 QCs for fully insured status and meets this requirement.

For special insured status, exclude the quarters of the PPD (in parentheses). We will not exclude 4th Qtr 2013 because it contains a QC and will be advantageous to use this quarter. There are 34 elapsed quarters in the bracketed period-after the quarter of age 21 attainment (3rd Qtr 2006) up to and including the quarter of alleged onset (2nd Qtr 2018). Jason only requires one out of two during the elapsed period for special insured status and has 17 QCs during this elapsed period. He meets the special insured status requirements for a second period of disability at onset.

EXERCISE #1

OBJECTIVE 1: Understand DIB Insured Status.

Answer True or False to the following statements.

1. To be eligible for benefits, a NH filing for DIB must be fully insured and meet 20/40 or special DIB insured status.

2. An individual who becomes disabled prior to age 31 must be fully insured and can only meet the special DIB insured status rules to be found disabled. In other words, we will not consider 20/40.

3. A blind individual must meet fully insured and 20/40 or special DIB insured rules.

4. An individual who is MQGE DIB insured will receive cash benefits.

EXERCISE #2

OBJECTIVE 2: Understand Date Last Insured (DLI), Date First Insured (DFI), and Documenting Insured Status

Given the following scenarios, indicate if you would send the Title II portion of the claim to DDS. If DLI is an issue, what remark will you show on the EDCS 3367? If DFI is involved, what DFI will you list on the appropriate ECDS 3367 screen?

1. The claimant needs 6 QCs for fully and special insured status. You review the earnings record and find the claimant only has 3 QCs, all earned in 2017. In your interview. the individual states he has worked in 2018 and shows you his last pay stub with YTD gross wages of $4,677.92.

2. The claimant's DISCO shows a DLI of 12/2017. The claimant states he suffered a heart attack in September 2018. He states his back has bothered him for years and he quit work in April 2017 due to the pain in his back.

3. Jackie is 19 years old and came into the office today to file for disability; she needs 6 QCs. She states she was involved in an automobile accident November 4, 2018 and has not worked since. Prior to that, she was healthy and working. She has been living on her own for the last year. Review of her earnings record shows she has 2 quarters of coverage in 2017. She supplies her last pay stub for 2018 showing she had YTD gross wages of $17,373.50.

4. John, age 54, was injured on the job November 5, 2018 when heavy material stored on the dock fell and crushed his spine. He had no prior medical conditions. His ICERS, which has 2016 and 2017 earnings added in, shows a DLI of 06/15.

5. Bobby, age 20, files for disability alleging an onset of December 14, 2018; he needs 6 QCs. Review of his earnings record shows 1 quarter of coverage for 2017 and he supplied his last pay stub for 2018 with YTD gross wages of $2,789.34.

EXERCISE #3

OBJECTIVE 3: Verify Insured Status.

To complete this exercise, you will have to go to Lesson Information for this Module. Click on the appropriate scenario name to access the interactive exercise needed for each specific claimant.

Danny Pruitt – Access and review EC screens to answer the following questions.

1. Review the DRMK screens. Is the claimant insured for disability? Why or why not?

2. Look at the DEI1 screen. To be fully insured, the claimant needed how many QCs? How many did he have?

3. Still on the DEI1 screen, to meet 20/40, he needed 20 QCs. How many did he have in the 40 quarter period?

Derrick Daniels – Access and review EC screens to answer the following questions.

4. Review the DRMK screens. Is the claimant insured for disability? Why or why not?

5. Look at the DEI1 screen. To be fully insured, the claimant needed how many QCs?

6. Still on the DEI1 screen, to meet 20/40, he needed 20 QCs. How many did he have in the 40 quarter period?

Morgan Martinez – Complete an ICERS to answer the following questions. Date of onset is 05/15/11. Date of filing is 03/02/12.

7. Review ICERS results summary. Is the claimant insured for disability?

8. What is her DLI?

Mac Anderson – Use DISCO to answer questions 9 and 10.

9. Use the DOB as Onset option. Review the DISCO report. What is the claimant's DLI?

10. Mr. Anderson states he worked some in 2017 and brings you a paystub with gross wages in the amount of $3,000.00. Add in the lag wages and re-run DISCO. What is his DLI now?

EXERCISE ANSWERS

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Exercise #1

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1. True. **RS 00301.120**

2. False. We should consider 20/40 first and use the special DIB insured status rules as an alternative if 20/40 is not met. **RS 00301.140**

3. False. A blind individual only needs to be fully insured. **RS 00301.150**

4. False. An individual who is MQGE DIB insured qualifies for Medicare only; no cash benefits can be paid. **RS 00301.160**

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Exercise #2

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1. Based on earnings of $4677.92, the claimant has earned enough for 3 QCs in 2018. We will send the file to DDS with remarks entered on the EDCS 3367 of "DFI: 07/18," which is the first day of the first quarter insured status is met. DDS must find the person disabled with the first date they are insured. **DI 11010.255I**

2. We will send the case to DDS and alert them the DLI is 12/17 on the EDCS 3367. Although the individual suffered a heart attack after the DLI, he had back problems prior to the DLI. **DI 11010.075A.1.c**

3. We will send the case to DDS with EDCS 3367 coding showing DFI 10/01/2018 (when she earned her 6th QC). **DI 11010.255I**

4. We will not send the T2 portion of the claim to DDS. He suffered a traumatic onset after his date last insured. We will technically deny the case in the FO. **DI 11010.075A.1.c**

5. We will not send the T2 portion of the claim to DDS. Adding in 2018 earnings gives him only 3 QCs, and he needs 6. He does not meet insured status. The case will be technically denied in the FO. **DI 11010.075A.1.a**

Exercise #3

1. No, Danny is not insured for DIB. He met fully insured status, but did not meet 20/40. **MS 03601.019**

2. To be fully insured he needed 28 QCs and had 31QCs. **MS 03601.012**

3. To meet 20/40, he needed 20 QCs and had 09. **MS 03601.012**

4. Yes, Derrick is insured for Disability benefits. He meets fully insured status and 20/40.

5. For fully insured status he needed 20 QCs and had 40 QCs.

6. To meet 20/40, he needed 20 QCs and had 37 QCs.

7. Yes, Morgan is insured for disability. **MS 02101.012**

8. Morgan's DLI is 09/2015. **MS 02101.012**

9. Mac's DLI is 12/31/2019.

10. After we add in lag wages for 2017 on the DISCO screen, we see the DLI is now 06/30/2020.

TABLE OF CONTENTS

LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Identify and determine the factors of entitlement to DIB.

2. Determine when benefits will be suspended or terminated.

Length of Chapter

12 hours

BACKGROUND AND RATIONALE

Introduction

A period of disability can have short and long range effects on an individual's economic welfare. The individual's family may suffer from financial hardships due to the disability of the worker. The SSA disability program provides protection to workers and their families against the economic consequences of prolonged and severe disability.

Legislative History

Social Security was originally conceived as a retirement-only program; later, survivor benefits were added. Finally, legislation enacted in 1954 provided disability provisions as a part of the Social Security program.

The 1956 Amendments provided for cash benefits to a disabled worker age 50 or older, with cash benefits for their auxiliaries beginning September 1958, paid on the same basis as in retirement claims. The 1960 Amendments removed the age restriction for disabled workers.

Synopsis of the Lesson

This lesson explains Social Security's definition of disability, the disability freeze and disability insurance benefits (DIB). It also lists the factors of entitlement for DIB. Entitlement factors are the basic requirements which must be met before a benefit can be awarded. Keep the factors of entitlement in mind as you interview claimants and adjudicate claims.

OBJECTIVE 1:

Identify and determine the factors of entitlement to DIB.

Definition of Disability

DI 10105.065

Definition

Disability is defined by Social Security as the inability 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 which has lasted, or can be expected to last, for a continuous period of at least 12 months. Substantial gainful activity (SGA) is the performance of significant physical and/or mental work for payment or profit.

Subsequent amendments specified workers are disabled only if the severity of the physical or mental impairment(s) prevents the individuals from performing their previous work. In addition, we consider their age, education and work experience, and their inability to engage in any other kind of substantial gainful work which exists in the national economy.

DIB Requirements for Entitlement

DI 10105.060

Factors of Entitlement

To be entitled to DIB (cash benefits), an individual must:

- File an application;

- Meet DIB insured status;

- Be disabled;

- Complete a five full month waiting period unless exempt from this requirement; and

- Have not attained FRA.

There is a special definition of disability for a statutorily blind individual. This special definition applies only for claimants who have attained age 55 but not yet FRA. (**DI 10105.065 B.2**)

Onset Date

DI 25501.000ff; **DI 11005.023**; **DI 11005.045**

The onset date is the first day a person meets the definition of disability or statutory blindness. Establishing a correct onset date is important because it affects when an individual may receive benefits and the amount of the benefit.

Alleged Onset Date (AOD)

DI 25501.210

The starting point to determine the onset date is always the date the claimant reports an inability to work because of the effects of the claimant's own illnesses, injuries, or conditions, regardless of whether the date appears to be appropriate. This is referred to as the alleged onset date or AOD. Develop the AOD during the initial interview. Enter the AOD on the MCS IDEN screen and the 3368 in EDCS. (**DI 25501.000ff**)

Determining the AOD is generally straightforward when the disabling condition is the result of a traumatic event, because the disability begins immediately.

If the claimant's illnesses, injuries, or conditions did not result in immediate disability, but have progressed over time, it may be more difficult to determine the onset date. If the month of onset is established, but the day is unknown, use the last day of the month as the date of onset.

We will establish the claimant's allegation as the onset date if the work record and medical evidence support it.

You must document all of the claimant's work activity performed after the AOD using the procedures you learned in your lesson on SGA.

EXAMPLE:

Ronald files for Disability on March 15th of this year. He alleged he has been disabled since December 28th of last year. He states he continued working full-time earning $2500 per month until January 31st of this year. The AOD listed in MCS and EDCS will be December 28th of last year, because it is the date the claimant alleged he became disabled, even though we know, it may not be an appropriate onset based on SSA rules regarding work activity.

Potential Onset Date (POD)

DI 25501.220

The potential onset date (POD) is the earliest possible date the onset of disability can be established based on non-medical factors. The POD alerts the disability examiner of the need to develop the case for an onset which is different than the AOD. The DDS uses the POD as the starting point for medical development. When you show the POD on the EDCS-3367, this alerts the DDS disability examiner there are non-medical factors present which, if supported by the medical evidence, could establish an onset date earlier or later than the AOD.

It is your responsibility to determine a POD and alert the DDS examiner about the need to develop the case for an onset other than the AOD.

Consider the following factors when establishing the potential onset date:

- The date the claimant believes health problems became so severe they prevented work;

- The last day the claimant worked;

- The changes in the claimant's work pattern related to impairment;

- The last date of SGA (considering unsuccessful work attempts);

- Special considerations, situations, assistance (subsidy – specific or nonspecific);

- Any allowable impairment related work expenses (IRWE) paid by the claimant; and

- Insured status.

EXAMPLE #1:

Sherman, files for disability benefits on March 15th of this year alleging an onset date (AOD) of January 23rd of this year. His DLI is December of next year. He did not work after his AOD. The POD in this case is January 23rd of this year.

EXAMPLE #2:

Sarah, files for disability benefits on March 3rd of this year, alleging an onset date of September 14th of last year. We determined she worked at SGA from November 15th, 2002 until January 30th of this year (no UWA, subsidy, or IRWE). Her DLI is December 31st of this year. In this case, the POD is January 30th this year – the last day Sarah worked at the SGA level.

Occasionally onset dates are alleged, and it is clear no medical evidence will be available. Before transferring the file to DDS for a medical determination, document EDCS stating there are no earlier medical sources.

EXAMPLE #3:

Rachel alleges onset of disability on June 4th, 2017, but did not contact a medical source about the impairment until February 13th of this year. Notify DDS the onset of disability can be tentatively established as June 4th, 2017 – the claimant's AOD. However, you must develop work issues if information in file indicates the claimant had periods of work after the AOD.

NOTE: A prior ALJ decision does not limit what date you can use for a POD. The FO should focus their POD development only on non-medical issues, i.e. SGA and insured status. However, it is important to list all prior filings on the SSA-3367 as instructed in **DI 11005.045 A.3**. This will allow DDS to consider reopening, if applicable.

Use of Alleged Onset Date (AOD) or Potential Onset Date (POD)

Evaluate any earnings the claimant had after the AOD, and notify DDS of the AOD and POD. Also, provide the date the claimant was last insured (DLI).

DDS will use the POD as the starting point for medical development then make the final determination of the established onset date (EOD) based on medical and/or work evidence.

Established Onset Date (EOD)

DDS disability examiners determine the EOD, which they base on the work history, insured status, medical and other evidence in file. The established onset date (EOD) is the date SSA uses to determine when disability entitlement will begin. There is **no retroactivity limit** on setting the EOD, so the earlier the onset date, the longer the period of disability. By using both medical and non-medical evidence, it may be possible for DDS to find an earlier onset date, which often results in a higher monthly benefit. (**DI 10105.015 B)**

Traumatic/Non-traumatic

DI 25501.440, **DI 25501.460**

Traumatic Onset

Traumatic onsets, such as an automobile accident, have a clear-cut date of onset because onset is usually the day of the injury.

If the claimant did not seek medical attention at the time of injury, alert DDS by stating the first medical attention was after the AOD.

Non-traumatic Onset

A non-traumatic onset involves conditions which may have existed for a long period or are progressive or gradual. Some illnesses, such as

diabetes or arthritis, may not be severe enough to meet the definition of disability when first diagnosed but increase in severity over time.

When interviewing the NH, it is important to find out the exact point at which the illness first made work at the SGA level cease. Without medical evidence covering earlier years, the DDS examiner may have to make informed judgments according to the facts of the case. The disability adjudicator must consider all allegations of physical and mental limitations or restrictions and make every reasonable effort to ensure the file contains sufficient evidence to determine the onset of disability.

Sources of Onset Information

Obtain information from the disability report form(s), the application screens, postings on the earnings record, information on the work activity reports, or statements from the claimant's employer(s), family, or friends.

Onset development is sometimes required after the initial interview, primarily when work development is involved. After attesting to the initial application, the claimant must attest to any subsequent changes in the AOD.

Development When Insured Status is an Issue

DI 20101.001 B; DI 25501.000 ; DI 25501.440-.460

The NH must be insured at the established onset date (EOD) to be eligible for benefits. If insured status is met in the future, DDS establishes the onset as of the first day of the quarter in which insured status is met.

Traumatic Onset

In cases of traumatic onset, do not develop for the specific onset date if the NH does not meet insured status as of the AOD or later based on posted and lag wages.

Non-traumatic Onset

If the probable onset of a non-traumatic condition is contradictory or unclear and is within 1 year of the calendar quarter in which the DLI is met, develop the case fully and forward it to the DDS for a disability determination.

While the field office has no role in medically determining an onset date, it is important for CSs to be aware of the presence of a non-traumatic condition. This is because we can refer to the DDS cases they might not otherwise examine. The non-traumatic condition could allow the DDS to explore setting an earlier EOD leading to an allowance rather than a denial for lack of insured status.

Waiting Period

DI 10105.070; **DI 10105.075**

Definition

The waiting period is five full consecutive calendar months during which benefits are not payable. The waiting period begins with the earliest full calendar month a claimant is disabled <u>and</u> meets the disability insured status requirements for benefit purposes. The waiting period cannot begin more than 17 months before the month the application was filed.

Purpose

The philosophy behind the 5-month waiting period is this period of time will be long enough to permit most temporary disabilities to be corrected or for the individual to show signs of possible recovery.

Exception

No waiting period is required if the NH had a prior period of DIB which terminated within 5 years (60 months) before the current period of disability began.

Retroactivity

DIB entitlement may be retroactive for up to 12 months before the month the application is filed. The waiting period begins with the earliest full calendar month a claimant is disabled and meets the insured status requirements, but not more than 17 months before the month the application was filed. These 17 months allows for the 5 month waiting period plus the maximum 12 months retroactivity for payment.

Disability Date of Entitlement

GN 00204.030; **DI 10105.015**; **DI 10105.075 A**

Three factors determine when a claimant's entitlement to disability begins:

- Established date of disability onset;

- Date of filing for disability; and

- Prior entitlement to disability within the last 5 years.

Established date of disability onset

Generally, entitlement to disability benefits begins after a claimant serves a five full month waiting period.

EXAMPLE:

- Date of filing: 12/08/18

- Established date of onset: 08/04/18

- Waiting period: 09/18, 10/18, 11/18, 12/18, 01/19

- Entitlement date: 02/19

EOD
08/04/18

DOF
12/08/18

MOE
02/19

WP
09/18, 10/18, 11/18, 12/18, 01/19
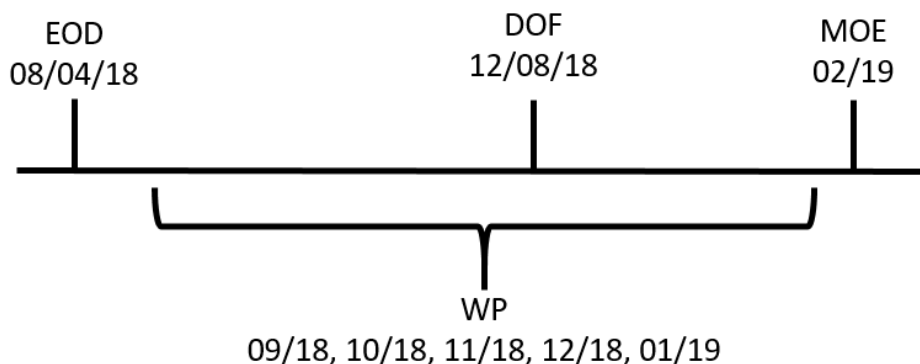
Date of filing for disability

The waiting period can begin no earlier than 17 months prior to the month of filing. If the onset date is more than 17 months in the past, the waiting period <u>immediately precedes</u> the 12 months retroactive from the filing date.

EXAMPLE:

- Date of filing: 12/10/18

- Established date of onset: 07/04/16

- Entitlement date: 12/17 (12 months prior to month of filing)

- Waiting period: 07/17, 08/17, 09/17, 10/17, 11/17

EOD
07/04/16

MOE
12/17

DOF
12/10/18

WP (5 mos before MOE)
07/17, 08/17, 09/17, 10/17, 11/17
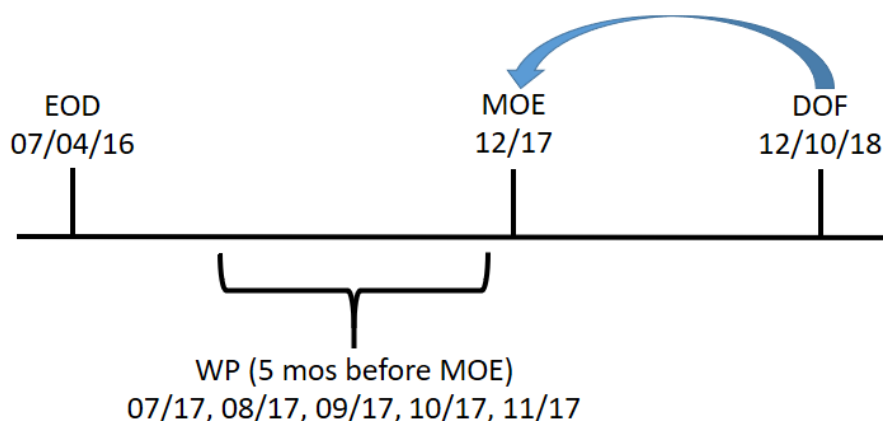
In this example, the waiting period is served the five months just before the month of entitlement.

Prior entitlement to disability within the last 5 years

No new waiting period is required if the NH had a prior period of disability which terminated within 5 years (60 months) before the month the current disability began.

EXAMPLE:

- Date of filing: 01/10/19

- Established date of onset: 01/04/19

- Prior period of disability ended: 08/31/14. T8 = 09/14
  The 60-month period is 09/14 through 08/19.

- New EOD 01/04/19 is before 08/31/19, the end of the 60-month period.

- New entitlement date: 02/19 (No waiting period)

Since the current EOD occurs during the 60-month period, we can waive the five month waiting period requirement. However, the NH must be disabled throughout the first month of new disability entitlement.

Re-entitlement to Medicare based on Disability

HI 00801.152; **DI 11010.261**

Disability beneficiaries must serve a 24-month qualifying period before Medicare begins. Months from prior periods of disability benefit entitlement may be counted towards the qualifying period requirement when:

- A prior period of DIB entitlement ended no more than 5 years (60 months) before the month of current onset; or

- A prior period of DWB or CDB entitlement ended no more than 7 years (84 months) before the month of current onset; or

- A prior period of DIB, CDB, or DWB entitlement ended after 02/29/88 and the current disabling impairment is the same as, or directly related to, the impairment which was the basis for the prior

period of entitlement. See **DI 11010.261** for processing instructions.

A person does **not** have to be re-entitled to the same type of disability benefit for these rules to apply. Entitlement to disability-based Medicare may be retroactive up to 12 months as long as all eligibility requirements are met.

EXAMPLES: Examples of HI/SMI effective dates for individuals with new medical conditions unrelated to the prior period of disability:

BENEFICIARY	PRIOR PERIOD OF Disability Entitlement	DOO	DIB DOE	HI/SMI EFF DATE
Mr. Cannon	None	07/15/17	01/18	01/20
Ms. Adams	None	12/20/16	06/17	06/19
Ms. Brown	01/98 - 01/07	11/26/17	05/18	05/20
Mr. Johnson	05/08 - 10/17	01/10/19	02/19	02/19

Medicare for the disabled (D-HI) continues during all months of entitlement to disability benefits even if no benefits are being paid because of earnings over the SGA limit. <u>When</u> coverage for a disabled beneficiary ends depends on <u>how</u> the DIB entitlement ends, whether after a return to work or medical improvement. Coverage ends no earlier than the last day of the second month after the claimant is notified of the termination of his Social Security benefits. (**HI 00820.025**)

NOTE: Be alert to situations in which a currently entitled beneficiary receiving surviving mother's or father's benefits is disabled and age 50 or older. These beneficiaries should file for DWB to establish earlier HI entitlement even though cash benefits will not increase. This also applies to widow(er)s past age 60 if establishing a disability will allow Medicare entitlement prior to age 65.

OBJECTIVE 2:

Determine when benefits will be suspended or terminated.

Cessation and Termination Events

DI 10105.010

Cessation

Disability ceases the month:

- The impairment is no longer severe enough to prevent SGA, or

- The impairment no longer meets the statutorily blind requirements, or

- The beneficiary demonstrates the ability to engage in SGA (completes the trial work period).

Benefits generally terminate at some point after a cessation. The reason for the cessation will determine the termination month.

Termination

Disability entitlement ends with the last day of the second month after the disability has ceased. Checks are due for the month of cessation plus two grace months. However, an extended period of eligibility (EPE) will delay the termination month.

In addition, there are several events which can terminate payment of a disability benefit. These are:

- Death;

- Attainment of FRA;

- Work activity (SGA); and

- Medical improvement related to the ability to work.

Termination is the end of the disability <u>benefit payments</u>. Effective dates of these terminating events are described below.

NOTE: In Advanced Training, you will receive more detailed information regarding when disability benefits terminate due to medical improvement and SGA.

Death

When death is the reason for termination, benefit entitlement ends the last day of the month before the month the beneficiary dies.

<u>EXAMPLE</u>:

DIB beneficiary, Louise, dies January 20; her benefit entitlement ends December 31. She was entitled to the December payment which is paid in January of this year. Benefits are terminated effective January. If the payment for January arrives in February, it should be returned.

FRA

Disability benefit entitlement ends the last day of the month before the month the beneficiary attains full retirement age (FRA).

<u>EXAMPLE</u>:

John Smith, a DIB beneficiary, attains FRA in May of this year. His last month of DIB entitlement is April of this year. His benefits automatically convert to a retirement insurance benefit effective May. Though his benefit amount may remain the same, the rules regarding retirement suspension and termination events would apply upon conversion.

SGA

During the TWP and EPE, disability benefits will not end due to SGA. However, after completion of the TWP and EPE, benefits will terminate once the beneficiary begins working SGA.

NOTE: More detailed information regarding when disability benefits terminate due to <u>SGA</u> will be covered in Advanced Training.

Medical Improvement Related to Ability to Work

Disability cases are reviewed periodically by the DDS to determine whether the beneficiary continues to be disabled. If DDS finds the beneficiary's disabling condition has medically improved, then benefits will cease and terminate after payment of the cessation month plus two grace months.

NOTE: More detailed information regarding when disability benefits terminate due to <u>medical improvement</u> will be given in Advanced Training.

Suspension Events

DI 10105.095; RS 02610.001

Suspensions

There are many events which can affect payment of DIB. Benefits may be suspended if:

- The beneficiary works at substantial gainful levels;

- The beneficiary is statutorily blind, over age 55, working at an SGA level and is not entitled to a TWP;

- Beneficiary is not a citizen or lawfully present in the U.S.;

- The beneficiary is an alien and has been out of the U.S. for more than six calendar months;

- The beneficiary has been deported;

- The beneficiary has been convicted of a charge involving subversive activity;

- The beneficiary is convicted of a crime or found not guilty by reason of insanity and is confined for more than 30 continuous days (**GN 02607.000ff**); or

- The beneficiary has an unsatisfied federal, state or international law enforcement warrant for more than 30 continuous days based on a felony (offense codes 4901, 4902, or 4999). (**GN 02613.001**)

Suspension Due to Work

DI 10105.095

Disability beneficiaries are not subject to the same work test as retirement beneficiaries. We must evaluate all work performed by a disabled beneficiary to determine if it is substantial gainful activity (SGA).

SGA

DI 10500.000; **DI 10505.000**

Substantial gainful activity describes a level of work activity and earnings. If an individual's work involves significant physical or mental activities, or a combination of both, and the work is performed for pay or profit, or is generally performed for pay or profit, then the work is considered SGA. Earnings guidelines for evaluating whether work activity is SGA change annually.

Effective January 1, 2018, earnings which exceed $1,180 per month generally indicate ability to engage in SGA. For statutory blind beneficiaries, SGA effective January 1, 2018 is earnings over $1,970 per month. (**DI 10501.015**)

Before we can apply these SGA guidelines, we must first deduct the value of any subsidies provided by an employer. Secondly, after the subsidies have been deducted, we deduct any impairment-related work expenses (IRWE). THEN, we apply the guidelines to determine if the work is SGA.

NOTE: Deductions must be applied in this order. If not, incorrect values will be received.

We use other criteria in addition to the earnings guidelines when evaluating work activity for self-employed persons. (**DI 10510.000**)

If a disability beneficiary works at an SGA-level, then benefits may be suspended or terminated.

Trial Work Period and Extended Period of Eligibility

DI 13010.035

Trial Work Period

The trial work period (TWP) is a work incentive intended to give DIB recipients the opportunity to test their ability to work without fear of losing their disability benefits. It allows them to perform services in as many as 9 months, which do not have to be consecutive, but which exist within a rolling 60 consecutive-month period. DIB benefits will not stop during the TWP based on the individual's work activity. The earnings amount which helps define a service month in the TWP changes frequently.

NOTE: An individual receives only one TWP per period of disability.

Months Counted Toward TWP

Any month in which a DIB beneficiary earns more than $850 in 2018 ($840 in 2017) or works more than 80 self-employment hours, is part of the TWP. (**DI 13010.060**)

EXAMPLE:

Ernest, a DIB beneficiary (non-blind), started working 01/15/18 and continues working until 06/30/18. His earnings record looks like this:

01/18	$700	04/18	$625
02/18	$860	05/18	$910
03/18	$860	06/18	$780

Based on this earnings record, Ernest would have completed three TWP months. The TWP months would be: 02/18, 03/18, and 05/18 because he earned more than $850 in each of these months. If Ernest has six more TWP months within 60 months of 02/18, meaning through 01/23, he will have exhausted his TWP.

After the completion of the 9-month TWP, SSA evaluates subsequent work based on SGA criteria. This period is referred to as the Extended Period of Eligibility. A disability beneficiary who is determined to be consistently working at an SGA level after the TWP ends will have their benefits ceased. In these cases, SSA will pay cash benefits during the month of cessation plus two grace months.

Extended Period of Eligibility

DI 13010.210

Before 1980, disability entitlement terminated effective with the third month after cessation. However, Congress devised another work incentive, the Extended Period of Eligibility, to assist beneficiaries in their effort to return to the workforce. Now each person who completes a 9-month trial work period (TWP) and continues to have a disabling condition receives an extended period of eligibility (EPE).

The EPE begins with the month immediately following the 9th TWP month. The re-entitlement period of the EPE ends with the 36th month following completion of the TWP. During the re-entitlement period, the first month SGA is performed is called the cessation month, and payment is made for the month plus the following two grace months. Thereafter, during this 36-month period, benefits are suspended any month the beneficiary works at SGA levels while benefits are reinstated for any month the beneficiary is not engaged in SGA.

After the end of the 36-month EPE re-entitlement period, if the beneficiary is not engaging in SGA, the EPE and benefit payment continue until the beneficiary either engages in SGA or is found to no longer be disabled. Once the beneficiary engages in SGA outside the 36-month EPE re-entitlement period, benefits are terminated.

EXAMPLE:

Gary completed his TWP in March 2018 and continues to engage in SGA. Gary's disability ceased April 2018. Payment is due for the month of

cessation plus two more months (e.g., April through June). Since Gary continues to work at SGA levels, his benefits will suspend effective July 2018. If Gary's work activity falls below the SGA level within the 36-month re-entitlement period, he will be paid for non-SGA months. The re-entitlement period ends March 2021. If Gary continues to engage in SGA after the 36 month re-entitlement period, his benefits will terminate with the first month of SGA after March 2021.
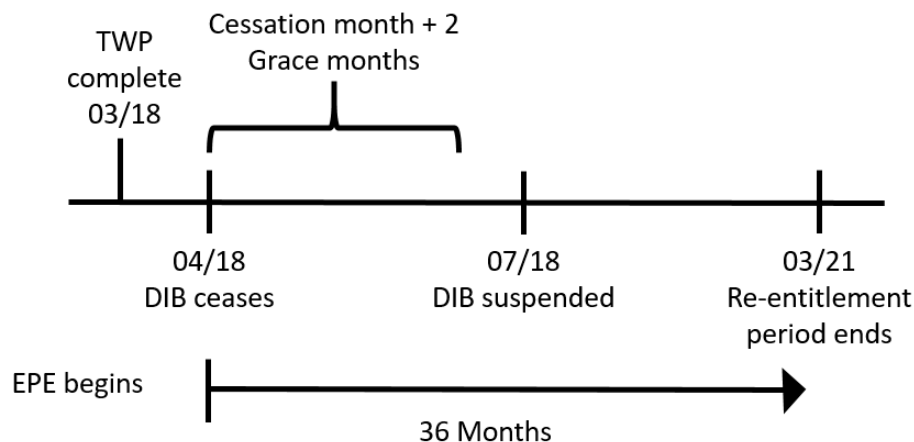
NOTE: The EPE provisions do not apply when there is a medical recovery. (**DI 13010.210**)

Extended Period of Eligibility Does Not Apply

DI 13010.210

An individual is not granted an EPE incentive in certain situations. The EPE does not apply when:

- A beneficiary's disability is determined to have medically ceased.

- A beneficiary is not entitled to a TWP.

- A beneficiary does not complete nine TWP service months.

- A beneficiary has already received an EPE during this period of disability entitlement.

- A beneficiary's disability ceased before 12/01/80.

There are also certain statutory blindness cases where a trial work period is not allowed. This means an EPE will not apply when:

- A statutorily blind beneficiary is in freeze status only (not receiving cash benefits).

- A statutorily blind beneficiary over age 55 is receiving benefits based on the special comparability provisions. See **DI 10515.015** for these rare cases.

While this is a very brief introduction to the Trial Work Period (TWP) and the Extended Period of Eligibility (EPE), these topics and Continuing Disability Reviews (CDRs) will be covered in greater detail in Advanced Training.

EXERCISE #1

OBJECTIVE 1: Identify and determine the factors of entitlement to DIB.

Part I:

Indicate whether each of the following statements is true or false and explain your answer (assume no prior disability).

1. A DIB applicant must always serve a 5-month waiting period.

2. A NH must be insured at the date of filing to receive SSA DIB.

Part II:

For each of the following, determine if the individual meets the requirements for entitlement to DIB. Explain your answers.

3. Cynthia Smith, age 52, files a disability application alleging she became disabled 8 months ago when she had a heart attack. Her earnings record doesn't provide her with any type of insured status.

4. Sam Jefferson, age 61, files for DIB. He was in a car accident a year ago and has not worked since. He is insured for DIB and is found to be disabled as of his alleged disability onset date.

5. Stanley Warman, age 68, inquires about filing for DIB. He says he hurt his back last week and cannot work anymore. He appears to meet DIB insured status.

Part III:

Identify and apply the non-medical factors for developing a date of onset for disability.

6. Henry last worked on March 5 when he went on a well-deserved two-month long vacation. On April 9 he was injured at an amusement park and now believes it will be some time before he returns to work. What is his best potential onset date?

7. Harry had a heart attack three years ago. After eight months of recuperating, he was able to return to work full time, earning $4,000 each month in gross wages. He alleged no subsidy or IRWE. On March 20 of this year, he had a second heart attack, and his doctor advised him not to return to work. What is his best potential onset date?

8. Georgia tells you she has had a bad back for "years." She had back surgery when she was 25; she is now 57 years old. Georgia tells you she worked as a waitress in restaurants for a long time, and although difficult at times, she received no special considerations from her employer. All of the lifting and time on her feet made her back problems get "worse and worse." Her spouse finally convinced her to quit working in March of the year she turned 50 and she has not worked since. She was last insured for disability when she turned 55.

    a. What is her best potential onset date?

    b. What special notification should be given to the DDS?

    c. What if she tells you she just started going to a doctor 6 months ago?

EXERCISE #2

OBJECTIVE 2: Determine when benefits will be suspended or terminated.

1. Georgette had been receiving DIB for over 10 years. She passed away in January this year. What is the last month for which she is entitled to benefits?

2. Ted has been receiving DIB since age 47. He reaches FRA in October this year. Determine the last month DIB is payable.

3. James, a DIB beneficiary, returned to work in February this year with no medical improvement and continues to work above an SGA level. What months count toward his TWP? When does his EPE begin? Assume he had not previously worked since his EOD.

4. Tammy, a DIB beneficiary, reports she made $1,500/month working 6 months last year. She has stopped working, and this was her only work activity since she became entitled to DIB. She is still disabled and wants to know what affect her work has on her disability benefits.

EXERCISE ANSWERS

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Exercise #1

</div>

1. True. (**DI 10105.070-.075**)

2. False. The NH must be insured at onset, or the beginning of the waiting period. (**DI 10105.060**)

3. No. She does not meet insured status. Review E/R carefully for possible lag earnings which could give her additional QCs.

4. Yes. He meets all requirements.

5. No. He is over FRA. (**DI 10105.060**)

6. The best potential onset date is April 9. Even though Henry last performed SGA on March 5, he had a traumatic onset. The date of the injury is the best POD in this case.

7. The best potential onset date is March 20 of this year. Harry returned to work at SGA levels for longer than 6 months, which is too long to be an UWA.

8.

   a. March of the year in which she turned age 50.

   b. Tell DDS the date she was last insured.

   c. Explain that DDS will make the final decision concerning her disability. The disability decision is based on her condition at the time she last met all the requirements for entitlement (prior to her DLI at age 55), including medical evidence they are able to obtain for the period she remained insured.

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Exercise #2

</div>

1. December, last year, month before month of death. (**DI 10105.010**)

2. DIB terminates September this year. This benefit converts to RIB effective in October (FRA). (**DI 10105.010**) **NOTE:** The termination date is generally contingent on the notice date.

3. Assuming he earned SGA in February onward, his TWP is nine months long, starting with February and ending in October. The EPE begins the first month after the end of the TWP - November. (**DI 13010.035**; **DI 13010.060**; **DI 13010.210 E**)

4. At this point, the work has no effect on her disability benefits. She used six of her TWP months and has three TWP service months remaining in her current rolling 60-month period. She should recontact SSA if she returns to work or her doctor indicates she is no longer disabled. (**DI 10105.010**; **DI 13010.060**)

TABLE OF CONTENTS

LESSON PLAN

Chapter Objectives

> At the completion of this chapter, the students will be able to:
>
> 1. Identify jurisdiction and responsibilities for a disability claim.
>
> 2. Identify the disability claim type and procedure for development.
>
> 3. Understand the electronic disability process.
>
> 4. Determine when non-medical development of a claim may be deferred.

Length of Chapter

> 14 hours

BACKGROUND AND RATIONALE

Introduction

This module covers the medical and non-medical portion of the disability interview. The discussion includes completing the MCS disability application screens and EDCS.

The Role of the State

Disability and Blindness determinations are made by participating state Disability Determination Service offices (DDS) in compliance with SSA published regulations.

States were given the responsibility of determining whether an individual is under a disability because state personnel are experienced in vocational rehabilitation (VR), welfare, blindness, and disability. **Exhibit 1**

In addition to making a determination, the DDS will prepare and release a personalized written notification for the claimant informing him/her of the decision when a claim is denied. SSA is responsible for issuing notices of awards.

The Role of the Field Office

During the initial contact with the claimant, inform them of SSA's responsibilities, their personal responsibilities, and an overview of the claims process.

Claims for disability are sometimes denied when they could have been approved because the claimant did not provide accurate and complete information at the time of the application. This can result in frustration for the claimant, delays in payment, additional work for both the DDS and the FO, and poor public relations.

The completion of the disability screens and related forms can be very time-consuming. It is only with skillful and thorough interviewing, you will ensure the claimant has provided a detailed description of all their ailments. You will also determine how these ailments affect their ability to work. **Exhibit 2**

Every piece of information requested and recorded in the disability interview process is important because the disability examiner needs it to make a fair and accurate determination. Critical evidence includes the claimant's allegations, date of onset, various sources of evidence, and contact information.

By taking a little extra time and care during the interview process, you will send a better product to the DDS, which will result in:

- Fair and accurate decisions for the claimants,

- Faster decisions,

- Fewer unnecessary appeals,

- Good and more efficient public service.

Administrative Responsibility

Although each DDS is an independent State agency, SSA funds these agencies and retains overall administrative responsibility for the disability program, which includes reviewing the determinations made by the State agencies and the right to change these determinations.

Jurisdiction

Most disability claims require a medical determination and will be the jurisdiction of the State DDS. Depending on specific non-disability medical criteria, the remainder of these claims come under the authority of a processing center - either the Office of Disability Operations (ODO) or the Program Service Center/Disability Process Branch (PSC/DPB) servicing the claimant's SSN.

OBJECTIVE 1:

Identify jurisdiction and responsibilities for a disability claim

Responsibilities

Field Office Action

DI 11005.000ff

The field office has specific responsibilities before, during and after a claim is sent to DDS. These include:

- Protecting the rights of potential DIB, DWB, CDB, freeze, or SSI disability claimants;

- Helping the claimant complete the appropriate applications, and assisting in securing supporting documents;

- Accurately recording the claimant's description of the disabling condition, medical sources, and vocational history;

- Asking the claimant to submit any medical evidence already in their possession;

- Developing onset, SGA, and other non-medical aspects of the claim (e.g., POA);

- Explaining disability provisions and processes, reporting instructions and responsibilities (e.g., medical CDRs), and work incentives for disability beneficiaries;

- Giving the claimant the appropriate pamphlets;

- Explaining SSA's policy on payment for medical evidence of records (**DI 11010.545**); and

- Working with third parties if special assistance is needed in development.

Claimant's Responsibilities

DI 11005.001

Give the claimant a thorough explanation of what is expected of him/her. The claimant's responsibilities include:

- Cooperating with the FO in developing non-medical issues and the DDS in developing medical evidence.

- Attending special medical examinations or tests scheduled by DDS. Failure to attend these consultative exams will delay the claim or cause the claim to be evaluated based on other evidence in file, which may result in a denial.

- Complying with requests for assistance in obtaining reports from medical sources when these sources have not responded to DDS requests. It is in the best interest of the claimant to assist the DDS in obtaining these reports.

Emphasize to the claimant the necessity for prompt reporting. Events unique to disability claims, which the claimant must report immediately, are:

- A return to work;

- Improvement of medical condition; or

- Receipt of, or any change in, workers' compensation or public disability benefits (WC/PDB).

Throughout the interview, ask questions to ensure the claimant has a full understanding of all the reporting events and their responsibilities.

At the close of the interview, give the claimant the printed application receipt, their reporting responsibilities and any pamphlets explaining the programs.

DDS Action

Once the disability file is received, the DDS will:

- Determine if an individual is disabled or blind/visually impaired;

- Determine the date the disability or blindness/visual impairment began; and

- Determine the date the individual no longer meets the disability or blindness/visual impairment criteria.

If the DDS denies a claim, they prepare and release the denial notices to the claimant. The notices are personalized and address the claimant's allegations of disability. The notices also include the reason DDS determined they do not meet our definition of disability and informs the claimant of their appeal rights.

Other Jurisdiction

PSC/DPB Action

The Disability Processing Branch (DPB) in the PSC functions similarly to a State DDS. DPB medical examiners make claims-related disability determinations for SSA jurisdiction claims and review cases for continuing eligibility. These cases (e.g. foreign claims, emergency clause cases, changed-identity claims, and career RR) are not routed to DDS.

Review the list of SSA jurisdiction cases in **DI 11010.262-.290**. Also review the Jurisdiction User's Guide in **DI 20101.045**.

Claims Involving Railroad

DI 11010.262, **DI 44001.105**

Disability claims involving a RR employee or annuitant with 120 or more months of RR employment, or, effective 1/1/2002, 60 or more months of RR work after 1995, are non-DOFA cases. The FO obtains the application, initiates non-medical development, and forwards the claim to

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the GLPSC/DPB. Also, we should refer the claimant to the nearest Railroad Retirement Board (RRB) to file an application.

The Systems Information section of the T2 CS Resource Kit has a DIB Career RR workflow that assists with the processing of these claims.

OIO

GN 01702.400-.420

The Office of International Operations (OIO) is located at SSA headquarters in Baltimore, Maryland makes the medical determinations and finally authorizes the following:

- Claims from individuals residing outside the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and American Samoa, and

- Totalization claims.

ODO Action

DI 11010.290 and **DI 11010.295**

Currently, the DIB claims processing responsibilities under ODO jurisdiction are:

- Final processing of non-DOFA disability claims, and

- Making medical determinations for cases transferred under the emergency clause. The emergency clause allows for the transfer of cases normally under DDS jurisdiction to ODO or PSC/DPB if a DDS is overloaded with pending cases.

OBJECTIVE 2:

Identify the disability claim type and procedure for development

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When a Claim Should be Taken

A disability application should be taken in all of the following situations:

- To protect the rights of potential DIB, freeze, CDB, or DWB claimants. You may suggest immediate filing for benefits, but the final decision to file the application must be made by the prospective claimant. Be sure to close out protective filings which do not result in an application.

- A claimant wishes to file even though it is obvious no eligibility exists (e.g., insured status is not met, SGA denial, etc.). When it is obvious the claim will be disallowed because of a non-disability factor, complete only the application screens and curtail the medical development. Even when it is evident the individual is ineligible, they have the right to file an application and to receive a formal decision which carries appeal rights.

- Concurrent claims (RIB-DIB, DIB-DWB, DIB-SSI, DWB-SSI, or CDB-SSI) may need to be taken and, if advantageous, fully develop each claim. For example, if a RIB claimant alleges disability, take a disability claim unless they are clearly ineligible and/or do not wish to file (**GN 00205.038**). If the claimant answers "yes" to the disability question on the IDEN screen, the file must be documented to show the following:

  - A disability application has been filed or an appeal has been requested on a disability denial or cessation determination, <u>OR</u>

  - A signed statement indicating the claimant does not wish to file for disability benefits and the reason for the decision. Enter a statement on the RMKS screen so it is included on the application MCS prints out.   **GN 00205.035**

> ▪ If the claimant alleges disability on a finally submitted Internet claim, it is considered a signed application. If the claimant does not wish to file for disability, that portion of the claim must be withdrawn following procedures in **GN 00206.000ff**.

Questions about disability are included in the scope of every prescribed application. Even if the disability question is answered, "No," you still need to be aware of potential entitlement to disability benefits. Possible indications of a disability are lengthy gaps in recent work or low/irregular earnings. **GN 00205.035**

Internet Filers

When a claimant files for disability using the internet, you should answer questions and assist the claimant by using (b) (2). ApPages allow you to see simulated versions of the internet pages the claimant uses to file Internet claims and complete PE actions.

Disability Information (DISB) Screen

MS 03505.027

Purpose

The DISB screen propagates to the claims path of every MCS disability application. This screen is used to record information about the disabling condition, the status of claims for other benefits, earnings after onset, and support of a dependent parent. It does <u>not</u> record all information needed for a disability claim. EDCS, electronic inputs, and paper forms are also used to record information about the claimant's disability.
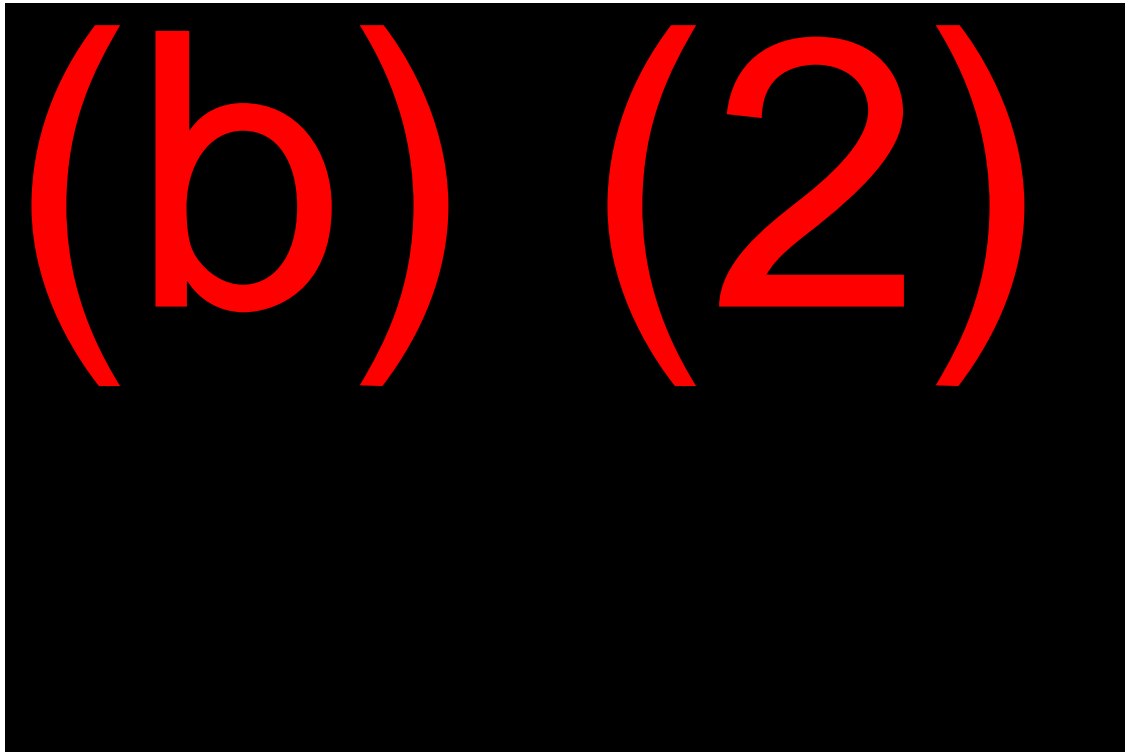
FIELD 1

> STILL DISABLED (Y/N)—Self-Explanatory.

FIELD 2

> IF NO, DATE DISABILITY ENDED (MMYY)—if the answer in field 1 was "N," then give the date the disability ended. (This would indicate a potential closed period of disability.)

FIELD 3

> BLIND OR LOW VISION EVEN WITH GLASSES OR CONTACTS (Y/N)— Indicate if the NH alleges blindness.

FIELD 4

> FREEZE (Y/N)—Answer "Y" if the NH is applying for a freeze only, meaning no monthly cash benefits.

FIELD 5

FILED OR INTEND TO FILE FOR:

- Enter "1" if the NH filed or intends to file for Veteran's Administration (VA) benefits.

- Enter "2" if the NH filed or intends to file for Workers' Compensation or Public Disability Benefits (WC/PDB). Selecting #2 will put the necessary Workers' Compensation screens in the pathway.

- Enter "3" if the NH has not filed and does not intend to file for any of the above.

FIELD 6

DISABILITY WORK RELATED (Y/N)—This field is a lead that workers' compensation might be paid to the NH.

FIELD 7

REASON NOT FILING—If the disability is related to work, an explanation must be given as to why the NH is not filing a Workers' Compensation claim.

FIELD 8-13

MONEY FROM EMPLOYER AFTER ONSET DATE (Y/N) and AMOUNT. ADDITIONAL MONEY EXPECTED FROM EMPLOYER (Y/N) and AMOUNT. These fields solicit amounts and types of money received after onset. They are an indication of earnings after onset which may need to be developed. Lag earnings needed for insured status may also be indicated here.

FIELD 14-15

NUMBER OF CHILDCARE YEARS—These fields solicit information on childcare drop out years (**RS 00605.235**). Use Form SSA-4162 to develop and document Childcare Dropout years.

FIELDS 16-23

IF PARENT RECEIVED 1/2 SUPPORT AT TIME OF ONSET OF DISABILITY—these fields solicit information which would result in a lead for parent's benefits.

Other Considerations

Leads/Protective Filings

If the disabled NH's potentially entitled current spouse is living at a different address, obtain their address and document the information on the RMKS or RPOC screen in MCS. Be sure to send the SSA-L445-U2 to the NH's spouse if the NH's claim is denied. The SSA-L445-U2 is notification explaining no benefits can be paid unless the NH is entitled to disability insurance benefits. If the NH does not know the address of the spouse or does not wish to furnish it, no action needs to be taken to secure it. **DI 11010.030B**

Basic Requirements

Proof of Age Development

The date of birth is a material factor for both entitlement and computation of benefits in all disability claims. POA must be requested at the initial interview unless the claimant meets the tolerance in **GN 00302.030**.

If proof of age is needed, you should make every effort to obtain it before you adjudicate the claim. Follow the guidelines in **DI 11010.025** and **DI 11010.055** to determine whether you must delay adjudication of the disability claim until proof of age is received or if proof of age can be obtained after adjudication.

When it will be necessary to develop proof of age after adjudication, you will establish Diary Code 51 on the DECI screen of your MCS claim per **GN 01040.005-.010.**

POA and Insured Status

Obtain POA before a medical decision if insured status is involved. For example, you may have one allegation in a disability claim stating the claimant is under age 31 and meets insured status, but another source alleges the claimant is over age 31 and does not meet 20/40.

The most accurate method of confirming insured status is to run a pre-adjudicative earnings computation (EC).

If the claimant is not insured, do not obtain the medical history or related medical forms.

Proof of Citizenship Development

DI 11010.055,

Develop proof of citizenship or lawful presence before a medical decision to prevent the case from being placed in suspense status unless the claimant meets the tolerance in **GN 00303.320A.1**.

Work Activity

DI 10505.005

Develop work activity unless the claim will be technically denied for lack of insured status. Work activity could affect the date of the disability onset (DDO) and/or the determination of disability.

Fast Track Claims

DI 23022.000ff

Quick Disability Determination (QDD)

A QDD case is an initial Electronic Disability Collect System (EDCS) case identified electronically via a predictive model (PM) as having a high degree of probability the claimant is disabled. In addition, evidence of the

claimant's allegations is expected to be easily obtained and the case can be processed quickly in the DDS.

Follow procedures outlined in **DI 11005.603** for developing QDD cases. Do not defer non-medical development in QDD cases.

Compassionate Allowance (CAL)

DI 11005.604

On October 27, 2008, the agency implemented the Compassionate Allowance (CAL) initiative. They are similar to the QDD cases and are actually processed the same way as a QDD. The biggest difference between the CAL and QDD is the predictive model (PM) criteria are simpler for a CAL.

A CAL case is identified solely when a claimant alleges having a disease or other medical condition which matches a disease or condition loaded in the PM (by name, synonym, and abbreviation). Currently over 200 conditions have been identified as CAL cases.

NOTE: cases determined to be CAL could also meet the criteria for QDD, therefore marking the case as both a QDD and CAL. For example, a case could meet the scoring criteria for QDD and also have an allegation of a CAL condition. If the PM identifies a case as both a QDD and CAL, the case can be removed from QDD yet maintain its CAL status and vice versa.

Another difference is only designated employees in the Disability Determination Services (DDS), the Office of Quality Review (OQR) and the Office of Disability Adjudication and Review (ODAR) can manually add a CAL indicator to a case. This function is not available with QDD. FO employees cannot add, reinstate, or remove CAL cases. Also, a CAL case can be processed directly to a denial determination while a QDD case must be removed from QDD status before a denial determination is made.

For a list of CAL conditions, see **DI 23022.080**.

Military Casualty/Wounded Warrior (MCWW Claims)

DI 11005.003, **DI 11005.006**

Field offices provide expedited handling of Military Service Casualty Cases (MSCC). These cases are more commonly referred to as Military Casualty/Wounded Warrior (MC/WW) cases. Procedures to expedite MMC/WW cases apply to any member of a military service who alleges sustaining an illness, injury, or wound, which caused a physical and/or mental disability and the following criteria are met:

- The impairment must have occurred on or after October 1, 2001 regardless of how or where it occurred (United States or on foreign soil), and

- The service member must have been on active duty status.

Follow the instructions per **DI 11005.006** for case identification, processing and tracking:

- Enter all claims in MCS.

- Follow normal interviewing guidelines, which include taking the claim in EDCS – **DI 81010.020**.

- Complete application information as thoroughly as possible to avoid unnecessary re-contact with the claimant.

- Establish a unit code of " ___XRQ" for military service casualty cases. **NOTE:** Use the first three characters of the unit code per local office instructions.

- Establish an issue of "MC/WW Case" on the DW01 screen to track the case. While the disability may not meet the criteria for TERI cases, all identified MSCC will be tracked under the guidelines of TERI cases per **DI 11005.601D.3.d**.

   NOTE: Although MMC/WW and TERI cases are tracked similarly, the TERI flag is not appropriate unless the case meets the TERI guidelines as outlined in **DI 11005.601C.**

- Establish a listing code of "108" on the Decision Input (DECI) screen at the beginning of case development. A decision code or non-medical sport is not necessary in order to add a listing code.

- Ensure the MC/WW flag has been added to the EDCS case if you are sending it to DDS.

- ▪ For Certified Electronic Folder (CEF) cases, follow instructions in **DI 81010.080B**.

- ▪ For a paper Modular Disability Folder (MDF) or EDCS exclusion, affix a MSCC flag to the front of the folder before sending it to the DDS. A copy of the flag can be found in **DI 11005.006I**.

- • Make a note in the EDCS remarks section with the words "Military Casualty/Wounded Warrior Case". For an EDCS exclusion, mail in a priority envelope with the same designation on the outside of the envelope.

- • Obtain a DDS query (DDSQ) to verify DDS case receipt two days (seven days for non-CEF cases) after FO transfer.

It is important to consider how SSA evaluates pay received by military personnel filing disability claims. A person in the military service who is being treated for a severe impairment usually continues to receive full pay. Active duty status and/or receipt of pay (e.g. sick pay) by a member of the military is not necessarily an indication of SGA. SGA determinations are based on actual work activity. **DI 10505.023** explains evaluating SGA in military casualty cases, and **DI 10505.025** explains the handling of special employment situations.

NOTE: It is important to consider the possibility of a closed period of disability for military disability cases. **DI 25510.010**

Prior Denials

DI 11005.085

For subsequent claims, review the MBR to verify the prior period of disability start and stop dates to ensure a proper computation.

If the DISALOW/DEN RSN (in the BEN DENY line) on the MBR shows the prior claim denial reason of 090, the claim was disallowed for lack of insured status. If the claimant alleges no additional work since the prior filing, you will <u>not</u> undertake any medical development. You will adjudicate the disability application in MCS as a technical denial. EDCS should not be completed with the exception of closing the case as a "No Determination." **DI 81010.140**

Exhibit 6 is an MBR showing a prior denial.

Non-medical Development

DI 11010.025

Non-medical Development Rationale

Because 60 percent of all initial disability claims result in medical denials, you have the option of deferring non-medical development in certain situations and then completing this development only if the claim is approved medically. Appropriate use of these options in processing disability claims saves effort, time, and expense for all personnel involved.

Depending on the situation, development may be required before sending the case to DDS, required while at DDS, or deferred until the claim is approved. Finally, it may not be required if the claim is medically denied. Refer to **DI 11010.025** for guidelines and medical examples for when deferral of action may be appropriate.

Deferred Development

Non-medical development consists of items such as lag earnings, military service, or even auxiliary applications. In most cases, non-disability development can be deferred until a medical allowance is made. Eliminating non-disability development on claims returned from DDS as medical denials results in significant savings for the Agency.

Development Required Before Sending the Case to DDS

Technical issues affecting eligibility must be identified as early in the process as possible so non-medical denial cases are not sent to DDS unnecessarily. Factors crucial to the basic eligibility for a benefit must be developed before sending a disability claim to DDS.

Do not forward the medical file to DDS if the claim will be denied for a non-medical reason (e.g., lack of insured status, current work exceeds SGA, etc.).

Whenever a medical file has been sent to DDS and subsequent development shows no medical decision is needed (e.g., earnings much higher than alleged, claimant dies in the waiting period, etc.), notify DDS immediately and request the medical file be returned to your FO. We must make every effort to prevent unnecessary work for the DDS.

Mandatory Simultaneous Development

Simultaneous development is when the DDS develops all medical factors while the FO is concurrently developing all non-medical entitlement factors.

Simultaneous development of **all** non-medical issues **is mandatory** in the following situations:

- Allegation of a terminal medical condition (TERI case);

- Military Casualty/Wounded Warrior (MC/WW) cases;

- End State Renal Disease (ESRD) in which a claimant undergoes a regular course of dialysis, or had a kidney transplant within the last 12 months;

- Title XVI issues – following the guidelines for Presumptive Disability (PD)/Presumptive Blindness (PB) provisions. In this instance, a claimant, including a child, applying for Supplemental Security Income (SSI) based on disability or blindness, may receive up to six months payments prior to the final determination;

- Quick Disability Determination (QDD) and Compassionate Allowance (CAL) cases;

- Amyotrophic Lateral Sclerosis (ALS) cases – Complete all information thoroughly to avoid unnecessary re-contact with the claimant.

Simultaneous development of **some** non-medical issues **is mandatory** with the following issues:

- Technical denials;

- Proof of Age required (impacts insured status);

- DWB and CDB critical eligibility factors (e.g., relationship);

- SGA;

- Insured status;

- Claimant dies while claim is pending; and

- Prisoner cases.

Technical Denials/No Medical Decision

DI 11010.075, **DI 40101.010**, **SM 00380.100**

The FO has jurisdiction and final authorization for DIB technical denials.

We do not send the following cases to DDS:

- Claims where insured status is not met (be sure to consider lag earnings before making this determination);

- DIB, freeze or MQGE claims when the NH died within the waiting period and there is no possible earlier onset;

- DIB after death freeze claim which was not filed timely (extremely rare situation);

- A DIB, freeze or MQGE claim which was filed in or after the twelfth month of FRA;

Example: Fred attained full retirement age (FRA) in 12/17. He is currently receiving RIB but is in the office today to file for DIB. Since more than 12 months has elapsed since he attained FRA, his claim would be a technical denial.

- A disability claim filed by a RIB beneficiary alleging disability within 5 months of FRA and no earlier onset is possible;

- SGA denials;

Example: Dan files for DIB today. He states he is currently working 40 hours per week and earns approximately $2,700.00 per month in gross wages. He alleges his employer provides no subsidy or special considerations based on his disability, nor does he have impairment related work expenses (IRWE). Based on his reported information and the SGA limit established at $1,180.00 per month in 2018, his claim is denied due to engaging in SGA at the time of filing.

- Failure to Cooperate (e.g. failure to submit the SSA-827).

Procedures for closing out EDCS will be discussed later.

Res Judicata

GN 04040.010, **GN 03101.160**, **DI 27516.000ff**, **DI 11010.075 D**

Definition

Res judicata is a rule in civil law stating once an issue is decided, it does not need to be decided again, provided the same person, same issue, and same facts are involved.

Under res judicata, even though a new claim may meet the other non-disability requirements for entitlement at the time of AOD, if SSA has already made a determination the individual was not disabled through the date last insured (DLI), the issue does not need to be decided again. The purpose of administrative res judicata is to protect SSA from having to consider the same claim repeatedly.

Example: Ron filed for DIB on 06/15/18, alleging an onset of 11/01/17 due to a back injury. DDS denied his claim 10/03/18. On 11/22/18, he

files a new DIB claim, alleging the same AOD and same medical condition as before. His DLI is 09/31/18. He has not worked since 11/01/17. Since DDS made a determination Ron was not disabled and this determination was made after his DLI, no new medical decision is necessary. His new DIB claim will be denied for res judicata.

Use res judicata as a basis for denial for Title II DIB, Freeze and MQGE cases if:

- The prior claim was final and denied after the date last insured for DIB, or the ending date of the prescribed period for DWB, or age 22 for CDB, **and**

- The law or regulations pertaining to the alleged disabling condition have not changed, **and**

- The subsequent claim presents no new facts or issues which were not considered in making the prior determination, **and**

- The claimant does not allege onset of a significant new impairment which occurred during the previously adjudicated period.

Res judicata claims are coded with the technical denial code of 0S1.

Exceptions

We cannot deny a claim under res judicata in the following instances:

- Subsequent claims involving an impairment found in **DI 27516.010F** if the DDS determination date for the prior claim is before the date of the listing change found in the same reference;

- The claimant demonstrates they failed to timely appeal an adverse initial or reconsideration Title II determination, made on or after 07/01/91, because of good faith reliance on incorrect, incomplete, or misleading information given by SSA regarding the effects of reapplying instead of appealing; or

- The claimant was not represented at the finalization of the prior determination, and the evidence establishes they lacked the mental capacity to understand the procedures for requesting review.

Exhibit 7 is a Res judicata workflow that you can use as an aid to establishing whether or not to send the case for a new disability determination.

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Collateral Estoppel

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GN 04040.020, **DI 11011.000ff**

Policy Principle

Collateral estoppel provides that a previously decided issue involving the same parties will not be considered again unless there are reasons to believe it was wrong.

When collateral estoppel applies to the medical decision in a disability claim, the FO has jurisdiction. In these cases, adopt the prior decision without sending the medical file to DDS, prepare an SSA-831, and process the claim as DOFA (District Office Final Authorization), unless a DOFA exclusion applies.

Example:

A Title XVI claimant was approved for benefits at age 24 due to back injury. After working for a number of years below the substantial gainful activity (SGA) level, he becomes insured for Title II benefits. The FO adopts the Title XVI medical decision and processes the Title II award without involving the DDS. No new SSA-3368 Disability Report is needed in this case.

When It Applies

A prior favorable disability decision under Title II or Title XVI will be adopted in any new Title II or Title XVI claim provided:

- The same criteria are used, **and**

- The same period is involved, **and**

- There is no reason to question the prior determination.

See **DI 11011.005** for instructions on specific case situations.

When It Cannot Be Applied

Per **DI 11011.001A** & **AM-18029**, previous determinations cannot be adopted under collateral estoppel when:

- The claim involves a mental disorder or HIV infection, and the prior favorable determination was made prior to January 17, 2017.

- The claimant is currently engaging in SGA;

- The Title XVI beneficiary filing for Title II performed SGA after the established Title XVI onset date;

- Different rules for determining disability in the other title apply. For example, a claimant awarded Title XVI as a Disabled Child (DC) later automatically converts at age 18 to a Disabled Individual (DI), but a medical determination using the adult criteria was never made;

- There is reason to believe the prior determination was wrong; or

- The case converted from a state disability plan to Federal Title XVI in 01/74 and no subsequent determination has been made under Federal disability criteria.

Post-adjudicative

In some cases, an earlier onset is possible. In these cases, the FO makes a partial award using the onset previously established on the prior award. Then the claim will be sent to DDS on a post-adjudicative basis for a decision on the earlier onset.

Example: DDS established a Title XVI beneficiary as a DI based on the Title XVI filing date. Title II entitlement was initially overlooked, but an onset prior to the Title XVI entitlement is possible. In this case, we would partially award Title II benefits based on the Title XVI onset date and forward the medical file to DDS requesting a decision based on the earliest possible onset for Title II benefits.

Closed Period of Disability

DI 25510.001, **DI 25510.010**, **DI 13010.105**

A closed period of disability occurs if the NH met the disability requirements for at least 12 months, but by the time of filing, the disability had ceased. The cessation must have occurred within 14 months of the date of filing. An extension on this time limit is possible in some circumstances. See **DI 25510.010** for further information.

Example: Julius files an application for DIB in November 2018. DDS establishes his onset as May 15, 2017 and determines his disability ceased August 2018. The waiting period would be June 2017 through October 2017 with entitlement beginning November 2017. Julius is due benefits for November 2017 through October 2018. Remember, he is paid for the cessation month (08/18) plus two grace months.

If the NH's current work is SGA but the individual alleges an onset date more than 12 months prior to the return to work:

- Take an application for disability in MCS;

- Prepare an SSA-821/SSA-820/SSA-823 and upload to the Certified Electronic Folder (CEF); and

- Complete EDCS and transfer to DDS with notification to develop the claim for a possible closed period of disability.

Do not assume a claim will be denied if an individual has returned to work, and do not deny an application based on SGA without proper application of the closed period policy.

DIB after Death

GN 00204.005

An application for DIB may be filed within 3 months after the NH's death by someone eligible to receive the deceased claimant's underpayment. This is referred to as "DIB after death." The disability requirements are the same as for a living NH.

Survivor claims include a question, which asks if the NH was disabled at the time of their death. A favorable determination may result in an underpayment, an increase in the death PIA, or both.

Example: Marjorie died on 09/15/18. Her husband Bill comes into the office on 10/12/18 to file a LSDP claim. During the interview Bill states Marjorie was diagnosed with cancer in 10/16, but never filed a DIB claim because she was still working. Marjory stopped working in 08/17 when her condition worsened; however, she never made it to the SSA office to file a DIB claim.

Based on the facts of this case, the criteria for filing a DIB after death claim is applicable:

- Claimant suffered from a medical condition, which lasted more than 12 months.
- Claimant dies before filing a valid application.
- A valid application for DIB is filed within 3 months after the month after the NH's death.

The law has no provision allowing for good cause for late filing of a DIB after death claim. If the application is filed more than three months after the number holder's death, the FO will process the claim as a "No Determination" case. See **DI 23510.001** and **DI 23510.025** for more information.

Instructions for processing are in KCNet under (b) (2)(b) (2)(b) (2)(b) (2) ".

OBJECTIVE 3:

Understanding the Electronic Disability Process

FO Determination Function

The FO Determination function in EDCS allows the FO to record a non-medical determination on a claim and close out EDCS when a DDS decision is unnecessary. Use the FO Determination function to process:

- Collateral Estoppel Adoptions **DI 81010.142**;

- SGA denials;

- Technical denials (e.g., insured status or excess resources); and

- Withdrawals after case transfer.

Refer to **DI 81010.140** for instructions on processing the three situations listed above in EDCS. Res judicata claims may be recorded in EDCS, though it is not a requirement.

Electronic Disability Process

The electronic disability process consists of:

- Use of an electronic folder (EF) to store all of the information and evidence pertaining to the disability determination in an electronic record.

- Use of electronic forms to document disability case issues and actions.

- Imaging paper documents received from external sources (e.g. claimants, medical providers, third parties, etc.) into the EF.

- Transferring Disability Claims to DDS.

- Contracting with a national scanning service to convert paper documents to image for the EF.

- Receiving Electronic Medical Evidence from medical sources into the EF.

- Controlling EF workloads and actions needed on electronic cases.

All case processing components involved in adjudicating and reviewing disability cases will have access to the EF.

Disability Reports Available for Completion in EDCS

DI 81010.000ff

The following are forms used in initial claims processing.

FORM	USE
3367	Completed by FO in each disability claim and includes information which does not involve input from the applicant.
3368	Used to obtain basic information about the claimant's condition, sources of medical evidence, and related information.
3369	Supplement to the SSA-3368 work history. FO must complete only when future contact with the claimant will be difficult (homeless, etc.).
827	Authorization to Disclose Medical Information
821	Used to develop work activity of an employed person.

FORM	USE
820	Used to develop work activity of a <u>self-employed</u> person.
823	Used to make an SGA determination (for SSA use only)

EDCS Exclusions/Limitations

DI 81001.005 A.2-3, **DI 81010.030**, (b) (2)

Most documents stored in a partial electronic disability case remain electronic. We don't need to print what is in the electronic file and place it in the paper folder. This applies to:

- Concurrent cases that use the same medical evidence–one claim is an EDCS exclusion, but the other is processed electronically; or
- Non-MSSICS claims added to EDCS, at any adjudicative level, even if no Title II claim is available.

IMPORTANT: When all claims in a case convert to paper, all documents must be printed.

Example

The Disability Determination Service (DDS) closes a case without a determination and the "No Determination" reason is "Stop Electronic Processing," all documents must be printed and added to the paper folder.

Exclusion- When we have multiple pending cases we must print all documents when the case closes. Multiple pending cases are those with a current pending CDR classification case and an initial classification claim at any level (initial, reconsideration, or hearing) pending at the same time.

Example

There is a Title II Medical Review pending and a new Disability Claim is filed. Even though one case can be decided upon electronically, it will need to be converted to all paper when the case is closed. The Modular Disability Folder (MDF) is the official folder for paper cases. Instructions for preparing the MDF are in **DI 70005.005.**

Completion of the SSA-3368

DI 81010.025B

The SSA-3368 is completed for all adult disability applicants. DDS uses the information in this form to develop medical and other evidence necessary to establish the correct onset date. The SSA-3368 is also used to assess the alleged disability in conjunction with non-medical factors, such as education and work history.

Obtaining a SSA-3368

You will obtain a form SSA-3368 in the following T2 claims:

- Disability Insurance Benefits (DIB)
- Disabled Widow(er)'s Benefits (DWB)
- Childhood Disability Benefits (CDB)
- Disabled Minor Child claims (DMC)

Completion of the SSA-3368

The SSA-3368 is divided into several sections:

- **About you**

    This page displays the claimant's name and daytime telephone number, which propagate from the mainframe application.

- **Contacts**

    On this page, you will enter the name of someone other than the claimant's doctors, such as a friend or relative, who knows about the claimant's disabling condition and can help with the claims process.

- **Medical Conditions**

    This page displays the alleged onset date and medical conditions. The alleged onset date is propagated from the mainframe

application. You must document the claimant's medical condition(s), height and weight.

- **Work and Onset**

   Use this page to document the claimant's alleged current work status and ability to work due to their condition. The AOD propagates from MCS or the MCS Exclusion Information page. If you need to change the AOD, you must change it in the MCS claim and re-propagate the information into EDCS.

- **Job History**

   Use this page to document the claimant's alleged number of jobs in the 15 years before becoming unable to work because of their disabling condition and information regarding the most recent job(s) (up to 5). If the claimant alleges only one job in the 15 years prior to disability, you must provide additional details about the job.

- **Medical Sources**

   On this page, include all medical sources who have examined or treated the claimant for the alleged disabling condition(s). Also document the tests and medicines associated with the medical source.

- **Test Summary**

   This page collects any medical tests the claimant alleges they have had or are scheduled to have, as well as who ordered the test(s).

- **Medicines Summary**

   This page collects the names of the claimant's current medications, who prescribed them, and the reason for the medicine.

- **Other Medical Information**

Use this page to collect information about other sources who can provide information about the claimant's alleged medical conditions.

- **Education and Training**

  Use this page to record, update, view and delete information about the claimant's alleged educational history, including special education, job training or vocational school.

- **Remarks**

  Use this page to document additional information not already collected on another section of the SSA-3368.

Completion of the SSA-827

DI 11005.055-.057

The SSA-827 (Authorization to Disclose Information to the Social Security Administration (SSA)) serves as the claimant's written request to a medical source or other source to release information. It also serves as the authorization for the claimant's sources to release the information to SSA. Generally, you will request one signed 827 authorization per case.

Signing and dating Form SSA-827

Like the application, we can use these signature methods for Form SSA-827:

- Pen and ink signature; or

- SSA's Internet click-and-sign process; or

- SSA's attestation process.

When Attestation is Permitted

The SSA employee can use the e827 in EDCS and the attestation process when:

- The claimant is:

    o An adult (age 18 or older) and signing on his or her own behalf, **or**

    o A child (under age 18) who is signing on his or her own behalf, **or**

    o A child whose claim is being filed by an individual with authority to sign on behalf of the child (a parent or guardian);

- The case is available in eView; **and**

- The individual signing the SSA-827 chooses to sign using the attestation process.

When Attestation is Not Permitted

We cannot use the attestation process to obtain the SSA-827 when:

- The claimant has not reviewed Form SSA-827;

- Two signatures are required (a paper form with pen and ink signature is required in this situation);

- The individual chooses not to attest; **or**

- The claims is an EDCS exclusion with no associated electronic folder. **DI 11005.056D.2**

Completion of the SSA-3367

DI 81010.025A, **DI 11005.045**

Complete the EDCS 3367 (or paper SSA-3367 in exclusion claims) in all disability claims. The 3367 is used to record information not involving the claimant's input and supplements their disability reports. The DDS examiner uses the information contained on this form to establish the most advantageous onset date. Proper completion of this form can also prevent the DDS from establishing disability for a period when the

claimant would be ineligible for non-medical reasons. In addition, the DDS examiner can review observations about the claimant recorded during contacts with the FO, including capability information.

3367 Onset

When the 3367 folder in EDCS is selected, the first screen is the **Onset** screen. This lists the type(s) of claim(s) and the AOD (Alleged Onset Date).

Clicking on the claim type opens a new window to input the POD (Potential Onset Date). Before transferring a claim to DDS, you must enter the POD for all claims. If there is more than one claim type, the FO must provide the POD for each disability claim type separately.
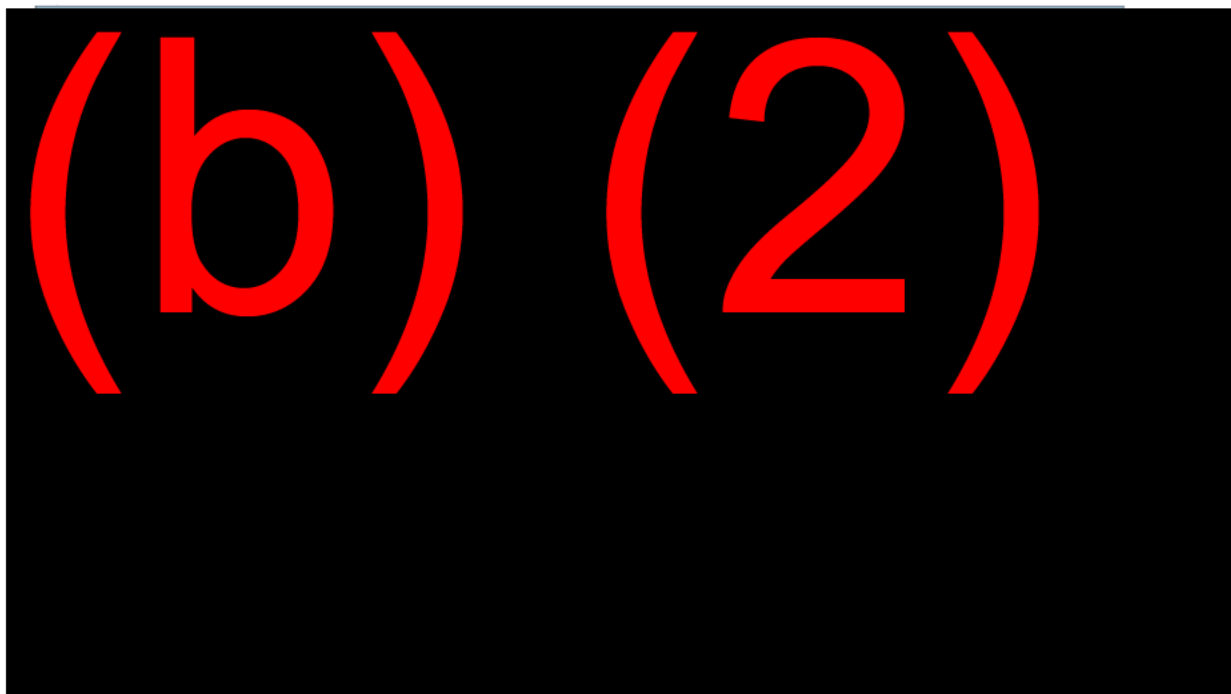
(b) (2)

3367 Miscellaneous, DWB and Prior Filing

Select Next Page to open the **Miscellaneous, DWB, and Prior Filing Information** screen. Completion of this page is necessary to indicate items pertinent to the case such as: protective filing date, non-blind date last insured (DLI), blind DLI, a closed-period case, or prior filings. DLI is very important as it informs the Disability Determination Services (DDS) of the last date an individual can be found disabled based on insured status.

NOTE: See **DI 11005.045.A.2** and **DI 11005.045.A.9f** when blindness or low vision is alleged.

(b) (2)

3367 Presumptive

Select Next Page to open the **Presumptive** screen <u>only</u> if Supplemental Security Income (SSI) is applicable to the case. If SSI is involved with the claim, more questions will appear.
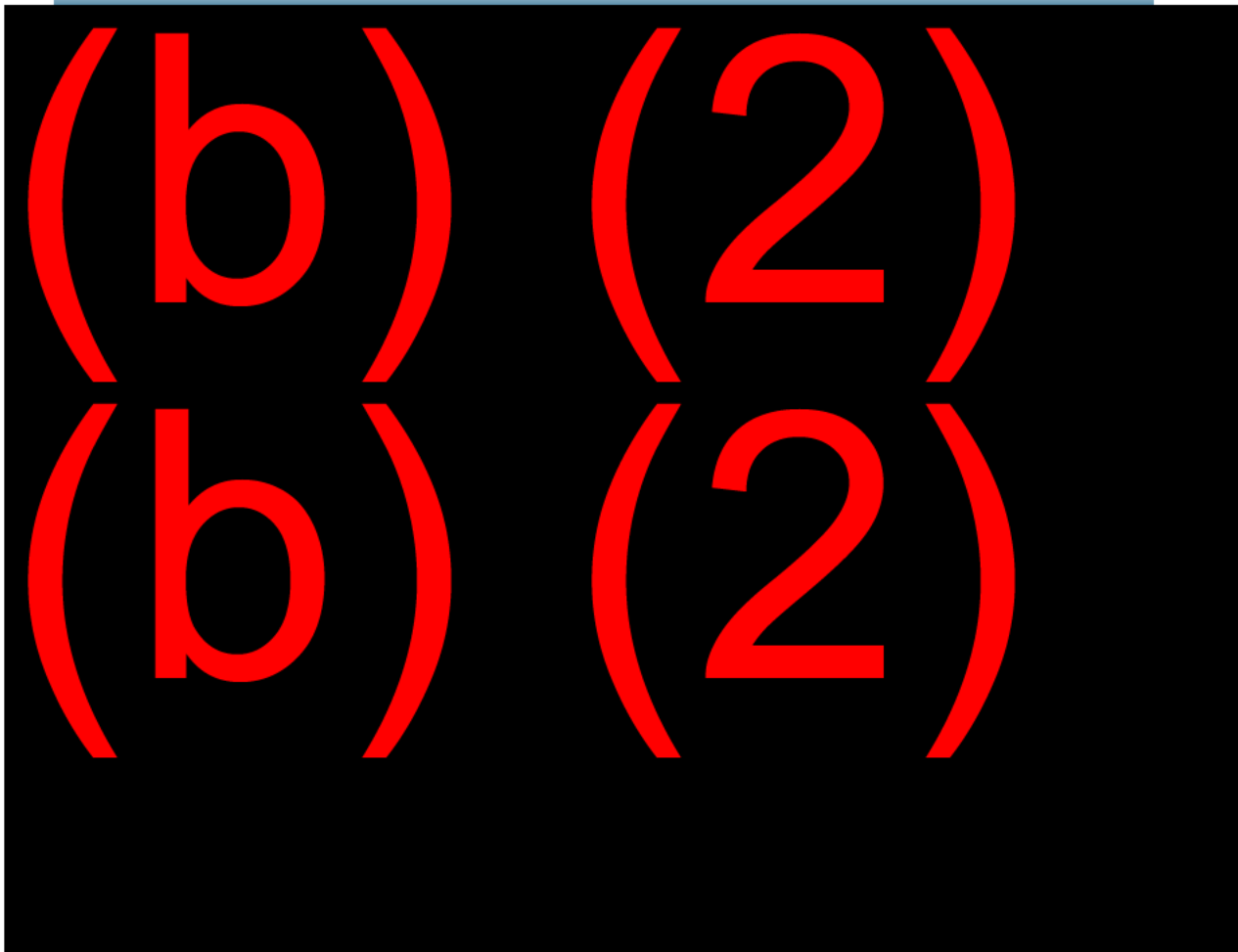
3367 Observations

Select Next Page to open the **Observations** screen. This screen is used to document any observations noticed about the claimant. The fields you must complete will change depending on the type of interview conducted, face-to-face or tele-claim. If the claimant communicated in another language other than, English note the language spoken here for DDS.

(b) (2)
(b) (2)
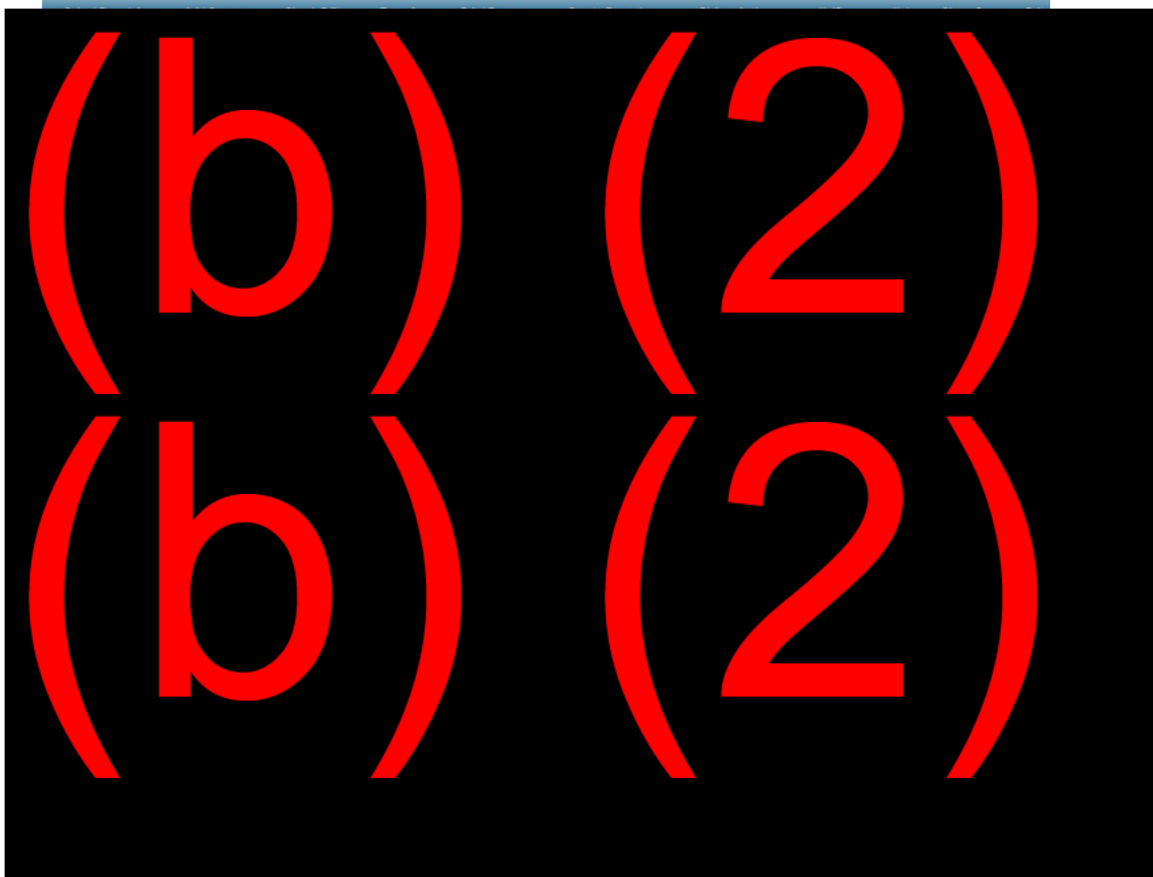
3367 FO Med Develop

Select Next Page to complete **FO Med Develop** screen if the FO initiated medical development and it is not contained in the electronic file at the time the case is sent to DDS.
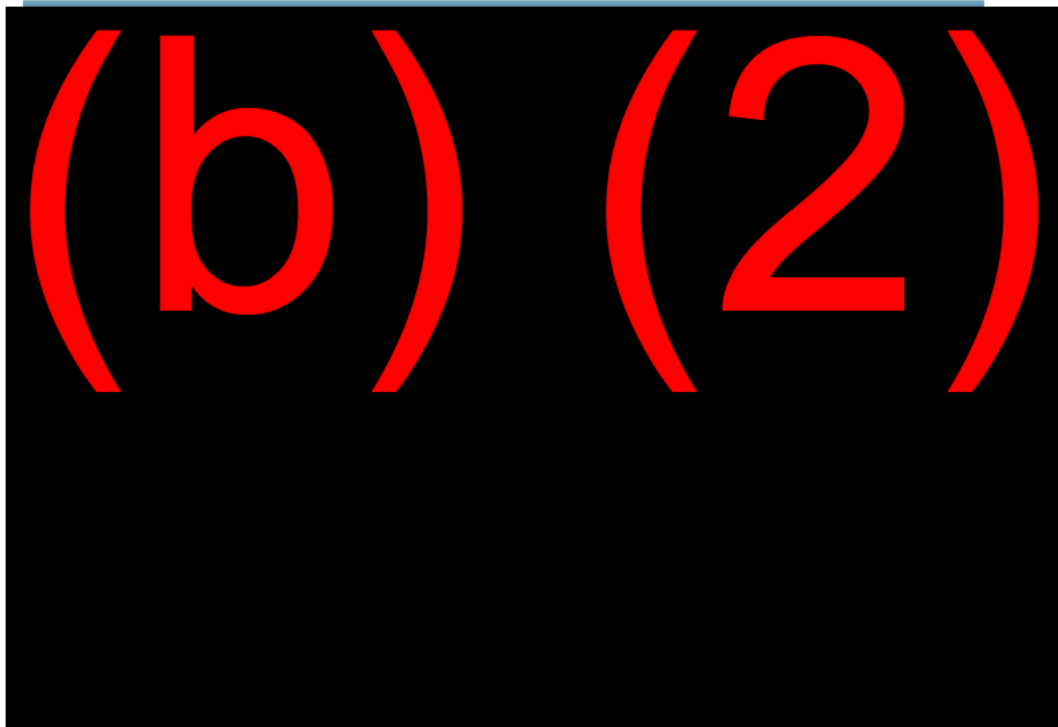
3367 Capability/Rmk

Select Next Page to complete the **Capability/Rmk** screen. If the claimant brought in medical evidence, check the appropriate box on this screen to notify DDS.   Select the DDS capability field if you feel the beneficiary may need a representative payee if approved for benefits and explain in the Remarks.
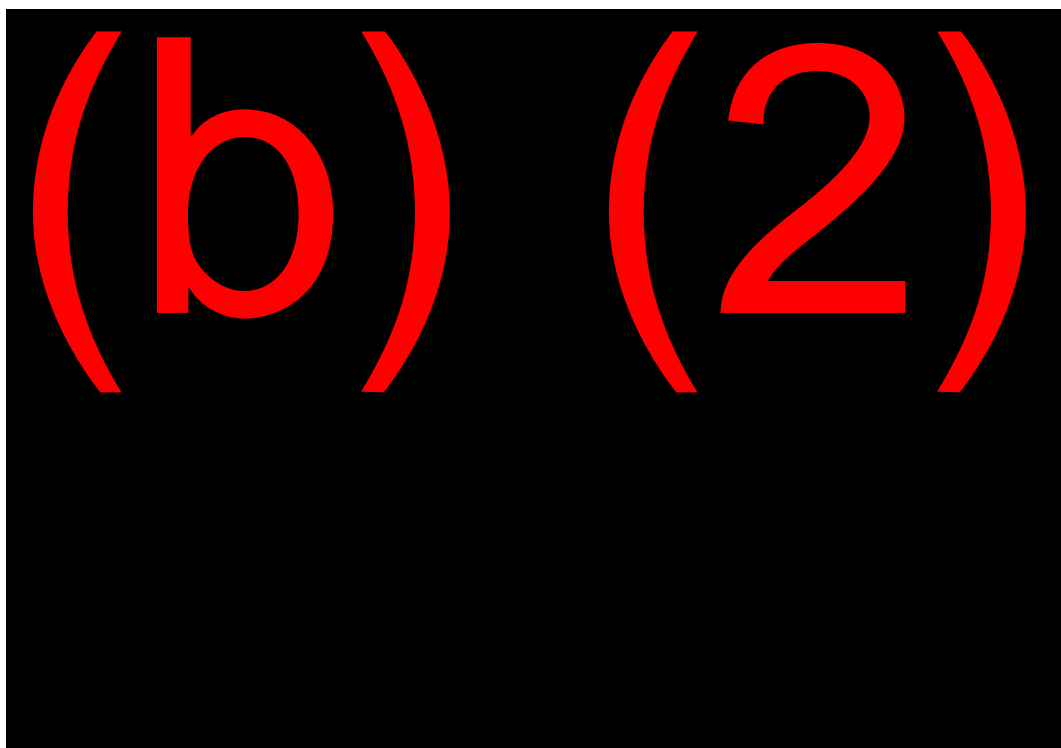
EDCS Edits

DI 81010.050

Located at the top of the EDCS toolbar is the **Check Edits** function. EDCS checks all data entered to ensure required fields are complete and the data is in a valid format. EDCS also provides relationship edits when one answer does not correspond with an entry on another screen.

Edits display any incomplete or incorrect field required for transfer of the case to DDS. The legend identifies the fields which are incomplete or incorrect and the page where the field is located.

Edits display when an attempt is made to transfer jurisdiction of the case to the DDS or when the **Check Edits** link on the toolbar is selected. You must resolve or have a supervisor override the edits to transfer the case from the field office to DDS. **NOTE:** some edits cannot be overridden. "Always Mandatory for Transfer" edits must be resolved before a case is transferred to DDS. They are displayed in the **Always Mandatory for Transfer** box at the top of the **Collect Edits** page.

(b) (2)
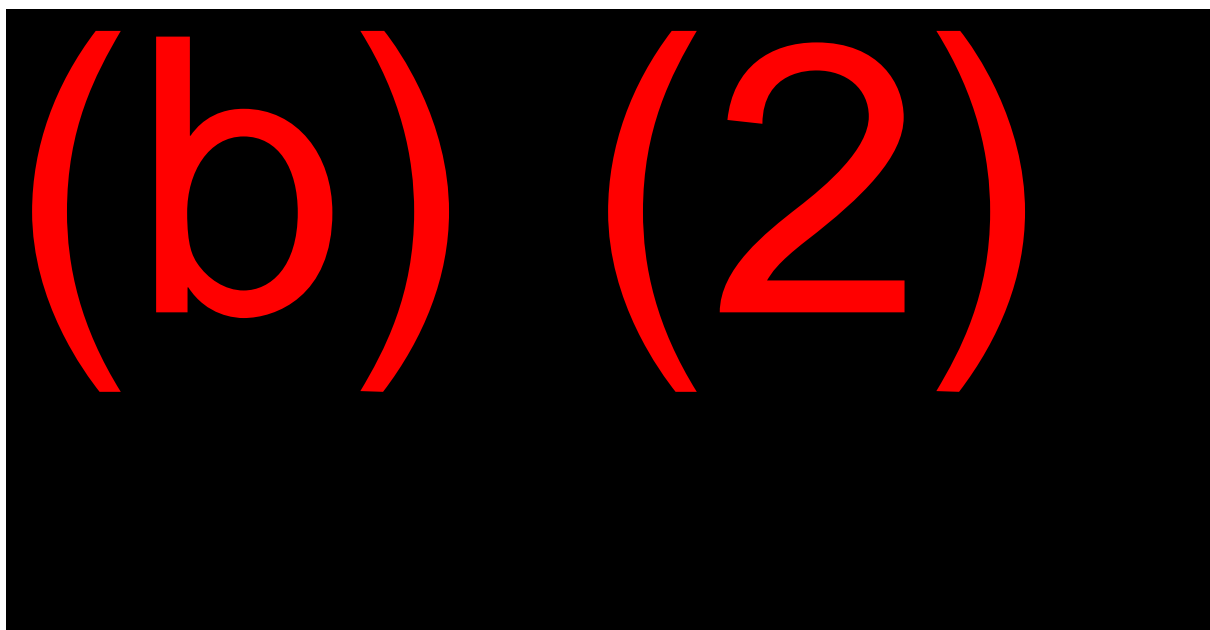
EDCS Flags/Messages

DI 81010.080

Another area of EDCS, which may be applicable to the claim, is the Flags/Messages folder in the left column under the 3368 and 3367 folders.

EDCS Flags

Click on the Flags/Messages dropdown menu to see all possible flags, which alert DDS to any issues that may change how the claim is processed.

(b) (2)
(b) (2)
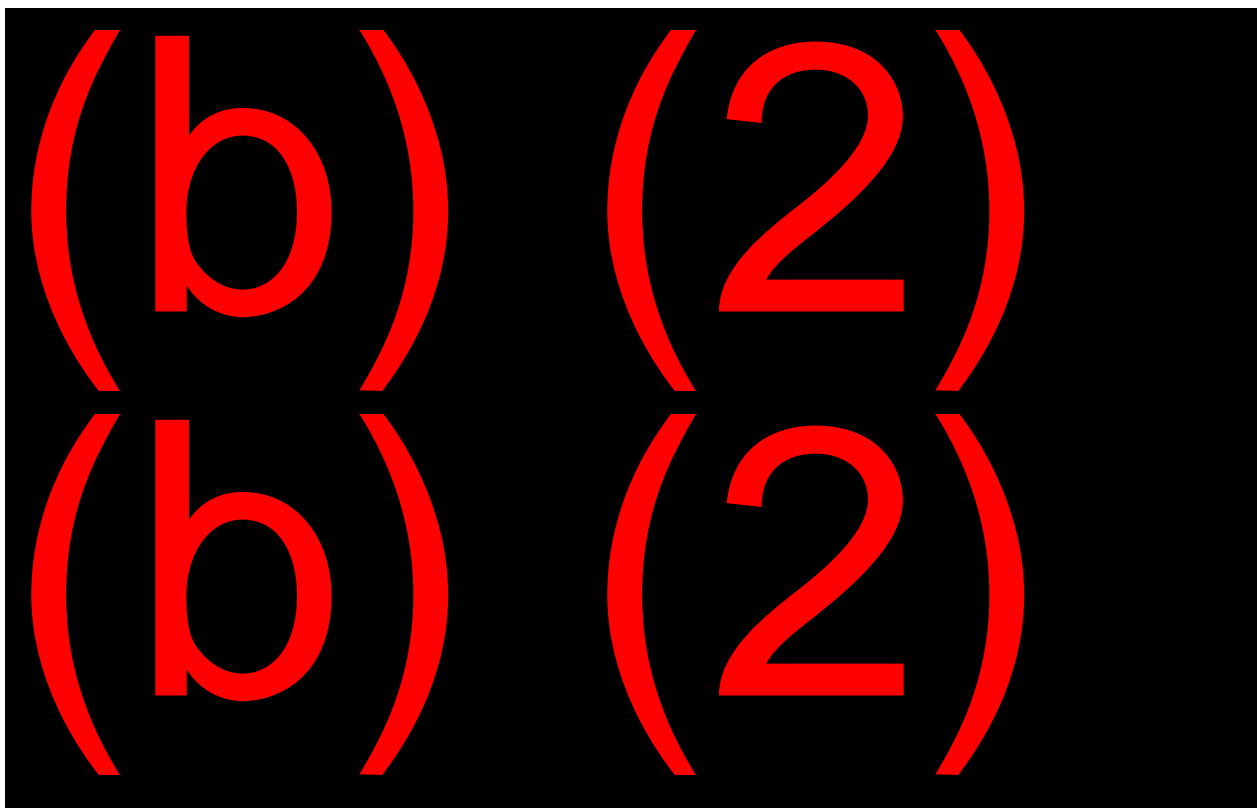
EDCS Messages

Under the Flags button, is the Messages button. Selecting Add Message is another way to alert DDS of any special issues. This function allows for a free format message to DDS and allows you to set an expiration date on the message(s).

(b) (2)
(b) (2)
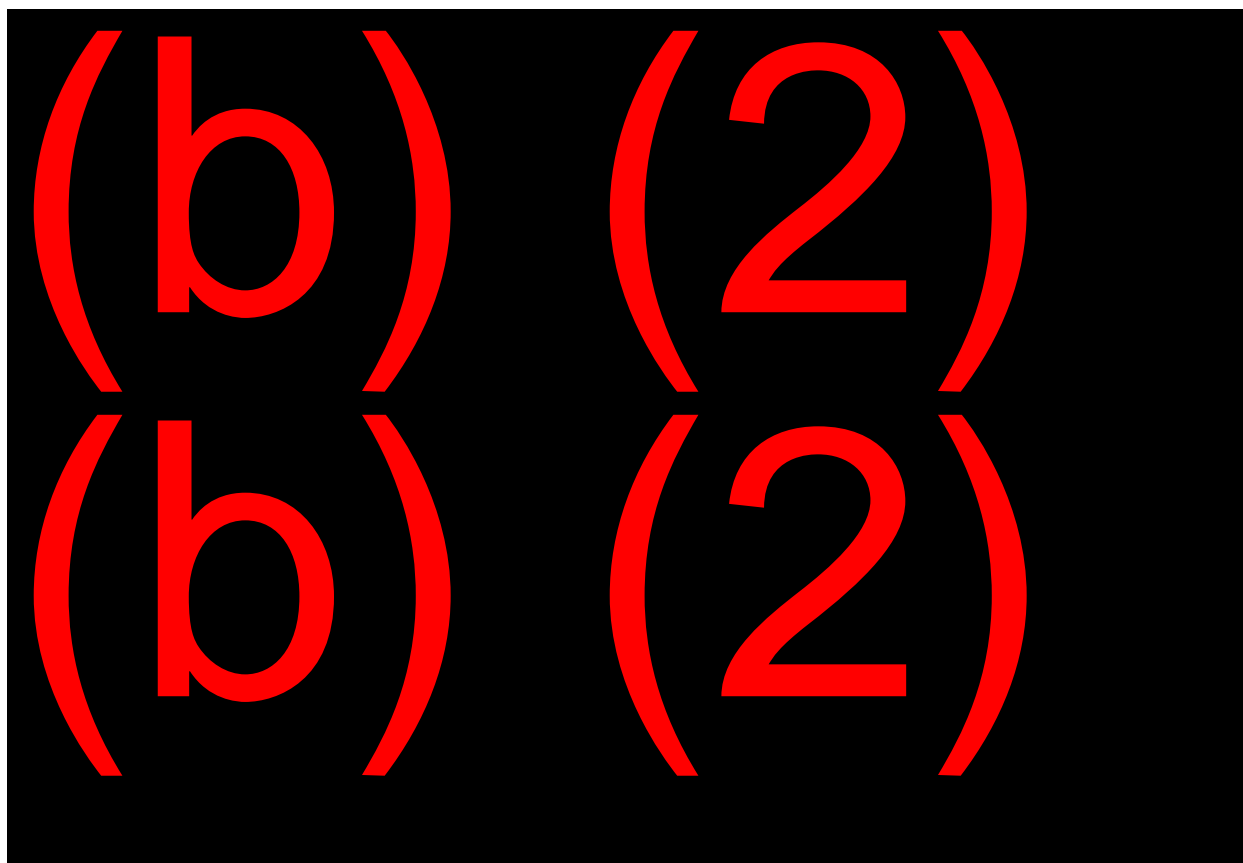
Transferring the CEF to DDS

DI 81010.085

After resolving any edits and adding any necessary flags and messages, transfer the case in EDCS. This ensures accurate information is sent electronically to the DDS and the EDCS record is locked. Before transferring the case, run a complete pre-adjudicative EC request (2/21) in MCS. This will eliminate Update After Transfer edits later.

Re-Propagation

When you attempt an EDCS transfer of jurisdiction, EDCS will first do an automatic re-propagation of mainframe data to ensure EDCS data corresponds to the current mainframe data. However, if changes were made in EDCS to the "Date Last Insured" and/or the "Alleged Disabling

Condition," mainframe data will not re-propagate and overlay the information keyed into EDCS. **DI 81010.035**

Ready to Transfer

> **DI 81010.085C**
>
> To transfer the CEF to DDS, you must:
>
> - Resolve or override transfer edits. **DI 81010.050**
>
> - Access the **Transfer** page in EDCS by selecting **Transfer** from the tool bar.
>
> - On the Transfer screen, select the radio button labeled **Transfer claim(s) to DDS** if you are ready to send the case.
>
> - Select "All actions completed" for at least one claim type.
>
> - Review the transfer destination.
>
> - For initial claims, you can change the EDCS transfer destination in EDCS. For transfer to another FO, you must enter a destination on the case transfer since EDCS will not provide a default destination.
>
> - Place a check in the "Transfer disability folder to DDS/ALJ" box.
>
> - Select the appropriate Prior Filing Indicators (PFIs) on the EDCS Transfer screen.
>
> - Choose the type of disability folder associated with the current claim. Possible answers are:
>
>   - A certified electronic folder (CEF)
>
>   - An official paper folder; or
>
>   - Not yet answered (this must be changed prior to transfer)
>
>   Selecting the appropriate radio button ensures anyone viewing the electronic folder will know if the official folder is paper or electronic. If a paper folder is created for the current filing, the case should not be processed as a CEF, and the paper MDF must be maintained

throughout the life of the case. Follow the procedures in **DI 81010.030** when a paper folder is the certified folder for the case.

- Check the appropriate box to indicate whether a prior paper file is also being sent. Possible answers are:

  - Yes, sending a paper folder (MDF);

  - No, not sending a paper folder; or

  - Not yet answered (this must be changed prior to transfer)

  Only answer yes if you have the paper folder and are sending it at the time you transfer the case. If there is a paper folder, but it is not being sent when the case is transferred, answer "No, not sending a paper folder." If DDS later obtains the prior paper folder, they will update EDCS.

- Select "OK" on the EDCS Transfer screen to transfer the case.

- If the e827 was not obtained, fax the front of one completed SSA-827 into the CEF prior to case transfer. Some offices are also required to mail the SSA-827 to DDS. This depends on your regional operating policy. Please speak to your mentor to determine your local policy.

  NOTE: If the case is a CEF Exclusion, attach the EDCS Routing Form to the front of the paper MDF and mail the paper MDF to the receiving office.

- Route paper Medical Evidence of Record (MER) per the instructions in **DI 81010.125** and follow the instructions in **DI 81010.135** for storing Non-Medical Evidence in the Certified Electronic Folder (CEF).

Routing Form

Type remarks or comments relevant to the case in the text box on the Transfer screen once the "Transfer disability folder to DDS/ALJ" box is selected.

If you are sending a paper 827 or other documentation, print the EDCS routing form and attach the EDCS routing form to any material you must mail to the receiving office.

Also, use the routing form to indicate special handling instructions including:

- Multiple claim situations when one or more claims are not being transmitted at the same time as the current EDCS transfer.

- EDCS exclusion claims associated with the EDCS case.

Results of Transfer

If there are no unresolved edits, a dialog box appears stating the EDCS case will be locked and summarizes the responses on the Transfer screen. If the information is correct, click "Yes" and the case will be transferred to the appropriate office. A print box will then appear allowing the routing form to be sent to the printer, if necessary,

If any information is incorrect, click "Cancel" and correct the information. Repeat the process described above to transfer the case to the appropriate office.

Update after Transfer

DI 81010.095

Update after transfer (UAT) is required when claims data in MCS has been modified after the CEF has been transferred to DDS. This update after transfer electronically notifies DDS of changes that were made to the mainframe.

Some examples of changes in MCS are:

- Change in DFI/DLI

- Change in Onset Date

- Change of Address/Telephone number

- Addition/deletion of authorized representative

You should also use the UAT utility in EDCS to add information to the Certified Electronic Folder (CEF) by creating an SSA – 5002 (Report of

Contact) in EDCS and to add or escalate a claim to your pending EDCS claim.

A Report of Contact might be necessary in EDCS if the claimant furnishes additional information pertaining to the disability report after you transfer the case to DDS. For instructions on how to complete a UAT, refer to **DI 81010.095**.

EXHIBIT 1: DISABILITY DETERMINATION SERVICES (DDS) RESPONSIBILITIES

The State DDS has been given the responsibility to make disability determinations based on standards and guides issued by SSA.

SSA pays 100 percent of the costs incurred by the states in performing this function. This partnership requires SSA to forward the completed forms and any available medical information to the state for them to use in making a decision. The work product you send to the DDS will determine the timeliness and accuracy of that. DDS has the responsibility to determine:

- Whether or not an individual is under a disability;

- The date the disability began (onset);

- The date the disability ceases, except where the sole issue is substantial gainful activity (SGA); and

- The need for VR referral.

> Disability determinations are made based on specific regulations issued by SSA. The disability decision requires participation by an examiner and a physician, or for mental impairments, a psychologist or psychiatrist. The physician/psychologist provides expertise in defining the impairment and the examiner determines the disability based on the impairment and other non-medical and vocational factors.

EXHIBIT 2: FO ROLE IN THE DISABILITY PROCESS

DI 11005.000ff

Applications and non-medical development are initiated in the FO. In carrying out its responsibility, the FO must:

- Explain to the claimant that disability benefits are paid to an individual with a disabling condition which prevents him/her from doing substantial, gainful work.

- Help the claimant complete the appropriate application and assist in securing supporting documentation.

- Recognize, develop, and make determinations on SGA issues and certain other non-medical aspects of the claim, such as proof of age.

- Report pertinent positive or negative observations of the claimant's appearance and behavior whenever possible.

- Advise the claimant of his or her rights and responsibilities. For example, the claimant must report any return to work activity or improvements in the disabling condition to the FO immediately. **DI 11005.001**

- Explain the Ticket to Work program and other work incentive provisions, such as TWP and EPE, to disabled beneficiaries.

- Explain the mandatory continuing disability review (CDR) requirements and emphasize to the claimant that disability benefits may not be permanent.

- Reconcile material discrepancies between statements given and other information in file (e.g., ICERS, DEQY).

- Give each claimant the pamphlet, "Disability Benefits" (SSA Pub. No. 05-10029), as you close the initial disability interview, placing special emphasis on the claimant's responsibilities.

- Identify and adjudicate claims where factors of technical entitlement are not met and curtail further disability development.

- Identify and document prior claims activity.

EXHIBIT 3: FIELD OFFICE WORKFLOW CHART

```
                    ┌──────────────────────┐
                    │  IS CLAIMANT INSURED? │
                    └──────────────────────┘
                       YES          NO          ┌────────────────────┐
                        │                   ───▶ │  FO TECH DENIAL    │
                        ▼                        │       090          │
                    ┌──────────────┐             └────────────────────┘
                    │ IS CLAIMANT  │
                    │  WORKING?    │   YES
                    └──────────────┘              ┌────────────────────┐
                       NO              ────────▶  │  COMPLETE 820/821  │
                        │                         │   IS WORK SGA?     │
                        ▼                         └────────────────────┘
                 ┌────────────────┐                 NO          YES
                 │ SEND MEDICAL   │ ◀──────────────              │
                 │ FILE TO DDS FOR│                              ▼
                 │ DETERMINATION  │                  ┌────────────────────┐
                 └────────────────┘                  │  FO NON-MEDICAL    │
                        │                            │  DENIAL N1 OR N2   │
                        ▼                            └────────────────────┘
                 ┌────────────────┐
                 │ IS NONMEDICAL  │
                 │ DEVELOPMENT    │──────  NO  ──────┐
                 │  NEEDED?       │                  │
                 └────────────────┘                  │
                       YES                           │
                        │                            │
                        ▼                            │
                 ┌────────────────┐                  │
                 │     CAN        │                  │
                 │ DEVELOPMENT    │  YES             │
                 │ BE DEFERRED?   │────────┐         │
                 └────────────────┘        │         │
                       NO                  ▼         ▼
                        │           ┌──────────────┐      NO
                        ▼           │  IS THIS     │──────────┐
                 ┌────────────────┐ │ "NON MED     │          ▼
                 │  COMPLETE      │ │ COMPLETION"  │   ┌────────────────┐
                 │  REQUIRED      │─▶│ EXCLUSION    │   │  FO INPUT OF   │
                 │  DEVELOPMENT   │ └──────────────┘   │  NONMEDICAL    │
                 └────────────────┘       YES          │  COMPLETION    │
                                           │           └────────────────┘
                                           ▼
                  ┌──────────────────────────────────────────┐
                  │  HOLD CLAIM FOR DDS DETERMINATION          │
                  └──────────────────────────────────────────┘
```

The above graph shows the FO Processing of FO and DDS Jurisdiction DIB claims.

<u>EXHIBIT 4: SSA RESPONSIBILITY</u>

SSA is responsible for the overall administration of the disability program, including:

- Examining state determinations for consistency with the established disability evaluation guides;

- Determining disability under Title II for persons living outside the 50 states, the District of Columbia, Puerto Rico, Guam, or for an individual whose case comes within a class of claimants for which the states are not making disability or blindness determinations (e.g., career Railroad employees);

- Determining disability under Title XVI for individuals living in the Northern Mariana Islands;

- Determining technical entitlement/eligibility issues—e.g., earnings requirements for DIB or freeze, the prescribed period requirement for DWB, or income and resources requirements for SSI;

- Determining whether the individual is entitled to DIB, CDB, or DWB and determining the first month of entitlement based on non-medical factors;

- Handling SGA issues; and

- Determining if the claimant is incapable.

EXHIBIT 5: ELECTRONIC FOLDER

Certified Electronic Folder (CEF)

DI 81001.005

The CEF is an electronic disability repository which stores the claimant's information. A CEF is established when a disability report is entered into the Electronic Disability Collect System (EDCS). Data entered in MCS and/or MSSICS is propagated into EDCS.

All disability documentation is electronically added to the CEF using scanning, faxing, or electronic uploads by case processing systems in the FO, DDS, OQA, and ODAR.

CFUI

SM 08001.001

Very few disability claims are stored in paper files. Almost all cases are now in an electronic format. Information is either captured electronically within a system of screens such as MCS or EDCS or, if a paper document is provided, by faxing the document into the electronic file. A claims file record is the electronic record of all claims filed on a particular SSN and can exist for Title II, Title XVI, and/or Title XVIII. A claims file record can contain multiple filings under each title.

The Claims File User Interface (CFUI) allows a consolidated view of the electronic folder. Artifacts are the individual documents and information stored in the electronic file, including medical evidence of record (MER) and records and notices stored in the Online Retrieval System (ORS).

EXHIBIT 6: MBR

AACT   DTE:05/04/13 SSN:XXX-XX-XXXX BIC: DOC:R07 UNIT:CLASS1 PG: 001+
STATUS   MBR YES LOU-06/05 DATA FILES YES LOU-06/07 SSACCS NO LOU-06/06 CPS NO
ACCOUNT   PCOC-6 SEX-F TAC-D CDY-0 SSI INVOLVED DRAMS READ
INACTIVE ACCT
PMT CYC   CYI-3 PCEFD-04/21/2013 PCCOM-05/13 PCCR-I
PRIMARY   JANE DOE   DOB-XX/XX/XXXX LSPA-$0.00
INSURED   CLAIM TYPE-DISABILITY DATE OF FILING-04/18/2013
        WAIT PER START-05/2013 20/40 EXCLUSION-TEST NOT MET
        20/40 NON EXCL-TEST NOT MET DIB QC REQUIRE-20 DIB QC EARNED-00
        FULL INS EXCL-TEST NOT MET FULL INS NONEXCL-TEST NOT MET
        FULL QC REQUIRE-35 FULL QC EARNED-19 CURR QC EARNED-00
        HLTHBEN QC EARN-00
PAYMENT   PIC-A MPA-$0.00 DOC-735 RD-04/21/13 LAP-T SERVICE IND-6
TELE NO   BTN-555-555-5555 BTC1-H CPND-05/2013
PAYEE   JANE DOE
        PAYEE UPDATED-04/21/2013
ADDRESS   1234 MAIN ST   ST LOUIS MO 63115-3133
        ADDR UPDATED-05/18/2012
        SCC-26950 SOURCE-X
BENEFIT   BIC-A JANE DOE SB-F DOB-XX/XX/XXXX Q ABN-DXF3 LAF-N
        MBP-$0.00 DRD-04/18/13 LANG-E
HIST TOC   TOC-5 START-05/2012

BEN DENY   DATE OF FILING-04/18/2013 APP RECEIPT-04/18/2013 ID CODE-A
        CUR ENT CODE-DISABLED DIB ONSET-05/04/2012 DISALOW/DEN RSN-090
        LEVEL OF DENIAL-INITIAL
DIB   DDO-04/04/13 LOD-1
CITIZEN   START-XX/XX/XXXX COUNTRY-UNITED STATES PROVEN
SID   SIFT-D SIED-04/13 SISC-P SCCR-26950

EXHIBIT 7: RES JUDICATA WORKFLOW

Res Judicata Workflow
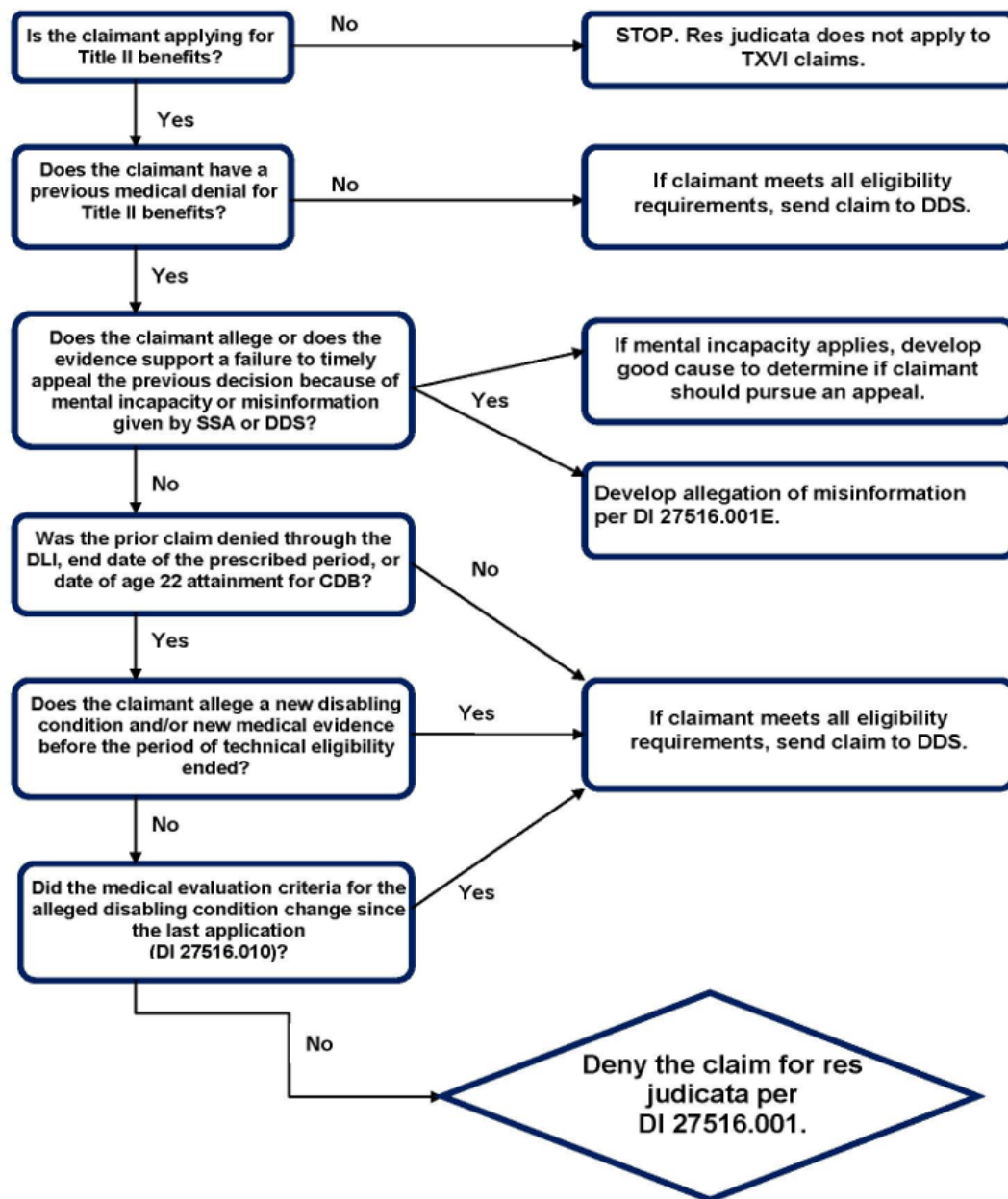
OFF AIR ACTIVITIES

- Read POMS **DI 81010.140 - .142**. This section outlines FO action in EDCS when a current claim will be adopted based on collateral estoppel, technically denied, or denied for performance of SGA.

- The student should observe an in-office disability interview and ask the interviewing CS questions about what criteria was or will be considered in establishing a potential onset date (POD). The student should complete the EDCS 3367. Have the CS who conducted the interview review the 3367 before transmitting the claim to DDS.

- Locate an informational website to assist with completing the "observation section" of the EDCS 3367.

    - Go to FORCE.

    - Select Kits from the Menu bar.

    - Next, find the T2 CS Resource Kit.

    - Once there, look under Program Information and click on the Disability Interview Guide.

    - On the left hand side of the screen is a list of the names of many common disabilities.

    - Choose the impairment you want, click on it, and scroll down until you see the section "Observations."

    - This section will give suggestions of appropriate observations to be made and noted on the EDCS 3367.

    If this guide appears to be a useful tool for future use, it can be made into a "favorite" site.

EXERCISE #1

OBJECTIVE 1: Identify which SSA component has jurisdiction for a disability claim and the responsibilities of that component in the claims process.

Identify which SSA component(s) have jurisdiction in the following claims situations and the processing responsibilities of each component.

1. George retired from covered employment at age 52. He worked at the same job for the last 28 years. At age 53, he files for disability based on health issues, which have bothered him for a number of years.

2. After working 20 years under covered employment in the U.S., Karen retired 2 years ago at age 55 and moved to Canada. Last month she became disabled after suffering a stroke and filed a claim with a border FO.

3. Alice worked for over 10 years for the Santa Fe Railroad. For the last 20 years, she worked for SSA covered wages. She has never filed a claim for RRB benefits.

EXERCISE #2

OBJECTIVE 2: Determine the steps necessary to develop and document a disability claim.

Determine the appropriate development for the Title II portion in the following claims situations.

1. Leonard is 22 years old. He began working in January last year and worked 11 months before he was forced to quit due to a back injury. He had no prior work history and just filed for DIB.

2. Patty is 49 years old. Her date last insured for disability was 09/30/18. She filed for disability benefits in July 2018 and alleged onset in November 2017. The MBR displays a medical denial for that claim of 10/04/18. She files again for disability in January 2019, <u>still</u> alleging an onset in November 2017. She has no additional work or new medical evidence.

3. Bill contacts you today to file for disability. He worked steadily for the last 15 years. He states he was injured in a car accident 3 months ago but forces himself to continue working. He wants to file for disability so he can stop working.

4. Henry was approved for Title XVI benefits at age 21. He has been working below SGA at a part-time job for several years and becomes insured for Title II benefits.

5. Mrs. Rhodes comes in to file a DIB claim on behalf of her husband who died two months ago after a long battle with cancer.

6. Reuben comes to the office to file for disability on 10/04/18 with an AOD of 08/08/16. He states he returned to work 05/18 and continues to perform SGA (No IRWE, subsidy/special considerations or UWA). You send the claim to DDS and they establish his onset as 08/08/16 and determine his disability ceased May 2018. What type of claim does Reuben have? Explain.

EXERCISE #3

OBJECTIVE 3: Conduct the non-medical portion of a disability interview.

Provide the answers for each question.

1. What items or forms are most commonly used in taking a DIB claim?

2. Besides completion of the necessary screens and forms, what else must you do prior to concluding all initial DIB claims interviews?

3. What action must you take to have jurisdiction of a CEF sent to DDS?

EXERCISE #4

OBJECTIVE 4: Determine when non-medical development of a claim may be deferred.

Select the answer which best describes the appropriate step for developing the following claims.

1. Stephanie is at your desk. She states she worked for "about" the last 5 years as a part-time clerk in a local department store. She had not worked previously. She was involved in an automobile accident last week, and her doctor told her it would be 6 to 8 months before she would be able to return to work. She understands she must have a condition which is expected to last a full year but wishes to file anyway. She is 35 years old and has five-year-old twins You should take an application for:

    a. Stephanie and the twins

    b. Stephanie only

    c. Stephanie only and request she furnish proof of age for herself and proof of her lag earnings

    d. Stephanie and the twins; request she furnish proof of age for herself and the twins

    e. Stephanie only and request she furnish proof of her lag earnings

2. Stephanie had proof of her lag earnings and current year-to-date earnings with her. You determine she is insured for disability benefits. You should:

    a. Route the claim to the servicing PSC/DPB for a medical determination and authorization because she meets insured status.

    b. Route medical file to the DDS for a medical determination because she meets insured status.

    c. Retain the claim in the FO for a technical denial.

3. After 3 months, the DDS returns Stephanie's medical file as an allowance. You should:

    a. Complete development for Stephanie and obtain an application and proofs for the twins.

    b. Route the claim to the servicing PSC.

    c. Route the medical file back to the DDS for verification of their determination.

    d. All of the above.

EXERCISE ANSWERS

Exercise #1

1. George's case requires a medical determination since he is fully insured and meets 20/40. A CS develops work activity if any was performed after George's alleged onset date. Forward the case to DDS for a medical decision. **DI 11010.255**

2. It appears Karen meets insured status, and foreign residency does not preclude entitlement; therefore, this case requires a medical determination. Due to foreign residency, OIO has jurisdiction, which is responsible for preparing a medical determination and final adjudication of the claim. **GN 01702.400- .420**

3. It appears Alice meets insured status. The FO develops all medical and non-medical evidence. Alice's claim goes to GLPSC-DPB for the medical decision. **DI 11010.262, DI 11050.000**

Exercise #2

1. Since a NH needs at least 6 QCs to be insured for DIB, and only a maximum of 4 QCs can be earned in a calendar year, Leonard is not insured for DIB. The FO retains jurisdiction of the entire file and processes the claim as a technical denial. No medical development (SSA-3368/3369, 827s) need to be completed. **DI 11010.040**

2. Since the NH had a medical denial after the DLI and no additional work, this case is denied based on res judicata and is processed by the FO as a technical denial. No medical development needs to be taken. **DI 27516.001 DI 11010.075** When DDS made their decision in October 2018, they would have considered all evidence through 09/30/18, the DLI.

3. Development of the work activity is necessary. An SSA-820 or SSA-821 must be obtained in addition to the application and medical development. The CS then makes an SGA determination and documents the determination on an SSA-823. If the work is SGA, an FO denial is done. If the work is not SGA, the CS will forward the report and determination with the medical file to DDS. **DI 10501.025**; **DI 10505.035**; **DI 10510.025**; **DI 11010.255**

4. Process as a collateral estoppel. Establish the new claim in MCS. Record non-medical development on MCS/Shared Processes as appropriate. Create a new claim in EDCS using the BOAN. Select **key** data but do not complete the 3368. Adopt the previous decision (select "Add FO Determination" and "Collateral Estoppel/FO Adoption" radio button).

5. This is a DIB after Death case. Obtain an application for DIB from the individual eligible to receive the underpayment. Also request medical evidence, if available, and proof of death. (**DI 11010.330**) Send the application to the DDS for a disability determination. If the DDS determines the claimant was disabled, prepare a manual award and forward it to the program service center (PSC) to process the underpayment. See **GN 01010.220** for processing manual awards.

6. This is an example of a Closed Period of Disability case. Based on the filing date 10/04/18, we can allow 12 months of retroactivity which takes us back to 10/17. His MOE would be 10/17. DDS determined his DIB ceased 05/18. This means Reuben is paid from 10/17 through 07/18 (remember, we pay for the cessation month plus two grace months).

Exercise #3

1. Disability application on MCS or paper forms, EDCS 3368, 3367, SSA-820/821/823 as necessary, and SSA-827s signed by the claimant.

2. Give the receipt, pamphlets, and handouts to the individual. Explain reporting responsibilities, disability procedures, and proofs needed if the claim is awarded.

    NOTE: Work incentives such as IRWEs and subsidies (which were discussed in detail in the SGA chapter) should also be explained to the individual when appropriate.

3. You must transfer the claim via EDCS to the appropriate DDS. Remember to forward any paper SSA-827s and any related data to DDS.

Exercise #4

1. e) Take an application for Stephanie, but not her children. Under deferred development guidelines, deferral of non-medical issues (proof of age, auxiliary claims) is warranted as her doctor projects her impairment will last only 6-8 months, and a medical allowance is not probable. However, development of lag earnings cannot be deferred as it is not clear if insured status will be met. **DI 11010.030**

2. b) Since Stephanie has proof she is insured, the possibility of a technical denial is removed and a medical decision is necessary. **DI 10005.001**, **DI 11010.025**

3. a) Since she is found disabled, Stephanie is entitled to benefits. We complete any non-medical development for Stephanie and process the claim. In addition, we need to secure auxiliary applications/proof for her twins. **DI 11010.340D**

THE MOD 24 COURSE MATERIAL HAS BEEN INCORPORATED INTO MOD 23.

TABLE OF CONTENTS

LESSON PLAN

Module Objectives

At the completion of this module, the students will be able to:

1. Compute a disability PIA using the NS 78 computation

2. Use ICF, EC and ICERS to compute a disability PIA

3. Compute the amount of a disability benefit taken after a retirement benefit (DIB after RIB) and identify when RIB entitlement is more advantageous.

Length of Chapter

24 hours

Local Supply

SSA-4162 (Child-Care Dropout Questionnaire)

BACKGROUND AND RATIONALE

Introduction

A period of disability can have short and long range effects on an individual's economic welfare.

The SSA disability program provides protection to workers and their families against the economic consequences of prolonged and severe disability.

Disability Computations

The computation of disability benefits is similar to the methods used in RSI computations. However, there are significant differences which have resulted from the historical background of the disability program.

A basic premise of the first disability program was that a worker's retirement benefit should be protected against loss due to a period of disability. As a result, two different disability computations are performed. One method considers earnings in the years of disability and one excludes earnings in the years of disability. These computations are compared to determine which one results in a higher PIA. The terms "disability exclusion" and "non-exclusion" are interchangeable with the terms "freeze" and "non-freeze" for the discussion of DIB PIA computations in this lesson. A period of disability or disability exclusion (freeze) can also affect a subsequent RSI computation.

At the conclusion of this lesson, you will have a good working knowledge of DIB computations which you will need to process and adjudicate disability claims properly.

OBJECTIVE 1:

Compute a disability PIA using the
NS78 computation.

Basic Information

RS 00605ff

NS 78/AIME PIA

In this lesson, we will discuss the 1978 NS Computation Method, the most commonly used computation. The basic procedures for disability computations are the same as those for retirement and survivor computations. You must:

1. Determine eligibility year (ELY), indexing year (IY), base years (BY), elapsed years (EY), dropout years, computation years (CY) and divisor months (DM).

2. Index the E/R and add earnings in the CY to derive the dividend.

3. Determine the AIME by dividing the dividend by the divisor months.

4. Calculate the RAW PIA (the PIA as of January of the year of first eligibility) by applying the PIA formula (bend points) to the AIME.

5. Apply cost of living increases (COLA) from January of the eligibility year through the MOET if applicable.

Disability and Disability Exclusion (Freeze) Computations

RS 00605.215 - .225

Two Computations

Two separate PIA computations are performed for every disability claim. The primary difference between the two is the Disability Exclusion (freeze) computation excludes periods of disability from the computation.

Usually, NHs have little or no earnings in the years they are disabled. Therefore, excluding (or "freezing") these years from consideration preserves a benefit related to the earnings represented in the years the person was not disabled. However, there are times when computing the benefit without using the freeze provision results in a higher benefit to the NH. In all cases both computations are done and payment is based on the higher PIA.

We will also perform the two computations (Disability Exclusion and Non-Exclusion) if a claim for retirement or survivor benefits is filed on the record of a NH who had a prior period of disability.

Exhibit 1 contains a side-by-side comparison of the computation factors of the NS 78 PIA for the exclusion and non-exclusion computations.

Eligibility Year

RS 00605.005

For disability, the eligibility year (ELY), also called Benchmark year, will depend upon which computation is used:

1. For a Disability Non-Exclusion computation, the eligibility year is the year in which the first month of the waiting period occurs. When there is no waiting period, the eligibility year is the same as the year of entitlement.

    The waiting period begins with the later of the 17th month before the claim is filed or the first full month of disability (after the date of onset).

2. For a Disability Exclusion computation, the eligibility year is the year of the disability onset.

NOTE: If the NH attains age 62 earlier than the start of the waiting period or the onset, the year of age 62 attainment will be used as the eligibility year.

Example (James):

James, DOB 02/28/1963, filed for disability benefits on 10/07/2018. He has been approved with a date of onset of 12/28/2016. His month of entitlement is 10/17. James' earnings are shown in **Exhibit 2**.

Disability Non-Exclusion: The eligibility year is the year the waiting period begins. The first month of the waiting period is 05/17. The eligibility year is 2017.

Disability Exclusion (Freeze): The eligibility year is the year of onset. With an onset of 12/28/2016, the eligibility year is 2016.

In a subsequent disability claim, if the new onset is within 12 months of the end of a prior period of disability, use the eligibility year from the prior period of disability. (**RS 00605.005 B.1**)

Example:

Susie Q had a prior period of disability from 10/31/2015-12/01/2017. She files a new claim 10/01/2018 and her claim is approved with an onset of 09/17/2018. The eligibility year for the new claim will be 2015 because her new onset is within 12 months of the end of the prior period of disability.

Indexing

RS 00605.018

It does not matter if you are computing the non-exclusion or exclusion computation. The indexing year is the second year before the eligibility year. Earnings in and after the indexing year are not indexed. We use the actual earnings in those years in our computation. The indexing year is two years before the eligibility year.

Example (James):

Disability Non-Exclusion: The eligibility year is 2017 so the indexing year is 2015.

Disability Exclusion (Freeze): The eligibility year is 2016 so the indexing year is 2014.

Base Years

RS 00605.017

Non-Exclusion

For the non-exclusion computation, the base years are the same as an RSI comp, 1951 through the year before the month of entitlement year. Do not include the year of entitlement in the initial computation. For recomputations of the non-exclusion PIA, the year of entitlement and subsequent years may be included in the base years.

Example (James):

The base years start with 1951 and end with 2016. The MOE is 10/17, so 2017 **cannot** be included in the base years.

Exclusion (Freeze)

To determine the exclusion base years, start with the base years from the non-exclusion computation and then exclude any year when the NH is disabled every single day of the year.

Example (James):

In this example, James is not disabled every single day of 2016, so 2016 cannot be excluded. However, the year of entitlement (2017) is excluded from the base year period. So, the base years for the Disability Exclusion comp are 1951 through 2016.

Elapsed Years

RS 00605.016

Non-Exclusion

The non-exclusion elapsed years are calculated by subtracting the year the NH attains age 22 from the non-exclusion eligibility year.

Example (James):

Disability Non-Exclusion: Add 22 to the year of birth:

Year of birth	**1963**
Up to age 22 not counted:	**+ 22**
Start counting with this year	**1985** (Year of attainment to age 22)

The non-exclusion eligibility year is the year the waiting period begins or the year of age 62 attainment whichever is first. Subtract the year of age 22 attainment from this eligibility year.

Year of waiting period (ELY)	**2017**
Year age 22	**- 1985**
Number of elapsed years	**32**

Exclusion (Freeze)

The exclusion elapsed year are calculated by subtracting the year the NH attains age 22 from the exclusion eligibility year. We would also exclude any years wholly or partially in a <u>prior</u> period of disability (if it applies).

Example (James):

Disability Exclusion: Add 22 to the year of birth:

Year of birth	**1963**
Up to age 22 not counted:	**+ 22**
Start counting with this year	**1985** (Year of attainment to age 22)

The exclusion eligibility year is the year of onset.

The date of onset is 12/28/2016. James' eligibility year is 2016.

Subtract year of age 22 from the eligibility year for the exclusion.

Year of onset (ELY)	**2016**
Year of age 22	**- 1985**
Number of elapsed years	**31**

If James DID have a prior period of disability from 10/14/2001-03/31/2006, the exclusion computation would require an extra step. You would count the number of years where James was disabled at least one day of the year: 2001, 2002, 2003, 2004, 2005, and 2006 for a total of 6 years. Then subtract that number from the elapsed years determined in the prior step:

Initial number of elapsed years	**31**
Years whole or partially in a PPD	**- 6**
Number of elapsed years	**25**

Dropout Years

RS 00605.230

In Retirement and Survivor PIA computations, there are always 5 dropout years. Remember, the number of computation years in any computation can never be less than 2.

For disability computations the drop out years may be less than five. The number of dropout years used is determined under the 1-for-5 Rule.

1. Divide number of elapsed years by 5, dropping any remainder.

2. Use this number of DIB dropout years if it is fewer than 5; if it is greater than 5, use 5.

Example (James):

Disability Non-Exclusion:

Elapsed years   1-for-5 rule
          32   ÷   5 = 6.4* > 5 Dropout years

Disability Exclusion (Freeze):

Elapsed years 1-for-5 rule
31 ÷ 5 = 6.2* **> 5** Dropout years

*Drop any remainder after the division. The number of dropout years **cannot** be more than 5.

Childcare Dropout Years

RS 00605.235

Childcare dropout years are years in which:

- the Number Holder (NH) had no earnings, AND

- was caring for a child under age 3 that was his/her own child or the child of his/her spouse, AND

- the year is a year, which would be used in the benefit computation

When there are less than three regular dropout years in the computation, we may be able to use Childcare Dropout Years. Additional dropout years in the PIA computation, due to childcare, can result in a higher PIA.

The Childcare Dropout Year question on the DISB screen must be answered in all claims.

(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

When the childcare dropout years cause a change in the computation, obtain the form SSA-4162 (Child-Care Dropout Questionnaire). To determine if documentation is required, review the DPIA screen in EC. If the Childcare dropout years are used, obtain the additional documentation. If they are not used, you do not have to request proof.

See the chart in **RS 00605.235 B** to determine the maximum allowable childcare dropout years.

Computation Years and Divisor Months

Computation Years

To determine the computation years, take the number of elapsed years and subtract the number of dropout years (both regular and childcare dropout years). Remember, that the number of computation years can never be less than 2. If the NH only has two elapsed years, we do not use any dropout years.

Example (James):

Disability Non-Exclusion:

Elapsed years	**32**
Dropout years	**- 5**
Computation years	**27**

Disability Exclusion (Freeze):

Elapsed years	**31**
Dropout years	**- 5**
Computation years	**26**

Divisor Months

To determine the number of divisor months, multiply the number of computation years by 12.

Example (James):

Disability Non-Exclusion:

Computation years	**27**
Number of months in a year	**x 12**
Divisor months	**324**

Disability Exclusion (Freeze):

Computation years	**26**
Number of months in a year	**x 12**
Divisor months	**312**

Computation of the PIA

Index the Earnings

RS 00605.018

Using the appropriate indexing year (ELY – 2) the earnings record is indexed. This means we take all of the earnings on the record and determine what they are equal to in current dollars. The indexed earnings for a given year are calculated as follows:

Actual Earnings for Given Year x Average Earnings for Indexing Year
Average Earnings for Given Year

Normally ICF programs #19 and #24 can be used to index earnings, even when they cannot compute the PIA. Charts of the average earnings amounts are in POMS if you ever need to manually index an earnings record.

Example (James):

Disability Non-Exclusion

Let's index the earnings for 1995. The ELY is 2017 and the Indexing Year is 2015. The 1995 actual earnings are $27,911.52. Per **RS 00605.018**, the average earnings for 1995 are $24,705.66 and the average earnings for 2015 are $48,098.63.

27,911.52 x 48,098.63 = $54,340.01 (Indexed Earnings for 1995)
    24,705.66

Disability Exclusion (Freeze)

Now, let's index the earnings for 1995. The ELY is 2016 and the Indexing Year is 2014. The 1995 actual earnings are $27,911.52. Per **RS**

00605.018, the average earnings for 1995 are $24,705.66 and the average earnings for 2014 are $46,481.52.

$\frac{27{,}911.52 \times 46{,}481.52}{24{,}705.66}$ = $52,513.06 (Indexed Earnings for 1995)

Dividend   **RS 00605.021**

The dividends for the exclusion and non-exclusion computations are calculated separately. For each, review the indexed earnings record specific to the indexing year determined for each computation. Choose the highest earnings years, with the total number of years used equal to the number of computation years. If the indexing year or years after that are high years, use the actual earnings amount. Remember, earnings included in the computation must be part of the base years.

Example (James):

Disability Non-Exclusion: There were 27 comp years used. The total of the highest 27 years of indexed earnings yield a dividend of **$1,379,387.80**.

Disability Exclusion (Freeze): There are 26 comp years. The total earnings of the highest 26 years of indexed earnings yield a dividend of **$1,294,636.71**.

AIME

The dividend is divided by the number of divisor months to determine the Average Indexed Monthly Earnings (AIME).

Example (James):

Disability Non-Exclusion: Divide by the divisor months:

Dividend		Divisor Months	AIME
1,379,387.80	÷	**324**	**= 4,257.37 = 4257**

Disability Exclusion (Freeze): Divide by the divisor months:

Dividend		Divisor Months		AIME
1,294,636.71	**÷**	**312**	**= 4,149.48**	**= 4149**

Bend Points & Raw PIA

Apply the bend points to the AIME to determine the Raw PIA. Remember, to use the bend points that correspond with the appropriate eligibility year.

Example (James):

Disability Non-Exclusion:

The bend points for the 2017 eligibility year are 885 and 5336.

Multiply the amount at first bend point by 90%: **885 x .90 = 796.50***

The AIME is less than the second bend point (5336), so determine the difference between the AIME and the first bend point: **4257 – 885 = 3372**.

We then multiply this by the second bend point percentage (32%):
3372 x .32 = 1079.04*

Add the amounts from each bend point calculation:
796.50 + 1079.04 = 1875.54* (dimes down rounded to 1875.50) = Raw PIA

Raw PIA effective 01/2017 after bend points applied: **$1875.50**

Disability Exclusion (Freeze):

The bend points for the 2016 eligibility year are 856 and 5157.

Multiply the amount at first bend point by 90%: **856 x .90 = 770.40***

The AIME is less than the second bend point (5157), so determine the difference between the AIME and the first bend point: **4149 – 856 = 3293.**

We then multiply this amount by the second bend point percentage (32%):
3293 x .32 = 1053.76*

Add the amounts from each bend point calculation:
770.40 + 1053.76 = 1824.16*

*Set calculator to three places. Do not round at the individual bend point calculation. After adding the bend point amounts, round down to the next lower dime to get the PIA.

Raw PIA effective 01/2016 after bend points applied: **$1824.10**

NOTE: If the NH is entitled to a non-Social Security funding pension, Windfall Elimination Provision (WEP) may apply. **RS00605.360**

COLA

The Raw PIA is in effect in January of the eligibility year. If there have been intervening cost of living increases given between that date and the month of entitlement, those must be applied to determine the PIA in effect at the MOE.

Example (James):

Disability Non-Exclusion:

Raw PIA effective 01/17 ($1875.50): There was no COLA applied between 01/17 and the MOE 10/17

10/17 Non-Exclusion PIA: $1875.50

Disability Exclusion (Freeze):

Raw PIA effective 01/16 ($1824.10): There was a 12/16 COLA increase of 0.3%.

$1824.10 x 1.003 = $1829.50

10/17 Exclusion PIA: $1829.50

Prior Period of Disability

RS 00605.210 – **RS 00605.225**; **MS 03601.001-6**; **MS 05205.003**

Definition

A prior period of disability (PPD) exists when the NH in a current claim was previously entitled to disability benefits which were later terminated. The PPD is important because the system excludes years the NH was disabled when computing the Disability Exclusion PIA. It is also important when determining the eligibility year and the DIB waiting period.

No Waiting Period Case

DI 10105.075

The NH will not have to serve a waiting period if they had a prior period of disability that terminated within 5 years (60 months) before the current period of disability began (i.e., the current onset date).

For purposes of determining no waiting period, the 60-month period begins with the month after the last month of entitlement. This month is the termination month and is identified as the T8 month on the MBR History line or the DBC entry on the DIB line.

Example:

Meredith Randolph's period of disability ended 10/31/14. Her termination month is 11/2014, the first month she is not entitled to benefits. The 60 month period would be 11/14 (the termination month) through 10/19. She filed for a new period of disability on 11/18/2018. DDS established she was disabled on 04/14/2018. Mrs. Randolph does not have to serve a waiting period because her new period of disability falls within the 60 month period. Mrs. Randolph's entitlement date would be 05/18 (the first full month of disability).

MBR PPDs

The DIB line will reflect the onset date (DDO), entitlement date (DIB DOED) and the benefit termination date (DBC):

(b) (2)(b) (2)(b) (2)

The T8 month in the HISTORY line also shows the termination date.

(b) (2)
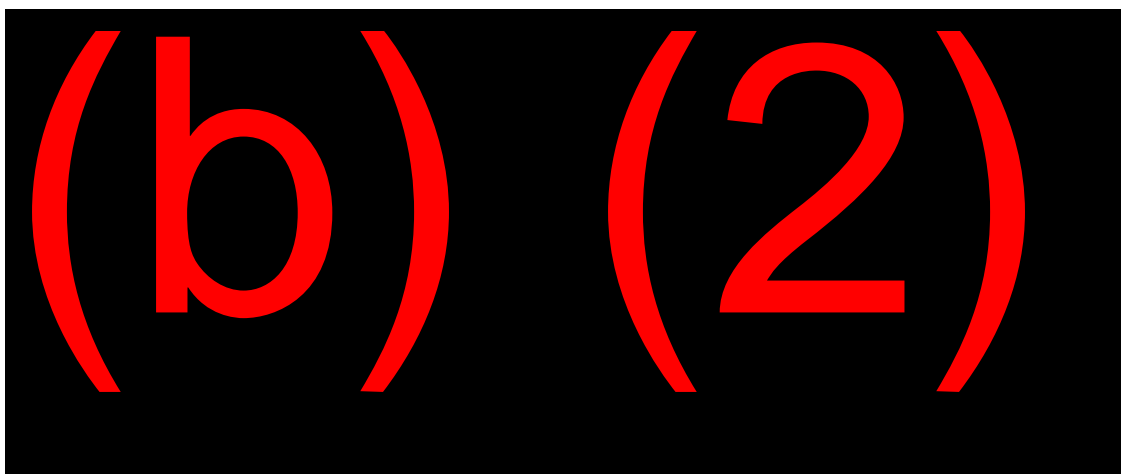
PPDs on the MBR are always used by MCS EC. If incorrect information is reflected on the MBR, the case cannot be processed via EC. Use ICERS or ICF #24 to obtain the PIA and process the case via an A101.

Disability Exclusion Computation (Freeze)

RS 00605.210 A

The Disability Exclusion computation excludes prior periods of disability when computing the PIA. For the computation the prior period of disability begins with the date of onset of the prior period and ends with the earliest of:

1. Last day of the month before the month the NH dies;

2. Last day of the month before the month the NH attains full retirement age (FRA); or

3. Last day of the second month after the month the disability ceases.*

4. Last day of the last month of any entitlement under the expedited reinstatement process. **NOTE:** Provisional payments period does not qualify unless there is an actual reinstatement decision.

*The month the disability ceases does not necessarily mean the disability benefits terminate. Remember, we always pay benefits for the month of cessation plus two grace months. Also, in some cases where the disabled NH is working, we extend benefits for many months before they are actually terminated (extended period of eligibility or EPE). Benefits may be suspended, but not terminated during the EPE.

In EPE cases, the ending date is the last day of the last month for which payment was due. **Suspension months after the last payment month are not part of the period of disability** per **RS 00605.215 A**. This payment information can only be found in the History field.

Example: Luisa, DOB 10/14/71, filed for disability benefits on 10/01/15. She alleged she became disabled 02/15/15. She had a PPD.

We will use the MBR to determine the months included in the PPD when computing the PIA for exclusion and non-exclusion computations.

```
FACT   DTE:10/12/15  SSN:XXX-XX-XXXX  BIC:   DOC:R07 UNIT:SSA     PG: 001+
STATUS   MBR YES LOU-04/11 DATA FILES YES LOU-04/11 SSACCS NO  LOU-04/10
         CPS NO
ACCOUNT   PCOC-7 NOP-01 SEX-F TAC-D LUM-03 LMM-11/13 RCC-5 ERC-01 FLI-M
          CDY-0 DRAMS READ
PMT CYC   CYI-3 PCEFD-07/03/2002 PCCOM-07/02 PCCR-I
PRIMARY   LUISA A LAST DOB-10/14/1971 LSPA-$0.00
INSURED   CLAIM TYPE-DISABILITY DATE OF FILING-04/15/2002
          FIRST MET-04/1996  DIB QC EARNED-00  FULL QC REQUIRE-08
          FULL QC EARNED-40  CURR QC EARNED-00  HLTHBEN QC EARN-00
          CONVERTED
PIA HIS   12/01 $1437.60 L2  FMAX-$ 2156.40D ELY-01 IME-$3362 YOC-00
          01/02 $1490.90 L22 FMAX-$ 2236.40D ELY-01 IME-$3687 YOC-00
          12/02 $1511.70 L2K FMAX-$ 2267.70D ELY-01 IME-$3687 YOC-00
          12/03 $1543.40 L2K FMAX-$ 2315.30D ELY-01 IME-$3687 YOC-00
          12/04 $1585.00 L2K FMAX-$ 2377.80D ELY-01 IME-$3687 YOC-00
          12/05 $1649.90 L2K FMAX-$ 2475.20D ELY-01 IME-$3687 YOC-00
          12/06 $1704.30 L2K FMAX-$ 2556.80D ELY-01 IME-$3687 YOC-00
          12/07 $1743.40 L2K FMAX-$ 2615.60D ELY-01 IME-$3687 YOC-00
          12/08 $1844.50 L2K FMAX-$ 2767.30D ELY-01 IME-$3687 YOC-00
          01/09 $1915.20 L 2 FMAX-$ 2873.30D ELY-01 IME-$4058 YOC-00
          12/09 $1915.20 L K FMAX-$ 2873.30D ELY-01 IME-$4058 YOC-00
          01/10 $1946.00 L 2 FMAX-$ 2919.30D ELY-01 IME-$4220 YOC-00
          12/10 $1946.00 L K FMAX-$ 2919.30D ELY-01 IME-$4220 YOC-00
          12/11 $2016.00 L K FMAX-$ 3024.30D ELY-01 IME-$4220 YOC-00
          12/12 $2050.20 L K FMAX-$ 3075.70D ELY-01 IME-$4220 YOC-00
          12/13 $2080.90 L K FMAX-$ 3121.80D ELY-01 IME-$4220 YOC-00
          12/14 $2116.20 L K FMAX-$ 3174.80D ELY-01 IME-$4220 YOC-00
PAYMENT   PIC-A  MPA-$0.00 DOC-815 RD-10/31/13 LAP-T
TELE NO   BTN-999-999-9999 BTC1-M CPND-09/2011
PAYEE     LUISA A LAST
          PAYEE UPDATED-03/07/2005
ADDRESS   1390 SECURITY BLVD      SAN ANTONIO TX 78232-4921
          ADDR UPDATED-10/31/2013
          SCC-45130  ZDPC-066  SOURCE-N
ZIP FLAG  ZF-P ZFDT-11/13
OTRAD     OZIP-78701     OTOM-01/03
BANK      RTN-123456789 DAN-C123456789 BDCD-09/14/11 SRCD-INTERNET INPUT
BENEFIT   BIC-A  LUISA A LAST SB-F DOB-10/14/1971 C  DOEI-12/01
```

```
            DOEC-12/01 ABN-QTCZ LAF-U  RFST-DIBCES MBP-$2016.00 DRD-03/26/12
            LANG-E CAUS INDICATOR-NO
            HI CONTS PRD-12/2003
HIST TOC    TOC-5 START-CONV
HBAD01      HAP-01 HEDA-07/03/02
HBAD02      HAP-02 HEDA-01/28/05
HBAD03      HAP-03 HEDA-03/07/05
HBAD04      HAP-04 HEDA-09/15/11
BENE ENT    START-12/2001 DATE OF FILING-04/15/2002 APP RECEIPT-00/00/0000
            ID CODE-A  CUR ENT CODE-DISABLED  FULL RETIRE AGE-10/2038
            ANN EARN FRA-10/2038  TERMINATION-03/2011  CONVERTED
DIB         DDO-06/15/01 DAC-R DIG-2940 SDIG-3460 DIB DOED-12/2001
            MEDICARE DOED-12/2001 ADC-03/08 CDR-E DBC-03/11 EBD-03/08
CITIZEN     START-10/14/1971 COUNTRY-UNITED STATES PROVEN
HI-DIB      START-12/2003 TERM-12/2015 BASIS-DISABILITY TYPE-FREE
            FILING-04/2002 NON COVER RSN-DIB CESS
SMI-DIB     START-12/2003 TERM-04/2012 BASIS-DISABILITY PERIOD-IEP
            FILING-04/2002 NON COVER RSN-ENROL WITHDRAW
SMI PREM    START-12/2003 PENALTY-000% CURRENT AMT- $0.00
VAR SMI     START-01/2010 TERM-12/2011 BASERATE-$96.50
DED/ADD     COM MTH  UPDATED     TYPE    SOURCE  AMOUNT      START    STOP    ITEM
            12/2011 11/19/2011 MBP     BRI     $ 2015.90 12/2011          010
            12/2011 11/19/2011 MBP     BRI     $   99.90 12/2011          420
            12/2011 11/19/2011 MBP     BRI     $ 1916.00                  999
            12/2011 11/30/2011 MBP     T2      $    0.00 12/2011          010
            12/2011 11/30/2011 MBP     T2      $    0.00                  999
HISTORY     12/01 $1437.60 $    0.00 600   01         $1437.00
            01/02 $1490.90 $    0.00 900   01         $1490.00
            12/02 $1511.70 $    0.00 700   01         $1511.00
            11/03 $1511.70 $   58.70 000   01       S $1511.70
            12/03 $1543.40 $   66.60 800   01       S $1542.60
            12/04 $1585.00 $   78.20 800   01       S $1584.20
            12/05 $1649.90 $   88.50 400   01       S $1649.50
            12/06 $1704.30 $   93.50 800   01       S $1703.50
            12/07 $1743.40 $   96.40 000   01       S $1743.40
            03/08 $1743.40 $   96.40 000   21       S $1743.40
            06/08 $1743.40 $   96.40 000   721 EPESGA S $1743.40
            12/08 $1844.50 $   96.40 100   721 EPESGA S $1844.40
            01/09 $1915.20 $   96.40 800   721 EPESGA S $1914.40
            12/09 $1915.20 $   96.50 700   721 EPESGA S $1914.50
            01/10 $1946.00 $   96.50 500   721 EPESGA S $1945.50
            05/10 $1946.00 $   96.50 500   720 EPESGA S $1945.50
            06/10 $1946.00 $   96.50 500   01       S $1945.50
            01/11 $1946.00 $   96.50 500   721 EPESGA S $1945.50
            03/11 $1946.00 $   96.50 500   T81 DIBCES S $1945.50
            11/11 $1946.00 $  115.40 600   T81 DIBCES S $1945.40
            12/11 $2016.00 $   99.90 100   T80 DIBCES S $2015.90
            03/12 $2016.00 $    0.00 000   T80 DIBCES   $2016.00
            12/12 $2050.20 $    0.00 200   T80 DIBCES   $2050.00
            12/13 $2080.90 $    0.00 900   T80 DIBCES   $2080.00
            12/14 $2116.20 $    0.00 200   T80 DIBCES   $2116.00
```

DIB PIA computations: To determine the prior period of disability to be excluded in a DIB Exclusion PIA computation:

- Start with the date of onset, and
- End with the last month for which payment was due.

Suspension months after the last payment month **are not** part of the period of disability. In Luisa's case, her prior period of DIB began 06/15/01 (date of onset)

```
DIB          DDO-06/15/01
```

and ended with 12/2010 (the last month payment was due).

```
06/10  $1946.00  $   96.50 500  01            S $1945.50
01/11  $1946.00  $   96.50 500 721 EPESGA S $1945.50
03/11  $1946.00  $   96.50 500 T81 DIBCES S $1945.50
```

For computation purposes her PPD is 06/15/01 – 12/10.

DIB waiting period: To determine whether she has to serve a waiting period, we look at when her prior period of DIB terminated in relation to her new onset date (EOD). If her new EOD is within 60 months of the termination month, she will not have to serve a waiting period. We find the termination month in the DIB line (DBC field):

```
DIB          DDO-06/15/01 DAC-R DIG-2940 SDIG-3460 DIB DOED-12/2001
             MEDICARE DOED-12/2001 ADC-03/08 CDR-E DBC-03/11 EBD-03/08
```

…or by looking at the HISTORY line for the first T8 month:

```
06/10  $1946.00  $   96.50 500  01            S $1945.50
01/11  $1946.00  $   96.50 500 721 EPESGA S $1945.50
03/11  $1946.00  $   96.50 500 T81 DIBCES S $1945.50
```

The MBR shows Luisa's DBC month is 03/11. The 60 month period is 03/11 through 02/16. Based on her new EOD of 02/15/15, she does not have to serve a waiting period. Her new onset is within 60 months of the termination month. Her date of entitlement for this subsequent period of disability is March 2015, the first full month of disability.

DIB Guarantee PIA

RS 00605.035

When the NH was previously entitled to DIB, the PIA for a new period of disability cannot be less than the PIA in the last month of entitlement of the prior period of disability. If the earlier PIA is higher than the current PIA, we will use the earlier PIA. This is called the "DIB GUARANTEE PIA." This happens most often when the new period of disability begins within a short time after the prior termination of disability.

The PIA for the new period of DIB entitlement has no subsequent COLAs added. However, the COLA is applied if the entitlement begins within 12 months following the prior termination date.

Freeze Only

DI 10105.005 C

An individual may be eligible for a freeze but not for cash disability benefits if they are:

1. Statutorily blind and able to engage in substantial gainful activity. This excludes individuals under an occupational disability and not working. **DI 26001.001** & **DI 26005.005**

2. Eligible for a period of disability based on railroad earnings or military service not creditable for Social Security benefit purposes.

Family Maximum

RS 00615.742

Background

A special limit applies when determining the FMAX payable in disability claims. This is called the DMAX.

The DMAX applies to individuals initially disabled after June 1980.

DMAX Amount

The DMAX is the smaller of:

- 85% of the AIME, but not less than the raw PIA before COLA increases, or

- 150% of the raw PIA without COLA increases.

Example (James):

James will be paid based on the Disability Non-Exclusion PIA. The AIME for this PIA is $4257. The Raw PIA (effective 01/2017) is $1875.50.

Step 1: Compare 85% of the AIME with 150% of the raw PIA and choose the smaller amount, after dimes down rounding.

- 85% x 4257 = $3618.45 dimes down rounded to $3618.40
- 150% x $1875.50 = $2813.25 dimes down rounded to $2813.20

$2813.20 is smaller, so we use that amount for step 2.

Step 2: Apply any COLAs from January of the ELY through the MOE.

In this example, there were no COLAs between 01/17 and the MOE 10/17.

So, $2813.20 is the DMAX for 10/17.

DMAX Equals PIA

There are cases in which the DMAX equals the PIA. This is sometimes called a "Pickle MAX." In these cases, no auxiliary benefits are payable. However, technical entitlement should be developed for any auxiliaries so survivor benefits can begin immediately if the NH dies. Also, relationship issues are easier to develop when the NH is living.

OBJECTIVE 2

Use EC, ICERS and ICF to compute a disability PIA.

Disability PIA Computation using EC

MS 03601.001ff

MCS Screens

When the disability application is loaded in MCS, there are several screens which can affect the EC computation. In the application path, the IDEN screen is where the alleged onset date is entered. This is the date that will be used for the initial computation of the PIA before the DDS decision is made.

EC will assume the date a claim is received is the correct filing date unless a protective filing exists. This information is reflected on the FDDS screen. EC will use the earlier date as the material filing date.

Upon final adjudication of an approved disability claim, the system derives the date of onset from the DICL screen.

**DIB Comp – No PPD involved**

Example (James):

James, DOB 02/28/1963, filed for disability benefits on 10/07/2018. He was approved with an onset date of 12/28/2016. His MOE is 10/2017. He did not have a prior period of disability.

Here are the pertinent screens for the disability PIA computation:

The MCR1 screen is the first screen in the EC path for an initial award. It displays the current PIA along with the basic computation data. **MS 03601.007**

(b) (2)
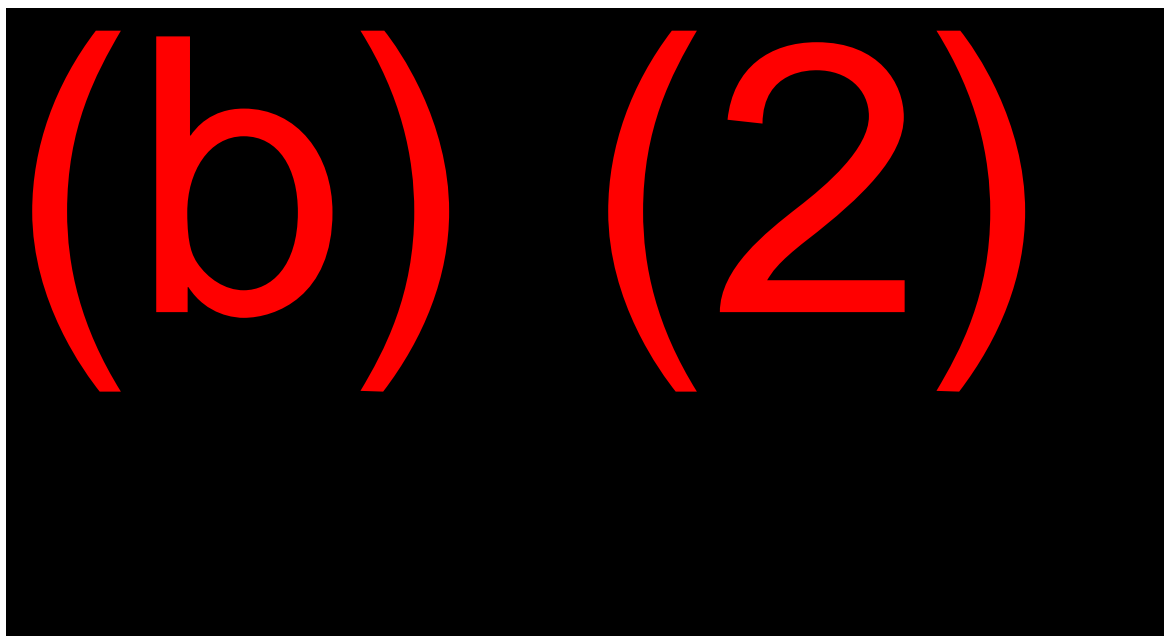
MCS selects the highest PIA that will be used to pay the NH. In this case the system selected the NS 78 Disability Non-Exclusion PIA.

The DPIA screen displays the NH's PIA calculations and relevant computational data. EC displays the PIAs effective with the MOE up through the most recent COLA. **MS 03601.017**
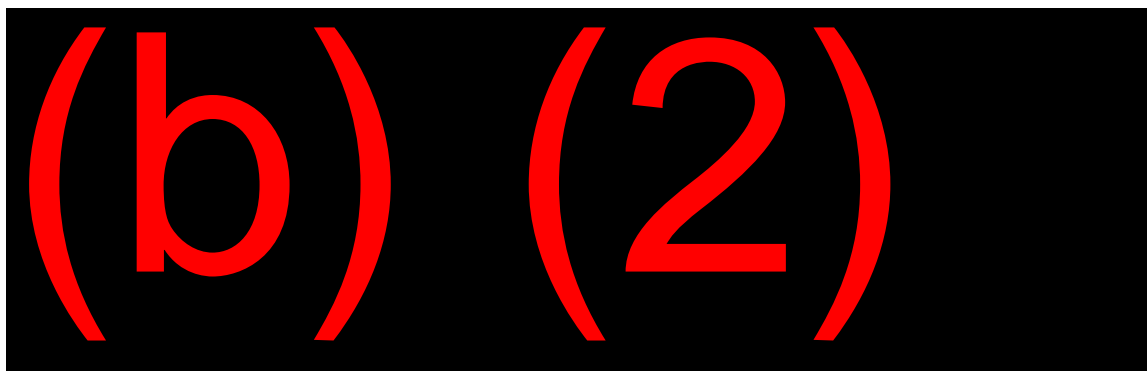
(b) (2)

DIB Computation – PPD Involved

    Example: Luisa

    Luisa, DOB 10/14/71, filed for disability benefits 10/01/15. Her current EOD is 02/15/15. She has a prior period of DIB with an onset of 06/15/01.

The last month payment was due in that prior period of disability was 12/10; entitlement ended 02/28/11 (03/11 is the first month of T8).

The EC screens reflect the last computation. Here are the pertinent screens for the disability PIA computation involving a PPD:

The MCR1 screen is the first screen in the EC path for an initial award. It displays basic PIA computation data. **MS 03601.007**

(b) (2)
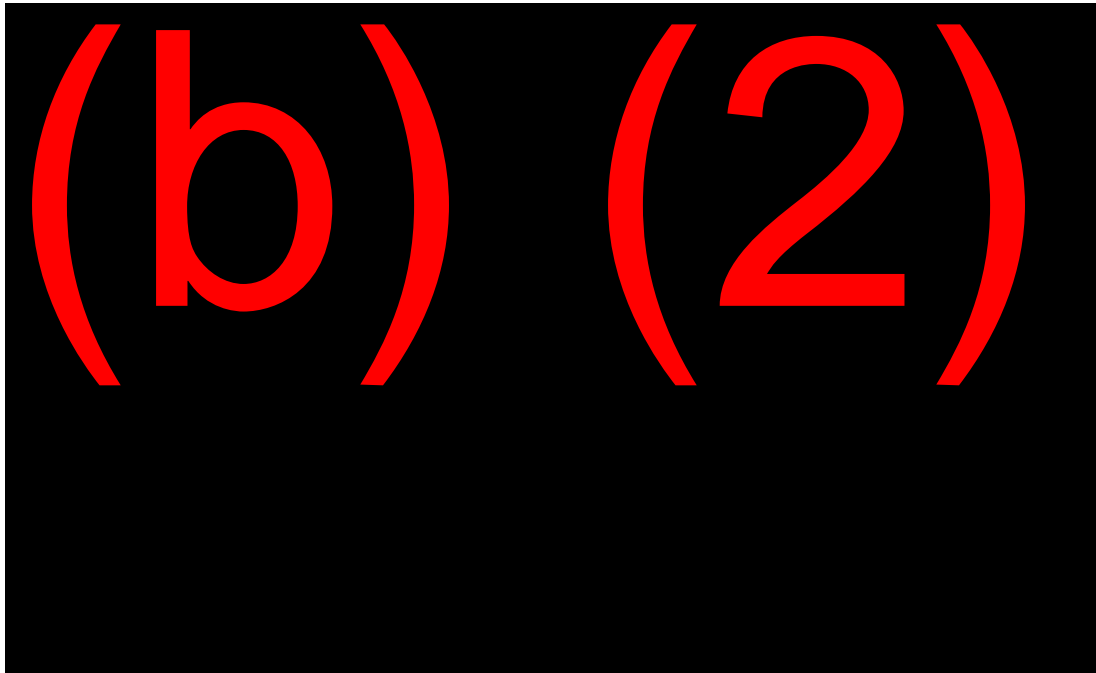
The DRMK screen displays Processing limitations, Exceptions and other remarks that MCS generates while processing an EC. This case has a processing limitation as shown below.

(b) (2)
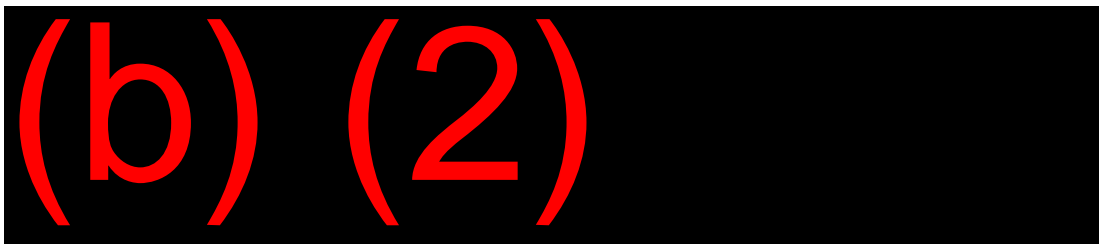
This case also shows a PPD was used when obtaining the computation. Note the third remark on the screen below. **MS 03601.019**
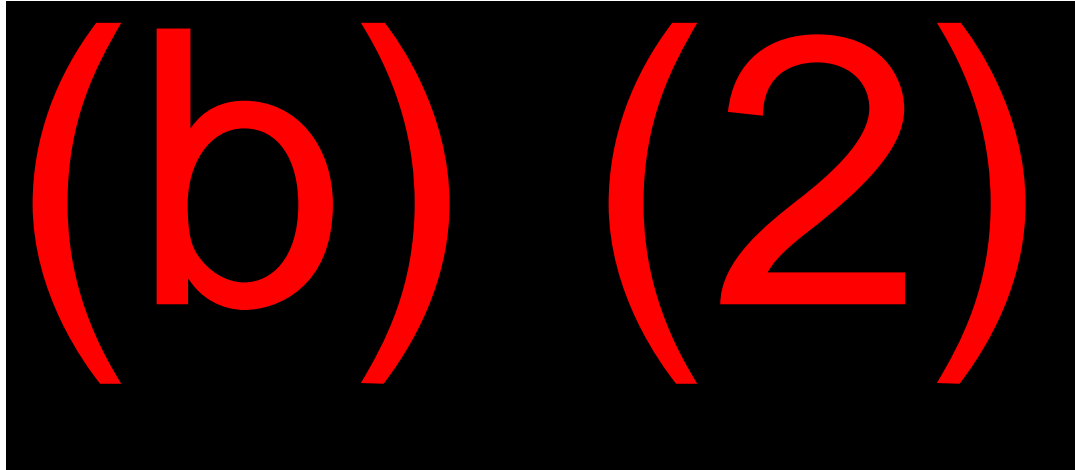
The DEI3 screen displays information regarding the PPD entitlement. **MS 03601.014**

This screen (DEI3) will only be displayed if there is a prior period of disability on the MBR or multiple SSNs. The prior period of DIB information is shown under DIB PERIODS.

- START is the date of onset for the prior period of DIB.

- DEED is the Disability Entitlement End Date which is used to determine whether a new waiting period applies to the new claim. It represents the last month of entitlement (month before the T8 month on MBR).

- DPED is the Disability Period End date which is used to determine exclusion decisions for insured status and PIA computations. It represents the last month for which payment is due.

If there is more than one prior period of disability involved, all periods should be reflected here. If the information reflected on this screen is incorrect and will make the PIA or insured status determination incorrect, the claim cannot be adjudicated via EC.

The DPIA screen displays the NH's PIA calculations. **MS 03601.017**

(b) (2)
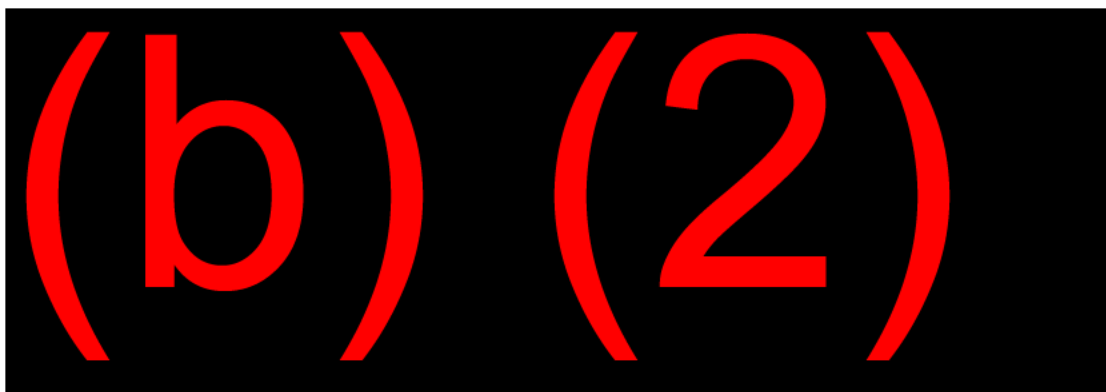
This screen displays the PIA that will be used for payment on the record, in this case the Computation Type shows it is the NS 78 Disability Exclusion PIA being used.

If the PIA is a Disability Exclusion computation and a recomputation of the Disability Non-Exclusion PIA causes it to be higher the next January, a second page of this screen will come up showing the increased ongoing PIA.

The TRIAL PIA COMPUTATIONS (DTPC) screen will show all other computations that were considered in determining the highest PIA. **MS 03601.021**

(b) (2)(b) (2)
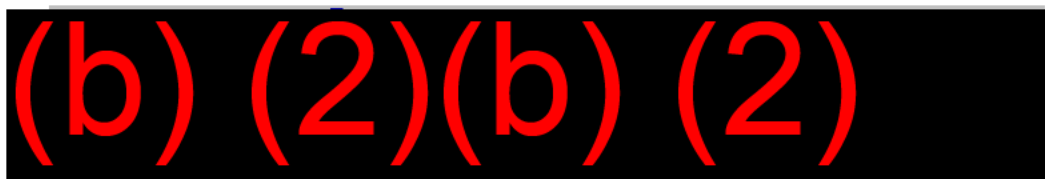
Disability PIA Computation Using Informational/Certified Earnings Records System (ICERS)

MS 02101.001ff

EC (Earnings Computations) is the system used to not only obtain computations but also process claims to completion. There are times when EC will be unable to give a computation because of a processing limitation. In these instances, ICERS may be used to obtain a certified computation.

ICERS Advantages

EC and ICERS use the same system when obtaining computations. So, if you receive a processing limitation in EC that affects the computation, then the same processing limitation will be received in ICERS. The exception to this rule is the computation of a PIA where prior periods of disability are involved. EC may be unable to process the computation because the MBR information is incorrect. However, ICERS allows correction, deletion or addition of PPD information.

Any correction, addition or deletion made to the PPD information propagated to the ICERS request will not make a permanent change to the MBR or other SSA records. If corrections are necessary, they will have to be made via other programs.

DIB Comp – No PPD involved

Example (James):

James, DOB 02/28/1963, filed for disability benefits on 10/07/2018. He was approved with an onset date of 12/28/2016. His MOE is 10/2017. He did not have a prior period of disability.

Here are the pertinent screens for the disability PIA computation using ICERS:

The ICIC screen is the input screen for ICERS. You will need to enter identifying data as well as certain other data related to a request for an earnings record. **MS 02101.003**

(b) (2)
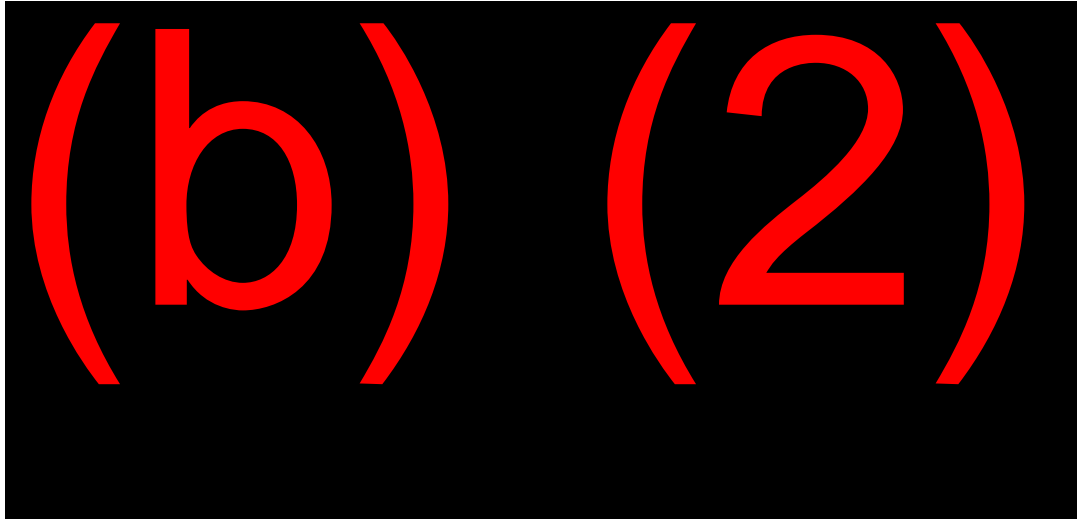
The ICRS screen is the results summary screen of ICERS. Notice it shows the PIA, FMAX, etc. This screen also allows you to request a full earnings record. **MS 02101.012**
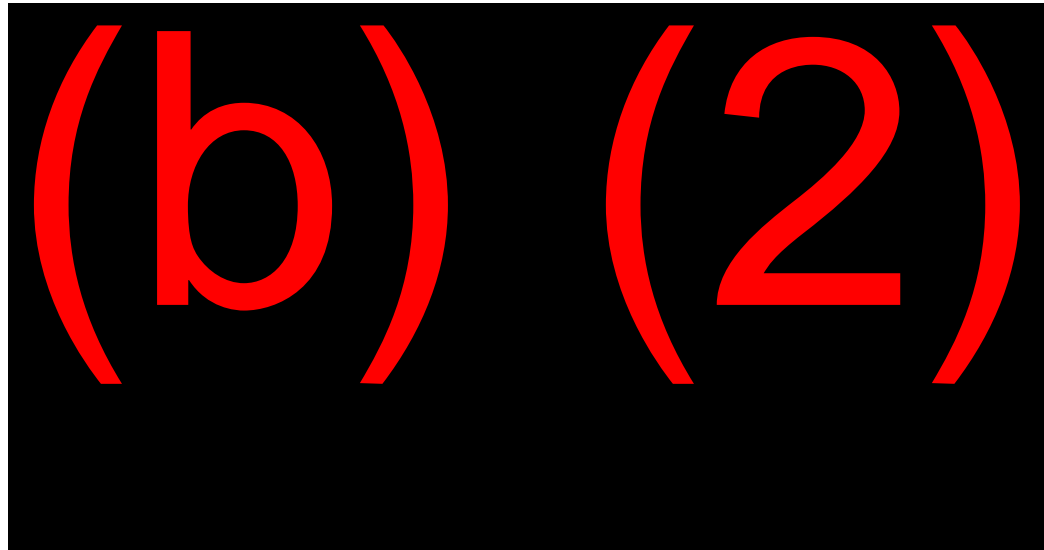
(b) (2)

A series of ICFR screens allow you to view a full record for the NH's SSN. It is very important to always view the full ICERS record to ensure you are using the correct PIA in the computation. Notice that ICERS will select the highest PIA that will be used to pay the NH. All of the computation data related to that PIA is found in the Comp Data field at the end of the full ICERS record. **MS 02101.013**

(b) (2)

DIB Comp – PPD involved

Example: Luisa

Luisa, DOB 10/14/71, filed for disability benefits 10/01/15. Her current EOD is 02/15/15. She has a prior period of DIB with an onset of 06/15/01. The last month payment was due in that prior period of disability was 12/10; entitlement ended 02/28/11 (03/11 is the first month of T8).

Here are the pertinent screens for the disability PIA computation involving a PPD using ICERS:

The ICIC screen is the input screen for ICERS. You will need to enter identifying data as well as certain other data related to a request for an earnings record. **MS 02101.003**

(b) (2)

The ICMD screen will be brought into the ICERS path anytime there is a DIB filing listed on the MBR. In this case Luisa has a PPD, notice her

EOD, DOE and Termination date are shown on the screen. Note the questions (circled) that you must answer. **MS 02101.009**

(b) (2)
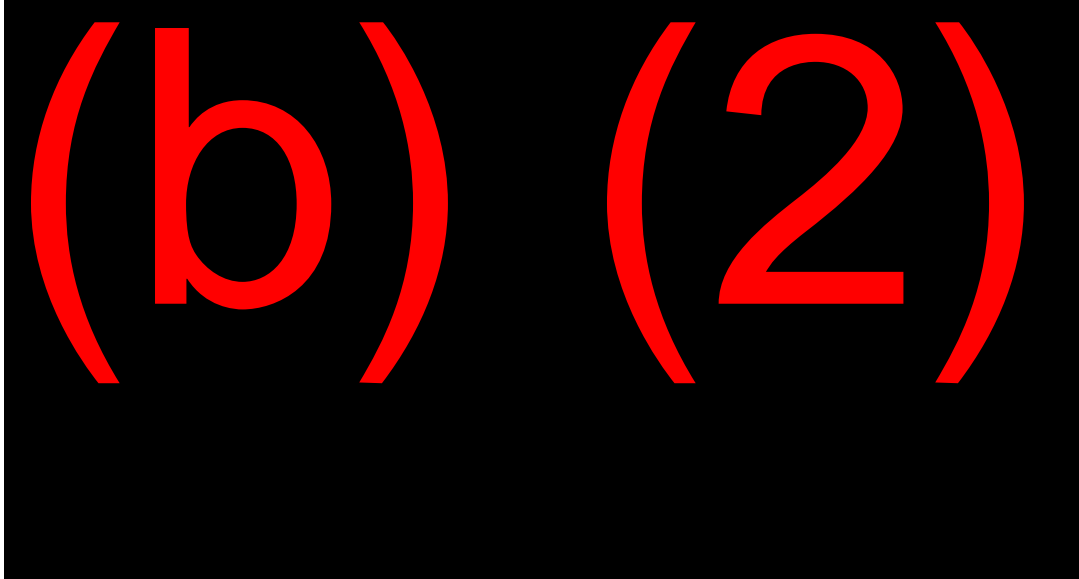
The ICDR screen provides you with data that is housed on the DRAMS file for prior periods of disability. You must answer the question "Disregard all prior periods of disability?" with a Y or N so you can let the system know whether or not to consider PPDs in the computation. **MS 02101.010**

(b) (2)
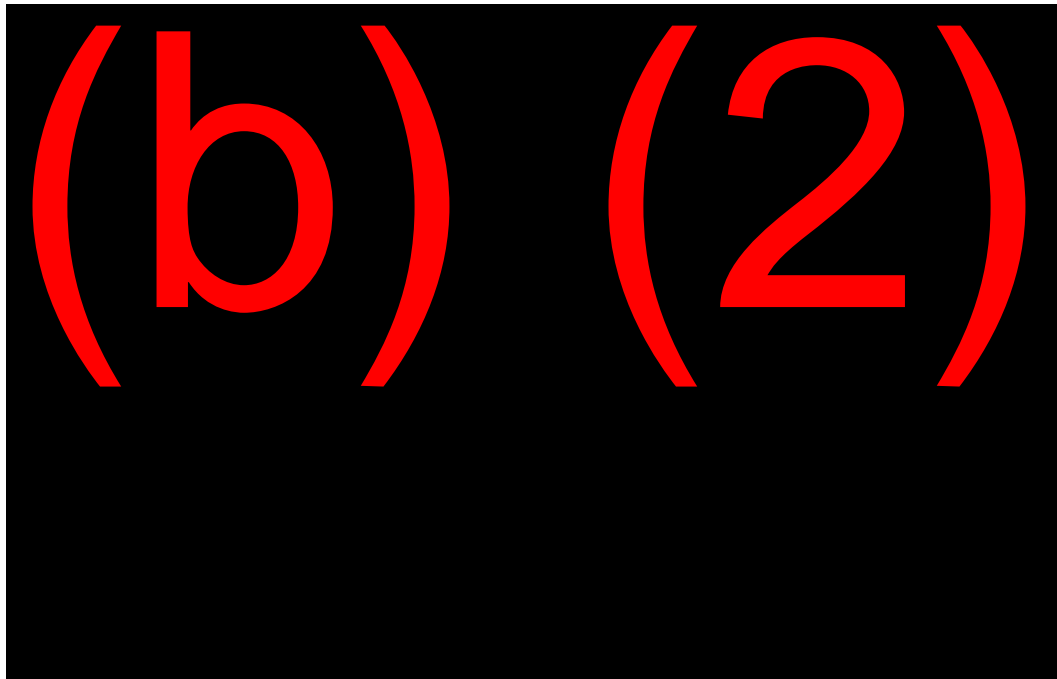
The ICRS screen is the results summary screen of ICERS. Notice it shows you the PIA, FMAX, etc. that is currently in effect. To find the PIA in effect at the MOE, you must view the full ICERS record. To view the full record, enter a "1" in the "Route Full ICERS to/Return to" field. **MS 02101.012**
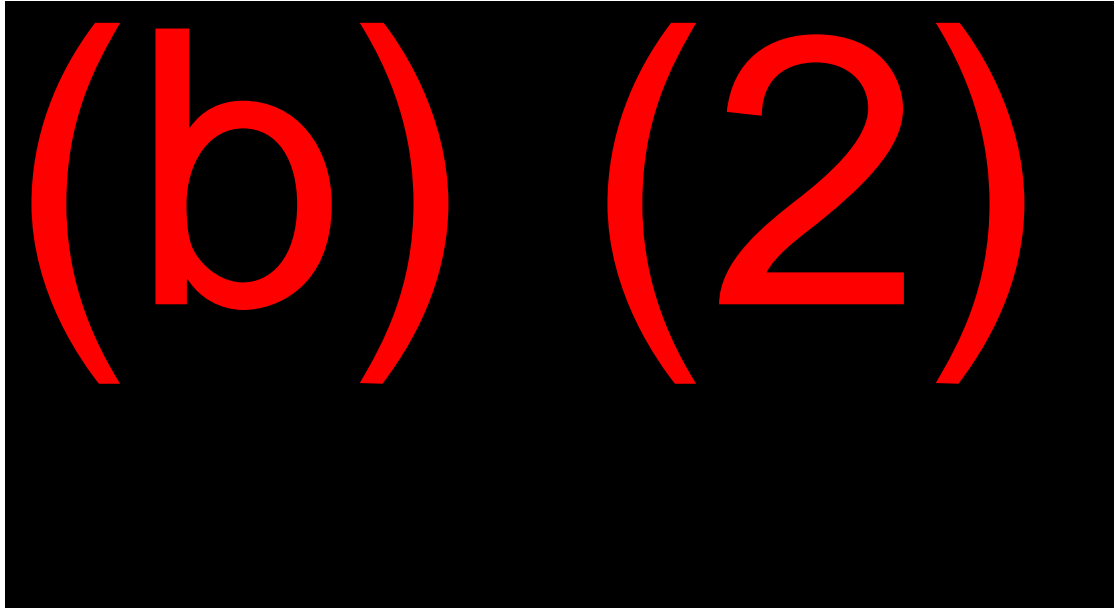
A series of ICFR screens allow you to view a full record for the NH's SSN. It is very important to always view the full ICERS record to ensure you are using the correct PIA in the computation. Notice that ICERS will select the highest PIA, which will be used to pay the NH. All of the computation data related to that PIA is found in the Comp Data field at the end of the full ICERS record. **MS 02101.013**
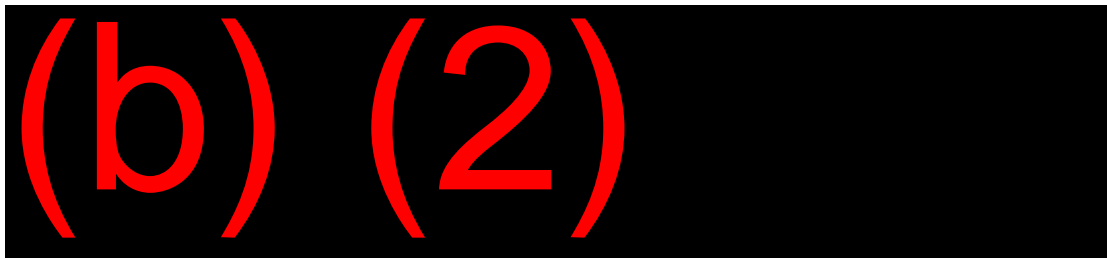
Disability PIA Computation using ICF

MS 02419.001ff

ICF #24

ICF #24, Online Computational Earnings, is used for the computation of a disability PIA. This program requires the name, SSN, and date of birth of the NH as well as disability information. ICF #24 uses the earnings record from the MEF in the computation.

DIB Computation – No PPD involved

Example (James):

James, DOB 02/28/1963, filed for disability benefits on 10/07/2018. He was approved with an onset date of 12/28/2016. His MOE is 10/2017. He did not have a prior period of disability.

The ICF #24 input screens are done the same as for a RIB or Survivor PIA until the NEW START GUARANTEE/AIME PIA COMPUTATION SCREEN (IC54) – shown below.

For a disability computation with no PPD, these entries are required:

- **CURRENT DATE OF ENTITLEMENT**—Enter the entitlement month for the current claim.

- **CURRENT DIB ONSET**—Enter the actual date of onset derived from the DDS decision. Use the alleged onset date if a decision has not been made. Use the date first insured as the date of onset if insured status is attained in the future.

- **CURRENT DIB WAITING PERIOD**—Input the first month of the waiting period. The first month of the waiting period is:

  1. the month following the month of onset; or

  2. the month of onset if the date of onset is the first day of the month; or

---

3. the fifth month prior to the month of entitlement (at most,17 months before filing date) if the date of entitlement is restricted by the rules of retroactivity.

On this screen, we entered the Current Date of Entitlement as 10/2017. The DIB Onset as 12/28/2016 and in the Current DIB Waiting Period field, we entered 05/2017 (first month of the waiting period).
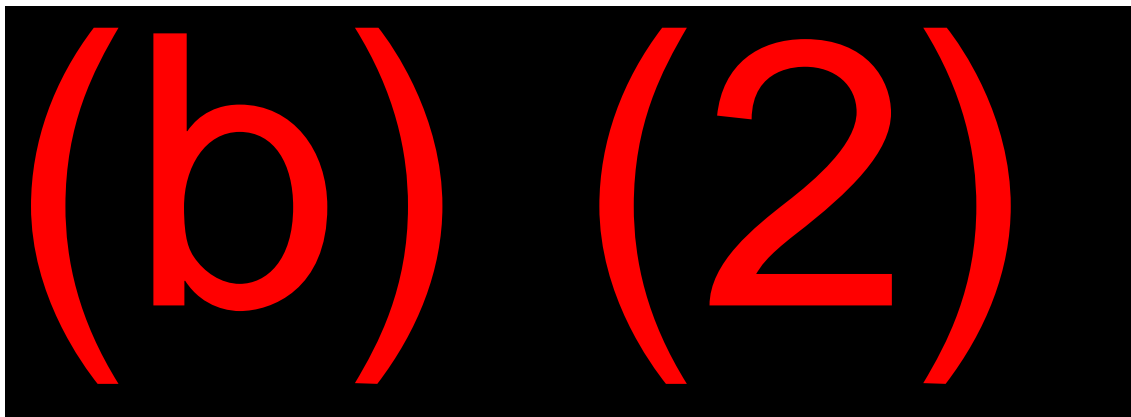
After pressing enter on the IC54 screen, the next screen is the IC5A. This screen shows the unindexed earnings. Changes to the earnings can be made on this screen for computational purposes only. If you need to make changes to the actual earnings record, you will use the Item Correction process.

The next two screens (IC57) display the indexed earnings for both computations. The first IC57 screen that appears shows the Indexed earnings for the DIB Exclusion Computation.
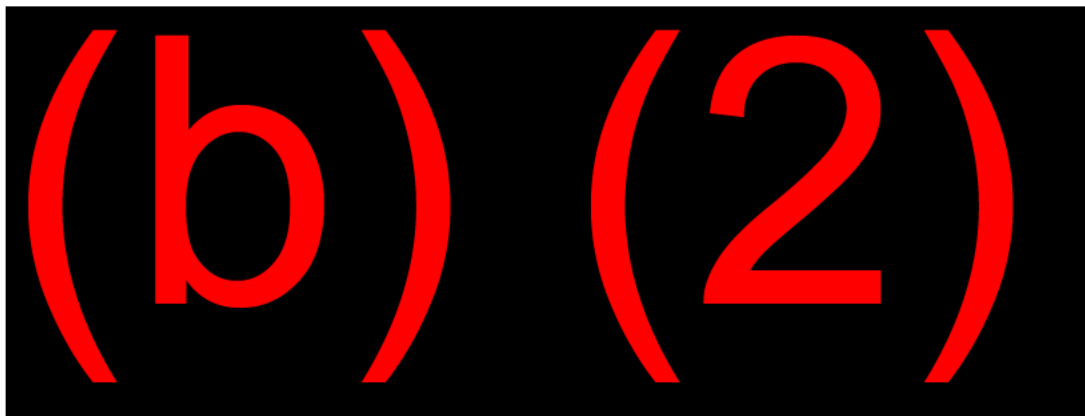
(b) (2)

The second IC57 screen that appears shows the Indexed earnings for the DIB Non-Exclusion Computation.

(b) (2)

There will be two AIME PIA RESULTS screens. The first screen displayed is for the Disability Exclusion computation.

(b) (2)

The next screen shows the Disability Non-Exclusion computation.

(b) (2)

When using ICF for disability PIA computations review both output screens and use the higher PIA.

It is possible that the Disability Exclusion PIA could be higher at the MOE but a recomputation would make the Disability Non-Exclusion PIA higher in a following year. In that case, the exclusion comp would be used first and then changed to the non-exclusion at the point it becomes higher.

DIB Computation – PPD Involved

Example: Luisa

Luisa, DOB 10/14/71, filed for disability benefits 10/01/15. Her current EOD is 02/15/15. She has a prior period of DIB with an onset of 06/15/01. The last month payment was due in that prior period of disability was 12/10; entitlement ended 02/28/11 (03/11 is the first month of T8).

When a prior period of disability exists, we code the ICF #24 NEW START GUARANTEE/AIME PIA COMPUTATION SCREEN (IC54) a little bit differently.

For a disability computation with a PPD these entries are required:

- **CURRENT DATE OF ENTITLEMENT**—Enter the entitlement month for the current claim.

- **PRIOR PERIODS OF DISABILITY IN ORDER OF OCCURRENCE**:
  Enter the date of onset and the "last month of entitlement" for each prior period of disability. **When EPE S7 months are involved, enter the last month a payment was due, which may or may not be the same as the last month of entitlement.**

- **CURRENT DIB ONSET**—Enter the actual date of onset derived from the DDS decision. Use the alleged onset date if a decision

has not been made. Use the date first insured as the date of onset if insured status is attained in the future.

- **CURRENT DIB WAITING PERIOD**—Input the first month of the waiting period. The first month of the waiting period is:

    1. the month following the month of onset, or the month of onset if the date of onset is the first day of the month; or

    2. the first month of the waiting period is 5 months prior to the month of entitlement (at most,17 months before filing date) if the date of entitlement is restricted by the rules of retroactivity; or

    3. in a no waiting period case, input the month of entitlement (DOEC).

For example, Luisa became entitled to DIB based on an onset date of 02/15/15 and a DOED of 03/15. She had prior period of DIB entitlement. The MBR shows the following information for the prior period:

- DDO (onset date) = 06/15/01

- DOE = 12/01 (DOF 04/02)

- S7 from 06/08 through 05/10 and 01/11 through 02/11

- T8 = 03/11

The last month of entitlement is 02/11. However, for computation purposes, when S7 for performance of SGA in the EPE is involved the period of disability ends with the last month of due payment. In this case the last month of entitlement for ICF is 12/2010. This is the last month Luisa was due a payment prior to the termination of entitlement. **RS 00605.210**

(b) (2)

(b) (2)
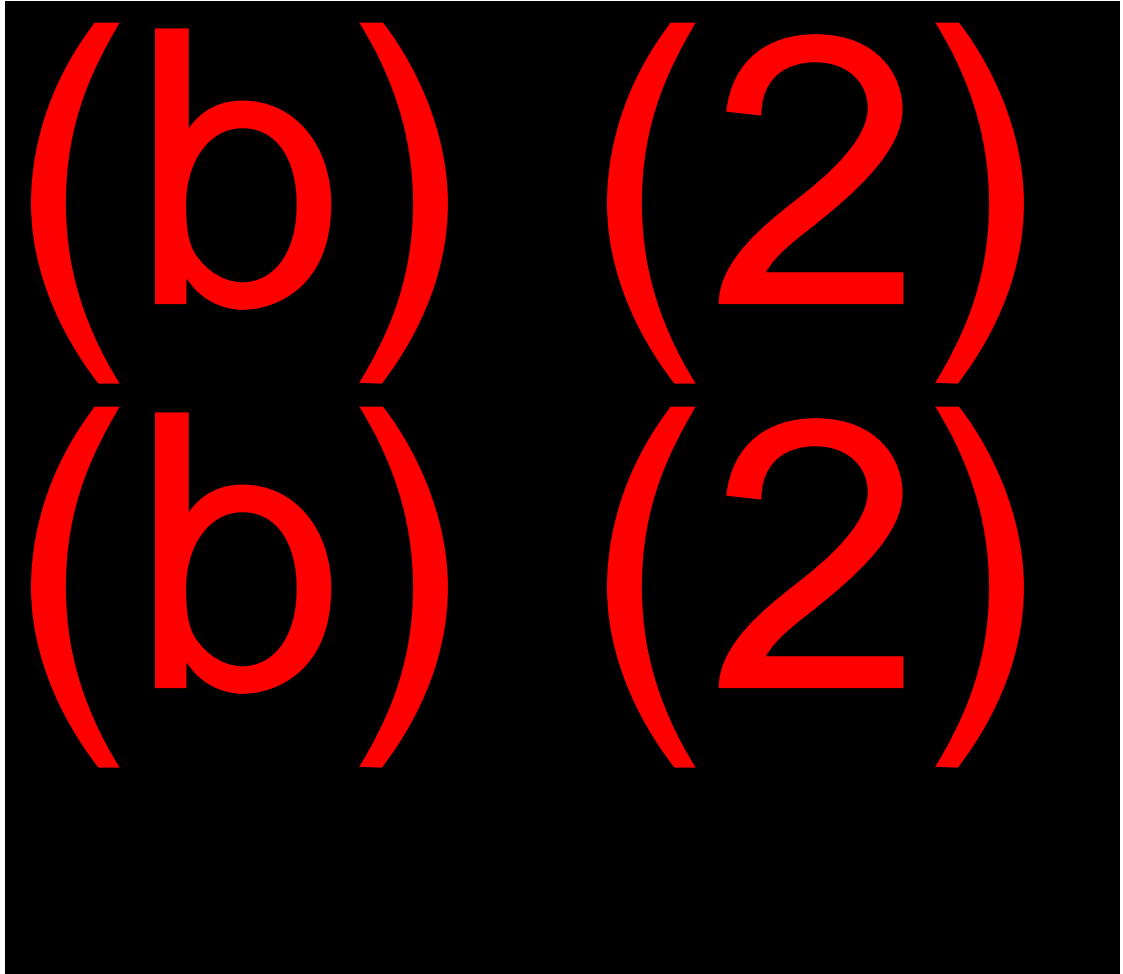
The first IC57 screen appears showing the Indexed earnings for the DIB Exclusion Computation.

(b) (2)

The second IC57 screen that appears shows the Indexed earnings for the DIB Non-Exclusion Computation.

(b) (2)

There will be two AIME PIA RESULTS screens. The first screen displayed is for the Disability Exclusion computation.

(b) (2)

The next screen shows the Disability Non-Exclusion computation.

(b) (2)
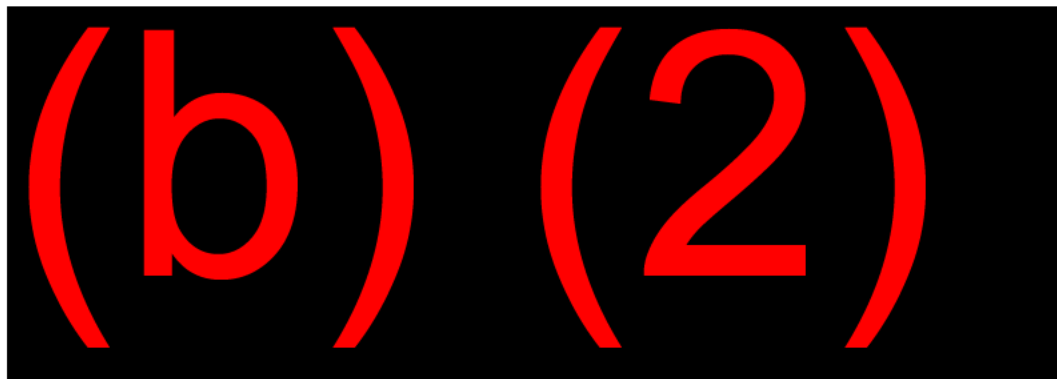
OBJECTIVE 3:

Compute the amount of a disability benefit taken after a retirement benefit (DIB after RIB) and identify when RIB entitlement is more advantageous.

DIB Awarded After RIB

RS 00615.401

The DIB MBA is equal to 100 percent of the DIB PIA **unless** the NH was entitled to RIB in any month before the DIB MOET.

The DIB MBA is reduced for the months of RIB entitlement before the DIB MOET.

Example:

Regina, DOB 08/31/1955, became entitled RIB effective 09/2017. On 11/25/2018, she filed for DIB. Her EOD is 08/15/2017. Based on her DOF and EOD, the DIB DOE is 02/2018. Because the DIB DOE is AFTER the RIB DOE, the DIB MBA will be reduced.

The reduction applied to the DIB PIA will be for the 5 months (09/17-01/18). This is because Regina was entitled to RIB prior to her DIB entitlement.

Determining the DIB MBA

RS 00615.410

Determine PIA to Use

You can use EC, ICERS, or ICF #24 to obtain the DIB PIA for these cases.

When DIB and RIB MOET differ:

- If the approved DIB onset is in or after the year the NH attains age 62, the PIA remains the same because the eligibility (benchmark) year remains the same (age 62 for both);

- If the approved DIB onset is in a year before the year the NH attains age 62, the DIB PIA may be different because of the differences in the eligibility year; or

- If the NH has additional earnings after the RIB MOE, a recomputation may be due which will increase the PIA. Use the recomputation information on the PIA HIS line of the MBR or use ICERS or ICF to determine the recomputed PIA.

NOTE: The RIB PIA may also change when the period of DIB prior to age 62 attainment is used to compute a DIB EXCLUSION PIA.

Compute the DIB Reduction

RS 00615.410

If the MOE to DIB is after the RIB MOE, the full DIB PIA is not payable.

Determine RF for DIB

The RF applied to a DIB after RIB will be the number of months a claimant was entitled to a reduced RIB prior to the DIB MOE. This calculation is similar to the method used to figure a RF for a reduced RIB. However,

---

with DIB after RIB, the MOE to DIB will take the place of the FRA attainment in the problem. If the RIB MOE is 12/17 and the DIB MOE is 06/18 determining the RF would look like this:

DIB MOE   **06/18**
RIB MOE   - **12/17**
                          6 months

DIB after RIB RF = **6**

Next, compare the DIB PIA and the RIB PIA (recalculated for the DIB Exclusion if applicable). If the PIAs are the same apply the DIB after RIB RF using the same formula used to compute a reduced RIB to the DIB PIA. If the RF is 6 and the DIB PIA is $1000.00, this would be the calculation:

$$\frac{(180 - 6) \times 1000}{180} = 966.60$$

Example:

Mr. Branch, DOB 07/07/1954, files for RIB and DIB on 08/03/18. His RIB is awarded with an MOE of 08/18. He is alleging a Disability Onset Date of 06/01/18. His RIB PIA is $1554.80. His DIB PIA is also $1554.80. His DIB after RIB MBA is calculated:

DIB waiting period: 06/18, 07/18, 08/18, 09/18, 10/18
DIB MOE: 11/18

DIB MOE   **11**   **18**
RIB MOE   **- 8**   **- 18**
              3 months + 0 yr

DIB after RIB RF   **3**

Apply the formula:
$$\frac{(180 - 3) \times 1554.80}{180} = 1528.80 \quad \text{DIB after RIB MBA}$$

If the DIB PIA is different than the RIB PIA (for reasons other than a COLA), a different method is used to determine the reduced DIB benefit amount. This is a rarely used method, but the DIB after RIB benefit calculation is easily computed using ICF. For more information, see **RS 00615.410 B.2.c**.

ICF #11

[MS 02411.001ff](#)

Interactive Computation #11 ("DIB after Reduced RIB") computes a reduced DIB MBA. You must input the initial RIB Date of Entitlement (DOE) and the PIA in effect at that time and the DIB MOE and DIB PIA. ICF will apply any COLAs. Enter any recomputations of the RIB or DIB PIA under "Subsequent," showing the month the new PIA is effective as the "DOE."

DIB/RIB Comp

Example:

The DIB after RIB benefit amount for Mr. Branch, as described above, can be determined by using ICF #11. On the input screen it is important to verify that the PIA for RIB corresponds with the PIA in effect at the RIB MOE. The DIB PIA must be the PIA in effect at the DIB MOE. The eligibility year must always be the eligibility year that corresponds with the PIA entered in the previous space:

Input Screen:
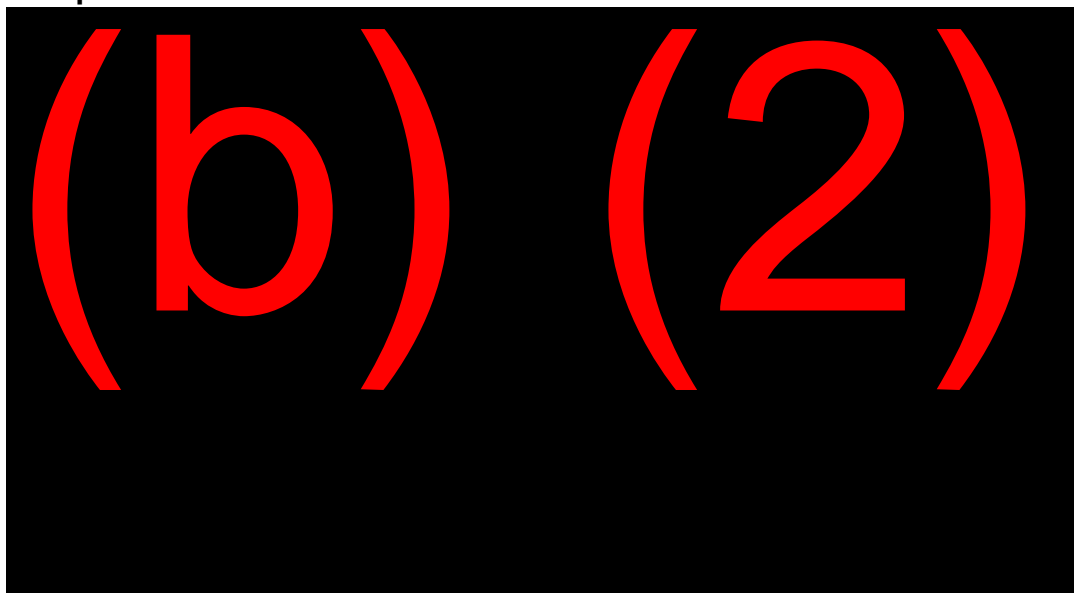
The IC31 screen reflects the RIB PIA in effect at the DIB MOE (This is the information we input into the system on the previous screen).

(b) (2)

Output screen:

(b) (2)(b) (2)

The IC32 screen gives the DIB after RIB MBA at the DIB MOE.

RIB/DIB – COLA involved

Example:

Mr. Fox, DOB 09/17/1955, filed for RIB 07/07/17. He requested a RIB MOE of 10/17. He filed for DIB on 12/15/18. His approved onset date is 05/25/18. His RIB PIA at the MOE is $1762.30. The DIB PIA at the DIB MOE is $1797.50. Here is the ICF #11 input screen to determine the DIB after RIB:

(b) (2)

Important: In this case, the RIB PIA and DIB PIA are different because of the 12/17 COLA increase. Each PIA is entered with the entitlement date

for that PIA. Be careful to enter the correct PIA and date for each entitlement.

The IC31 output screen shows the RIB PIA at the MOE. It also shows any applicable COLAs and recomputations.

(b) (2)(b) (2)

The last output screen gives the DIB after RIB MBA.

(b) (2)(b) (2)

RIB/DIB Considerations

RS 00615.110

There are many considerations in cases where both RIB and DIB entitlements exist. A NH may be entitled to a RIB PIA that yields a reduced MBA higher than the DIB rate.

DIB Technical Entitlement

A DIB claim should always be secured because:

- A NH entitled to both RIB and DIB can choose to receive the reduced RIB rate while maintaining DIB technical entitlement, <u>and</u>

- A NH can receive Medicare based on the DIB MOET, even though paid the RIB rate, <u>and</u>

- A NH can be eligible for an ARF at FRA to exclude the months of simultaneous entitlement.

DMAX

Because the DMAX is computed differently than the FMAX, the maximums will normally be different even when the DIB and RIB PIAs are the same. The DMAX, if smaller, may prevent or reduce payments to family members.

Example:

Mrs. Adams, DOB 09/30/1956, is receiving DIB benefits for herself and two entitled Disabled Adult Children. In 10/2018, she comes into the office to discuss the possible advantage of filing for retirement benefits. Here are the facts effective with 10/18, the first month of potential RIB entitlement:

	DIB Entitlement	RIB Entitlement
PIA	481.80	481.80
MAX	**481.80** (DMAX)	**722.70** (FMAX)
NH MBA	481.80	355.30
C's MBA (x2)	**0.00** (each)	**120.40** (each)
Total to Family	481.80	596.10

The increase in the maximum due the family at the point of RIB entitlement more than offsets the reduction in Mrs. Adams' benefit. As long as there is no termination to her DIB entitlement she remains technically entitled to DIB, even though she is receiving RIB checks. When she attains FRA, she will receive an ARF on her RIB benefit and each month where she was technically entitled to DIB is a credit month. If she remains technically entitled to DIB until she attains FRA, then all age reduction is removed at FRA.

Use ICF #1, Initial A or B Max Not Involved, to compute the NH's Reduced RIB MBA.

Use ICF #30, Life Family Rates, to compute the MBA for the children on either the RIB or DIB records. Code the TOM (Type of Max) field with either a D (Disability Max) or T (Table Max) to obtain the rates based on each entitlement.

Workers' Compensation Offset

Receipt of Workers' Compensation payments causes an offset on DIB benefits. For individuals born 12/20/50 or later, this offset remains in

effect until FRA. Individuals born 12/19/50 or earlier are only offset until age 65. RIB benefits are not subject to offset due to receipt of Workers' Compensation.

Example:

Mr. Stone, DOB 04/07/1953, has been receiving DIB benefits since 08/15. His current DIB PIA is $832.10, but the amount payable after offset due to his Workers' Compensation is only $157.30 each month. He comes into the office to discuss filing for RIB benefits. His RIB PIA is also $832.10, but after reduction for age, his MBA is $753.50. Although his RIB MBA is smaller than the DIB MBA, after WC offset the RIB amount is higher. Again, while he receives RIB benefits, he can remain technically entitled to DIB.

NOTE: Some states offset a NH's WC/PDB amount if he/she becomes entitled to RIB. This could impact the NH's decision to file for RIB or not. Refer to **DI 52120.001ff** to determine if the RIB would be offset in each state.

Other Considerations

The NH may also have personal reasons for restricting the filing to RIB, including other disability or pension benefits. Sometimes a pension program will reduce the pension or disability amount due if the individual is also receiving DIB, but not if they are receiving RIB. The NH should always be advised to contact the agency paying their pension to verify any effect of a Social Security benefit on their pension or disability benefit. There also may be insurance issues involved.

Documentation

RS 00615.482; **RS 00615.110**

In RIB/DIB cases, it is extremely important to include a diary code 018 with the month and year of FRA attainment. This ensures a technician in the PC will review the case when the NH attains FRA to verify the correct ARF is applied and the MBA is adjusted timely.

Whenever a claimant elects to receive one benefit instead of the other, the reason for requesting that particular benefit must be documented. The NH should also be made aware that as long as he remains technically entitled

to DIB he can change his entitlement from RIB to DIB at any time. If the circumstances change, he stops receiving workers' compensation or the family composition changes, it could be to his advantage to go back to DIB entitlement.

EXHIBIT 1: COMPARISON OF COMPUTATION FACTORS FOR EXCLUSION (FREEZE) AND NON-EXCLUSION (NON-FREEZE) NS 78 PIA

	Exclusion	**Non-Exclusion**
Eligibility Year	Earliest of: • Year of disability onset, or • Year of age 62 attainment, if earlier	Earliest of: • Year of the first month of the Waiting Period, or • First month of entitlement, if no waiting period, or • Year of age 62 attainment
Indexing Year	Eligibility Year minus 2	Eligibility Year minus 2
Base Years	1951 through the year before the year of the first month of entitlement.* *Exclude any years *wholly* within any period of disability	1951 through the year before the year of the first month of entitlement.
Elapsed Years	Eligibility year minus year of attainment of age 22.* *Exclude any years *wholly or partially* within any period of disability	Eligibility year minus year of attainment of age 22.
Dropout Years	Elapsed years ÷ 5 • If answer is a fraction, round down to the next whole number. • Cannot have more than 5 dropout years • If fewer than 3 dropout years, consider Child Care Dropout Years	Elapsed years ÷ 5 • If answer is a fraction, round down to the next whole number. • Cannot have more than 5 dropout years • If fewer than 3 dropout years, consider Child Care Dropout Years
Computation Years	Elapsed Years minus Dropout Years* *Cannot be fewer than 2	Elapsed Years minus Dropout Years* *Cannot be fewer than 2
Divisor Months	Computation years x 12	Computation years x 12
Index the Earnings	Index the earnings using the formula in RS 00605.018 and the Indexing Year for the Exclusion computation	Index the earnings using the formula in RS 00605.018 and the Indexing Year for the Non-Exclusion computation

	Exclusion	Non-Exclusion
Dividend	Add the highest years of indexed earnings for the number of computation years for the exclusion computation.	Add the highest years of indexed earnings for the number of computation years for the non-exclusion computation.
Average Indexed Monthly Earnings (AIME)	Dividend ÷ Divisor Months (Round down to the nearest dollar)	Dividend ÷ Divisor Months (Round down to the nearest dollar)
Bend Points	Apply the bend points for the Exclusion Eligibility Year to the AIME to derive the Raw PIA	Apply the bend points for the Non-Exclusion Eligibility Year to the AIME to derive the Raw PIA
COLA	Apply all COLA increases due from January of the Eligibility Year through the MOE.	Apply all COLA increases due from January of the Eligibility Year through the MOE.

COMPUTATION REMINDERS:

- Base Years are the *range of years* of earnings <u>from</u> which we can choose for a computation.
- Computation Years are the *number of years* we pick from the base years to use in a computation.
- A DIB Exclusion Comp can result from a Prior Period of Disability (PPD) or a current period of DIB.
- A DIB Exclusion Comp can be used for a RIB, Survivor or DIB claim.
- In a DIB Exclusion Comp, we cannot <u>use earnings from a year wholly within a period of disability</u> by definition of the Base Years. We can use earnings from partial years of disability.
- In a DIB Exclusion Comp (freeze), the ending date is the last day of the last month for which payment should have been made; suspension months after the last month a payment was due are not part of the period of disability.
- If a prior period of entitlement begins before 07/80, use 5 drop out years for the freeze computation.

EXHIBIT 2 JAMES' EARNINGS

(b) (2)
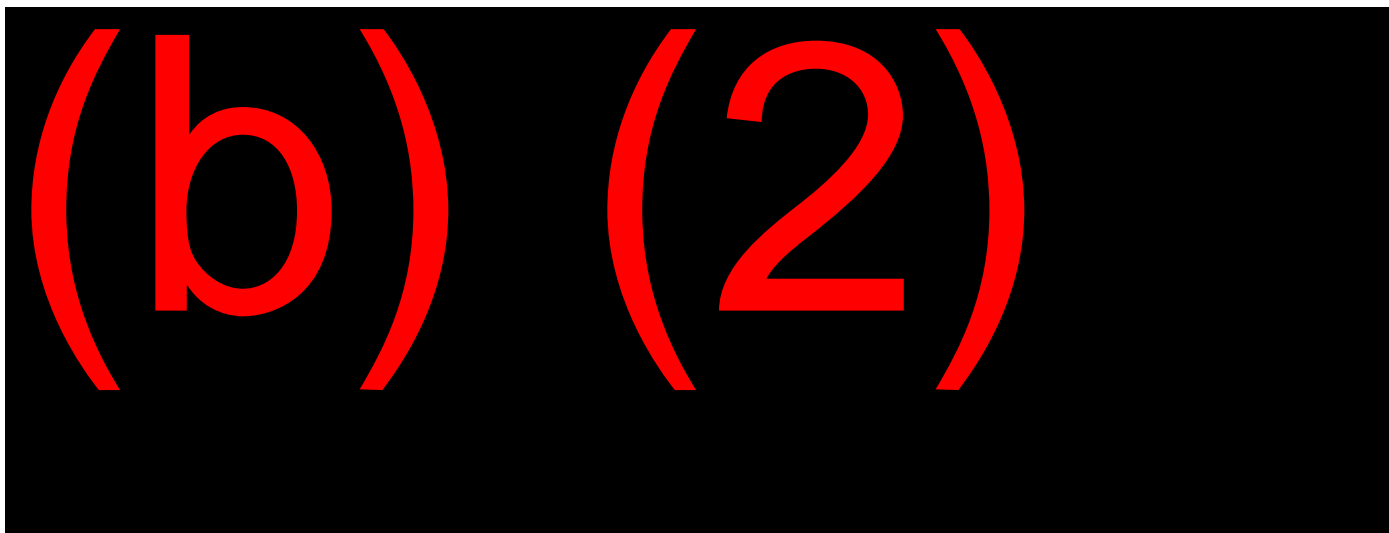
OFF-AIR ACTIVITIES

After IVT Broadcast

- Work the Off-Air Activities located on the Lesson Information page.

EXERCISE #1

OBJECTIVE 1: Compute a disability PIA using the NS78 computation.

A. Alex Peña, DOB 02/04/82, was approved for DIB based on a protective filing
    date of 02/06/19. His approved date of onset is 01/02/16.

    a. What is his MOE?

    b. What is the first month of the waiting period?

    c. What is the Eligibility Year for the DIB Non-Exclusion Computation? The
        DIB Exclusion Computation?

B. Ms. Harvey, DOB 08/17/84, filed for DIB 10/27/18, and was approved with an
    onset date of 09/21/18. Her MBR reflects she had a prior period of DIB. The DIB
    onset for her prior period is 06/19/08 with an entitlement date of 12/2008. She
    returned to work in 04/2011. The first month of suspension due to her work (S7
    month) was 04/2013. She was not due benefit payment for any month 04/2013
    or later. Her benefits terminated (T8) in 03/2015.

    a. What is her MOE for the new period of DIB?

    b. What is the first month of the waiting period?

    c. What is the Eligibility Year for the DIB Non-Exclusion Computation? The
        DIB Exclusion Computation?

EXERCISE #2

OBJECTIVE 2: Use EC, ICERS and ICF to compute a disability PIA.

Due to the limited number of Cloned SSN Scenarios, we have limited this exercise to reviewing the MBR. If you need additional practice in ICF, EC and ICERS, please refer to the interactive exercises shown during class as well as the Mod Review for this Module.

1. Mr. Bass, files a new claim on November 18, 2018 alleging an onset date of 07/31/2017. Use the following MBR to answer the questions below.

(b) (2)
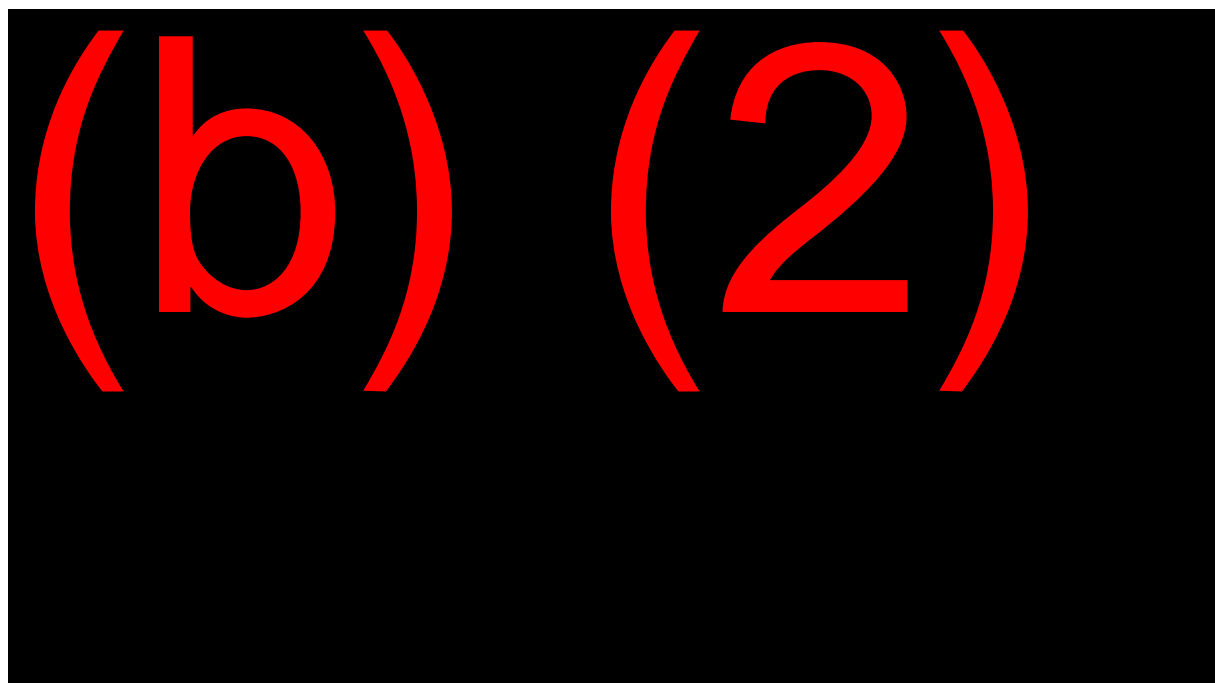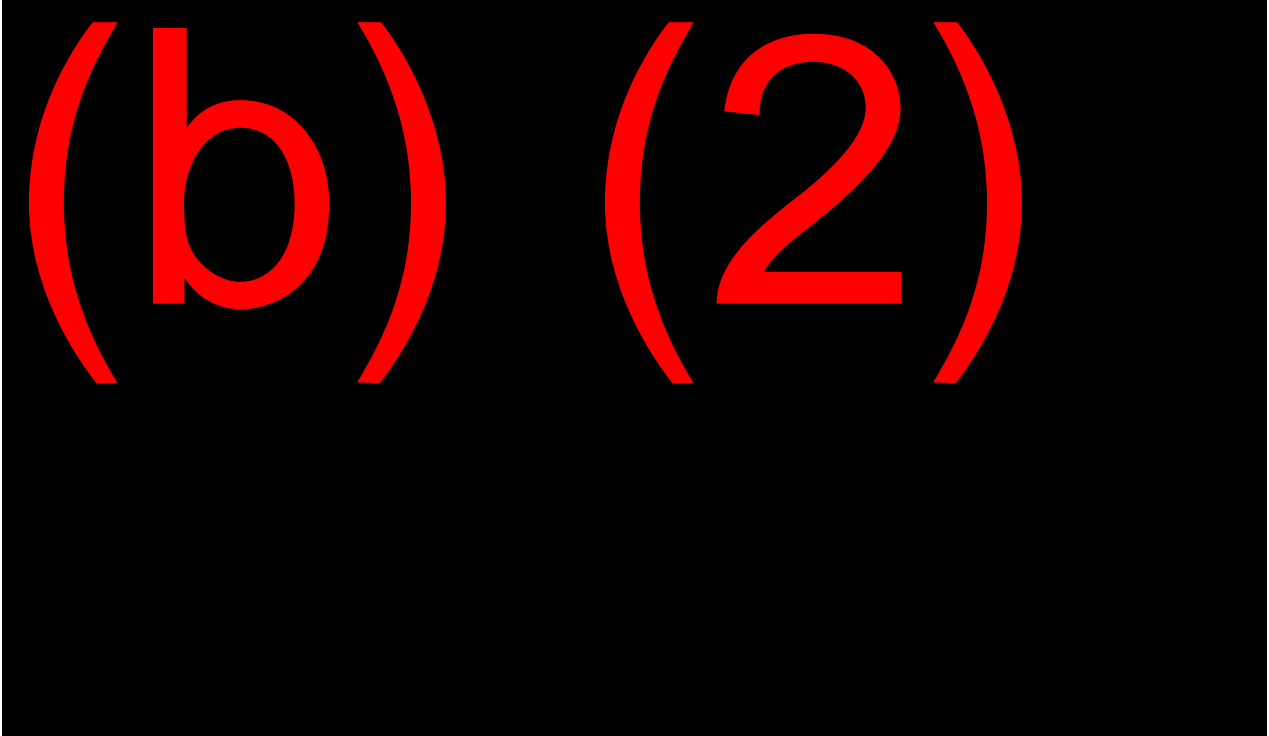
If he is approved for DIB with his AOD,

    a)   Will he need to serve a waiting period? Why or why not?

    b)   What will his month of entitlement be?

2. Patricia, files a claim 12/15/18 for DIB with an onset of 09/01/15. Take a look at this MBR and answer the following questions:
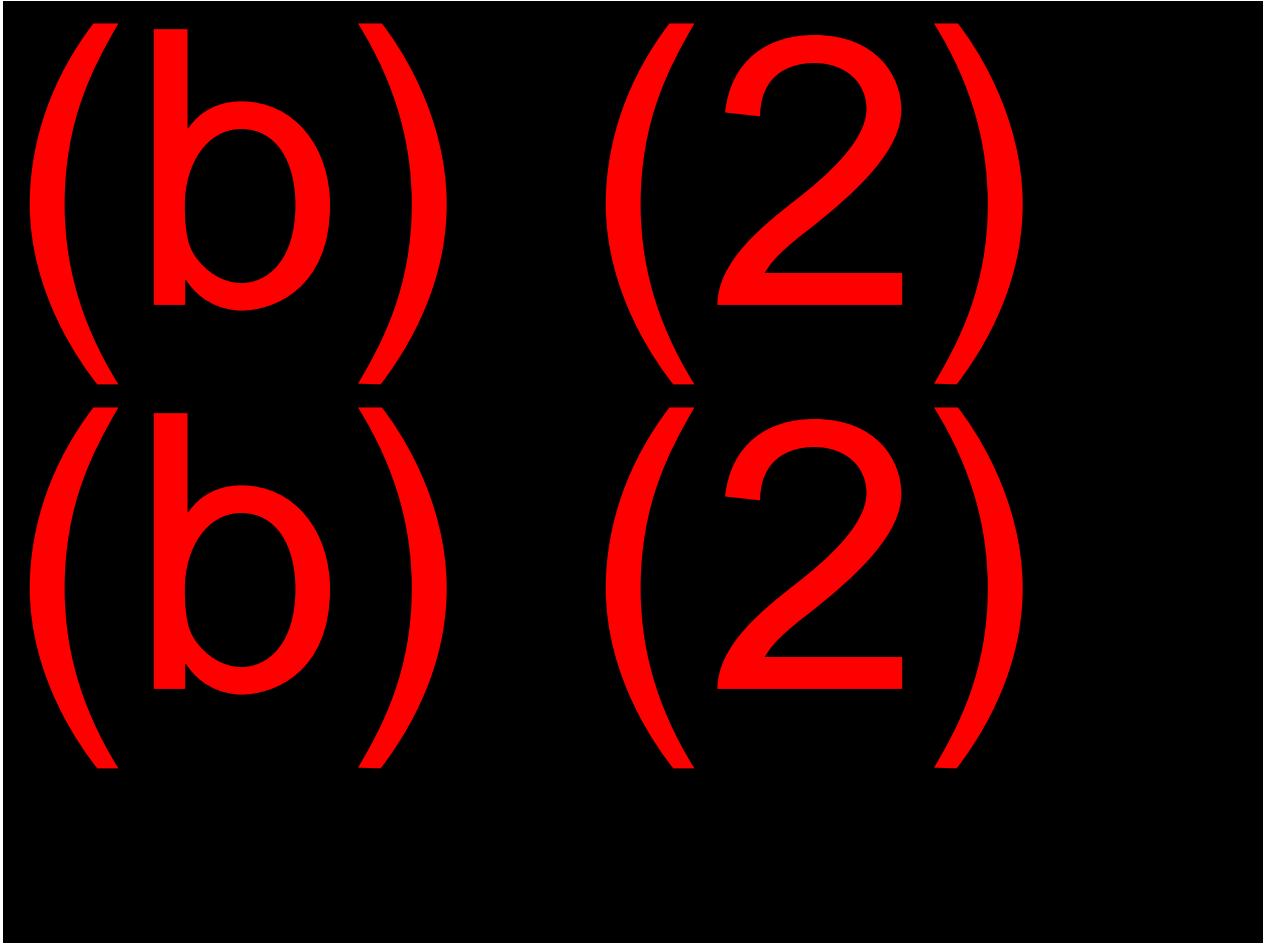
If she is approved for DIB with her AOD,

      a.   Will Patricia have to serve a waiting period? Why or why not?

      b. What would be her MOE?

EXERCISE #3

OBJECTIVE 3: Compute the amount of a disability benefit taken after a retirement benefit (DIB after RIB) and identify when electing RIB entitlement is more advantageous.

1. Ms. Holthusen, DOB 09/15/56, filed for RIB and DIB 10/18/18. Her RIB PIA effective 10/2018 (RIB MOE) is $1892.60.

    a. What is her RIB MBA at MOE?

    b. If her DIB is approved with the alleged onset of 05/31/18, will the DIB MBA be reduced?

    c. The current DIB PIA is also $1892.60. What is the DIB MBA?

2. Ms. Caraway, DOB 09/29/56, files for RIB and DIB in 07/2018. Her RIB is awarded with an MOE of 10/2018, PIA $1109.80. She alleges a disability onset of 04/28/16.

    a. If her DIB is approved with the onset date alleged, will the DIB MBA be reduced?

    b. If DDS determines her actual DIB onset is 05/04/18 and the DIB PIA is $1109.80, what would the DIB MBA be?

EXERCISE ANSWERS

Exercise #1

1. Alex Peña

    a. 02/18 – the MOE is restricted to 12 months retro from the filing date. **GN 00204.030 B.3**

    b. 09/17 – the waiting period begins 5 months before the MOE because of the retroactivity restriction. **DI 10105.070**

    c. The eligibility year for the DIB Non-Exclusion Computation is 2017, the year the waiting period begins. The eligibility year for the DIB Exclusion Computation is 2016, the year of Disability onset. **RS 00605.005**

2. Ms. Harvey

    a. 04/18– No waiting period since prior period terminated less than 60 months ago. Use the T8 month, 03/15, and add 60 months. As long as she becomes disabled before 02/28/2020, she does not need to serve a new waiting period. **DI 10105.075**

    b. There is no waiting period. For completion of ICF#24 we would use 10/18 in the **first month of the WP field. DI 10105.075**

    c. The eligibility year for the DIB Non-Exclusion Computation is 2018. There is no waiting period in this case, so we use the year of the first month of entitlement. The eligibility year for the DIB Exclusion Computation is also 2018, the year of Disability onset. **RS 00605.005**

Exercise #2

1. Mr. Bass

    a. Yes, he does need to serve a waiting period. His prior period of disability ended 05/03 (T8 month in the History field or DBC entry in the DIB line). His new onset is 07/31/17. This is not within the 60-month period (05/2003-04/2008).

b. His month of entitlement will be 01/2018. He must serve a waiting period. His waiting period will run from 08/2017 – 12/2017.

2. Patricia

   a. Yes, Patricia does have to serve a waiting period. We look at her MBR and determine that her disability terminated 10/31/04, T8 month is 11/2004. (Look at History Field T8 or DIB line DBC). If approved, the new onset is beyond the 60-month period (11/2004–10/2009).

   b. With 12 months of retroactivity, her MOE would be 12/2017. Her waiting period would be served 07/2017-11/2017.

<div style="border:1px solid black; text-align:center;">

Exercise #3

</div>

1. a. $1395.70. Use ICF #1.

   b. Yes. The DOE is 11/2018 after the 5 month waiting period. The DIB DOE is after the RIB DOE, so the DIB MBA will be reduced.

   c. $1882.00;

DIB MOE	11/18
RIB MOE	-10/18
	01 RF

$$\frac{(180 - 1) \times 1892.60}{180} = 1882.00$$

The ICF Input and Output screens are as follows:

(b) (2)
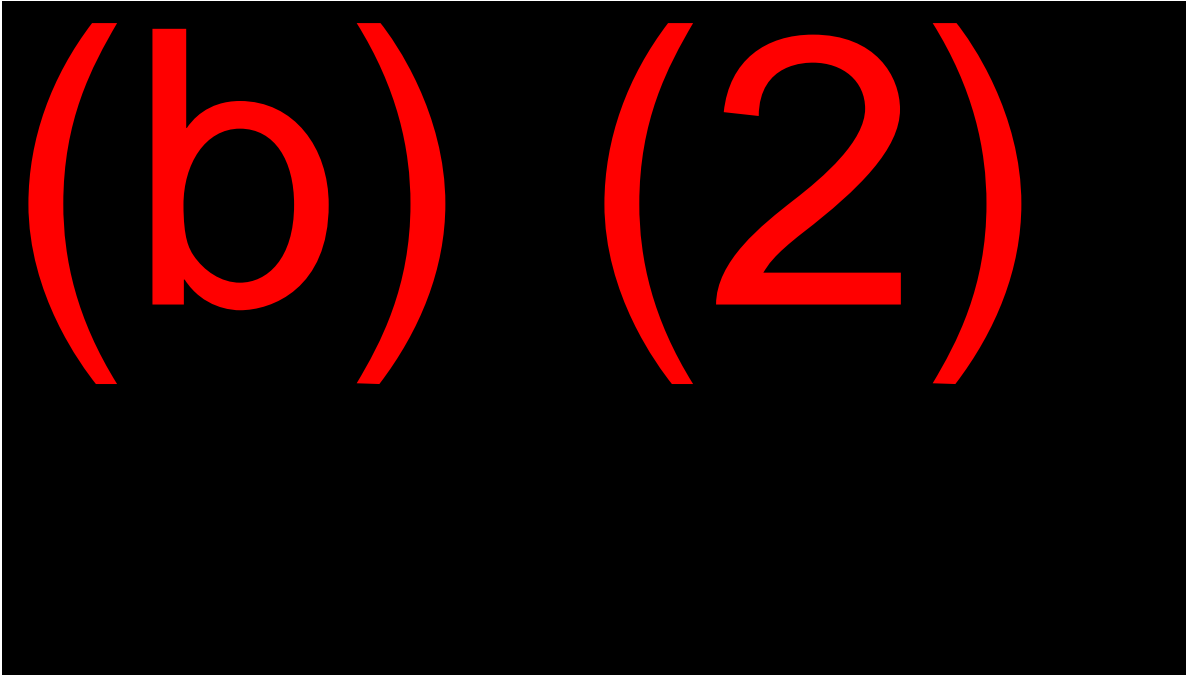
The first output screen shows the RIB PIA at the RIB DOE.

(b) (2)(b) (2)
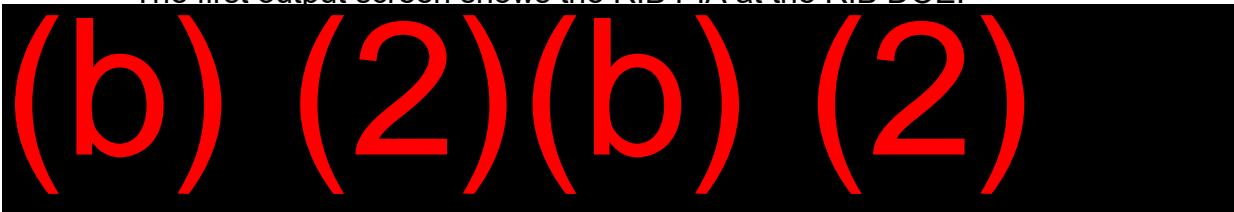
The second output screen shows the reduced DIB MBA at the DIB DOE.
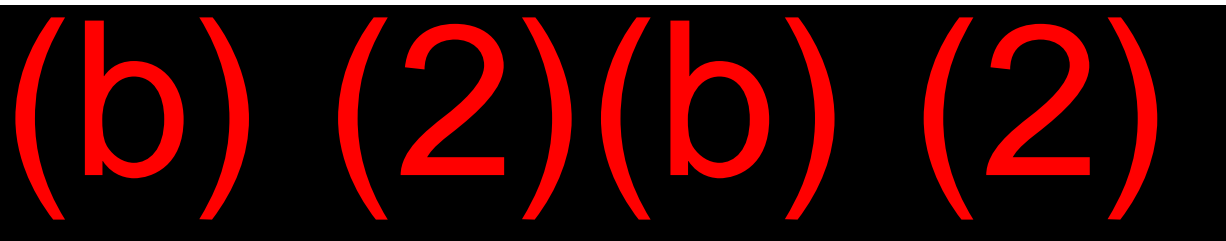
(b) (2)(b) (2)

2. a. No, the DIB MOE based on the 04/28/16 onset would be 07/2017 (DOF 07/2018 – 12 months retro = 07/2017). This precedes the RIB entitlement (10/2018).

    b. $1103.60 with 1 RF.

        We can get this MBA using ICF #11. The input and two output screens are shown below:

(b) (2)

(b) (2)(b) (2)

(b) (2)

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)(b) (2) **TO FIND MORE INFORMATION CONCERNING THIS TOPIC.**

TABLE OF CONTENTS

LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Apply the factors of entitlement for childhood disability benefits (CDB) and determine a CDB's date of entitlement for HI/SMI.

2. Identify the evidence, forms, and procedures needed to process a CDB claim.

3. Compute a CDB benefit, including a dual entitlement benefit, and identify nonpayment and termination events for CDB.

Length of Chapter

10 hours

BACKGROUND AND RATIONALE

Definition

A child who has a disability which began prior to age 22 can be eligible for benefits beyond age 18 even if not a full-time student. We refer to an individual in this benefit category as a CDB (childhood disability beneficiary) or a DAC (disabled adult child).

Medical Evidence

In general, CDBs must satisfy the same medical criteria (listing of impairments) as regular DIB beneficiaries. Many CDBs receive special education and school records are often an excellent source of evidence.

Waiting Period

Although CDBs are subject to many of the same provisions as DIB and DWB beneficiaries (e.g., TWP, Medicare after 24 months of entitlement), there are differences. One important difference is CDBs do not have to serve a 5-month waiting period.

Keep in mind many CDBs work in spite of their impairments and may become insured for disability benefits on their own accounts.

OBJECTIVE 1:

Apply the factors of entitlement for childhood disability benefits (CDB) and determine a CDB's date of entitlement for HI/SMI.

CDB Entitlement

DI 10115.001; **RS 00203.000ff**

Entitlement Factors

The first four factors of entitlement for CDB entitlement are the same as for child benefits. The child must:

- Be the child of a number holder entitled to a RIB or DIB, or of a number holder who died fully or currently insured.

- Be dependent on the number holder.

- Be unmarried. For initial entitlement, a child who has been married is considered unmarried if their marriage has been terminated by annulment, divorce, or death, or the marriage was void. The rules for re-entitlement are listed later in the objective.

- File an application.

Additionally, the claimant must also:

- Be age 18 or over and have a disability which began before attainment of age 22 (**DI 25501.330 A**).

Definition of Disability

SSA defines disability as the inability to engage in substantial gainful work activity (SGA) due to a medical impairment, which is expected to last at

least 12 months or to result in the death of the claimant. This is the same definition of disability as for DIB benefits.

NOTE: Unlike DIB, there is **no waiting period** in CDB cases.

Application Process

MS 03505.014; **RS 00203.080**; **GN 00204.010**

The same basic application process is required in initial CDB claims and in re-entitlement cases. However, in some situations a new application is not needed.

Protective Filing

The first step in the CDB Application Process is to determine the earliest possible protective filing date. While this process is no different for CDBs than it is for other T2 applications, it is critical you determine the protective filing date for a CDB BEFORE taking an application.

Refer to **GN 00204.010** for additional guidance on determining the earliest protective filing date.

New Application Is Required

A new application is required in the following situations:

- An initial claim for Childhood Disability Benefits is filed and the child is 17 ½ or older.

- A subsequent claim for Childhood Disability Benefits is filed, and

  - The child was correctly terminated at age 18 or later, and

  - The child is now filing a new claim based on a disability, and

  - The disability began after their benefits were terminated.

  This means there is a period of non-entitlement between the termination of child's benefits and re-entitlement due to the onset of

a disability. There was a break in entitlement, so a new application is required.

EXAMPLE: Mary, DOB 04/15/98, became entitled as a child in 2004. She received benefits as a child until age 18, and then as a student until she graduated from high school in June 2016. In February 2018, she became disabled. She would have to file a new claim.

- A subsequent claim for Childhood Disability Benefits is filed, and

  ▪ The child was correctly terminated at age 18 or later, and

  ▪ The disability onset date is prior to the prior termination, and

  ▪ The child is filing more than four years after the earlier termination.

  EXAMPLE: John, DOB 12/06/95, was entitled to child's benefits when he was 10. His benefits terminated 12/13, at age 18, as he was not in school. In 03/18, he filed a CDB claim, alleging a date of onset of 04/12. A new application is necessary, as more than four years have elapsed since termination, even though his onset was prior to his termination.

New Application Is Not Required

A new application is <u>not</u> required in the following situations:

- To convert a currently entitled minor child or student to CDB benefits on the same SSN.

- A CDB claimant has an onset date prior to the termination of the previous entitlement as a child on the same NH's record and contacts SSA to file within four years of the termination of the prior entitlement.

  EXAMPLE: Roger, DOB 08/06/97, was entitled as a child in 09/00. He received child's benefits until 08/15, age 18, when benefits terminated. In 03/18, he contacts the field office to file as a disabled child, alleging he has been disabled since 03/15. A new application would NOT be necessary, and if allowed, benefits would be paid to him back to his termination date**.**

NOTE: A medical determination is still necessary as stated in **RS 00203.080B**.

CHD1

The MCS application pathway is the same for a child's claim whether it is filed for a minor child or a disabled adult child (**MS 03505.014**).

The Child Identification 1 (CHD1) screen contains the questions which designate the claim as a claim for disability benefits. When completing the application for CDB, the questions "IF OVER 16 IS CHILD DISABLED?" and "FILING AS DISABLED CHILD ON THIS ACCOUNT?" should both be answered "Yes." To "IF YES, ONSET DATE", the answer should be completed with the exact date if known. If the exact date is unknown, use age 18, the date of birth, or another date prior to attainment of age 22, depending on the facts of the case. All other questions on this screen are answered the same as a regular child's claim.

When the case is sent to the state Disability Determination Service (DDS), they should be advised of the earliest possible MOE as a CDB so they do not do unnecessary development. **DI 25501.330**

Representative Payment

Beneficiaries are assumed to be capable with age 18 attainment. However, CDBs often have disabilities which indicate a need to have a representative payee. Capability should be considered whenever CDB medical development is obtained, and a Representative Payee application should be obtained if necessary.

Internet Filers

When a claimant completes the i3368/69 on the internet, it will appear on an iWMI listing. This is also true if a third party completes the i3368/69. If the internet filing appears on the iWMI or you receive a cover sheet, you must determine if a lead has been established or a claim has been taken in MCS or MSSICS. The instructions for development and completion of these claims are in **DI 81007.040**.

Month of Entitlement

RS 00203.000ff

Life Cases

The first possible month of entitlement for a child qualifying on the record of a **living** NH is the first month throughout which the child is disabled and the NH is entitled. Therefore, unless the date of onset is the first day of the month, the child's earliest possible MOET is the month following the month of onset (if the NH is entitled for that month).

EXAMPLE: Carol, DOB 08/03/98, became disabled 03/28/18. Her father has been entitled to RIB since 2015. Carol's first month of entitlement is 04/18.

Death Cases

If the NH is **deceased**, the child may be entitled in the month of onset (or the month of death of the NH, if later), no matter the day of onset in the onset month. Unlike life claims there is no "throughout the month" requirement on survivor claims.

EXAMPLE: Laura, DOB 07/06/97, became disabled 02/20/18. Her mother died 12/15. Laura's first month of entitlement is 02/18.

REMINDER: There is no 5-month waiting period in life or survivor CDB cases.

Maximum Retroactivity

DI 10115.030

If the NH is a RIB beneficiary or deceased, the maximum retroactivity is 6 months for a CDB claimant.

If the NH is a DIB beneficiary, the maximum retroactivity is 12 months for a CDB claimant.

Potential Onset Date

We assist DDS in avoiding unnecessary medical development when establishing an onset for a CDB claimant. If the onset of the disability is traumatic, use the exact onset date. If the onset is non-traumatic, notify DDS of the earliest POD required to allow for entitlement and maximum retroactivity.

Claimant 22 or older:

The POD should be the day before the date of attainment of age 22 as long as full retroactivity is possible given the particular date. Otherwise, use a date, which allows for full retroactivity. Keep in mind, for life cases, the child must meet all factors of entitlement throughout the month. So, when selecting the POD, you should consider the last day of the month before the first possible month of entitlement.

EXAMPLE 1: Joe, DOB 10/07/1990, filed for CDB on 12/13/18. He says he has been disabled since birth. His father became entitled to RIB 09/2018. We would notify DDS of a POD of 10/05/2012. Joe must be found disabled by the day before the date of attainment of age 22. Reminder: A person attains an age on the day before their actual birth date. Further development of the onset date by DDS is not necessary because no additional benefits would be due based on an earlier onset date.

EXAMPLE 2: Susan, DOB 08/08/1995, filed for CDB on 10/08/2018. She alleges she has had asthma for 10 years. Her mother became entitled to DIB 10/2017. We would notify DDS of a POD of 09/30/2017. Since Susan is over age 22, we need to select a POD prior to the attainment of age 22 while also allowing for full retroactivity. Susan's mother is alive, so we will notify DDS of the last day of the month before the month we want entitlement to begin.

Claimant under 22:

The POD should be set to allow for full retroactivity, either 6 or 12 months based on the status of the NH. Keep in mind, in life cases, the child must meet all factors of entitlement throughout the month, so the POD should be the last day of the month before the first possible month of entitlement.

EXAMPLE: Rex, DOB 06/28/1997, filed for CDB on 02/17/19. He alleges he has been disabled for five years due to a heart condition. His father passed away 01/04/2019. We will notify DDS of a POD of 01/04/19. No

earlier onset is necessary because 01/2019 is the first possible month of entitlement based on the other factors of entitlement.

NOTE: If the child is insured on their own record, you should follow the necessary steps to provide a POD based on the rules for a DIB claimant.

Re-entitlement to CDB

RS 00203.015; **DI 23505.010**

A CDB may become re-entitled to CDB on the same record:

- At any time when the previous entitlement terminated due to substantial gainful activity (SGA) (no time limit); or

- Within 7 years when the previous entitlement ended due to any other reason, including medical recovery.

If the requirements are met, then the child may be re-entitled to CDB benefits after age 22. **DI 23505.010** and **DI 26005.001**

EXAMPLE: Joanne, DOB 06/13/83, was found disabled as of 12/28/04 and entitled to survivor benefits as a CDB effective 12/04 when the NH died. Her entitlement terminated 06/30/12 after a medical review found her condition had improved and she was no longer disabled. On 02/03/19, Joanne contacted her local FO to file a new claim for CDB because her condition had once again worsened as of 01/07/19. Joanne may be re-entitled to CDB benefits as of 01/19 because her new onset falls within 7 years of the prior period of disability. She must file a claim in MCS, and it would still be sent to DDS for a medical determination.

Marriage

A CDB claimant who has married since the CDB entitlement ended cannot be re-entitled unless the marriage is void or annulled. A marriage which ended in divorce or death prevents re-entitlement of a CDB claimant.

EXAMPLE: Drew was previously entitled as a CDB from 03/09 – 11/12. His benefits terminated when he got married. Today he comes into the office and tells you he has recently gotten divorced, and he would like to begin receiving benefits again. Drew cannot be re-entitled to CDB

because he has been married, and the marriage ended in divorce. If Drew's marriage had ended due to an annulment, he could be re-entitled to CDB as long as he meets all other factors of entitlement.

Use the following link for POMS references about CDB Initial Entitlement and Re-entitlement:

(b) (2)(b) (2)

HI/SMI Coverage

HI 00801.146 B; **DI 10115.015**

Entitlement

A CDB is entitled to Part A (D-HI) and may elect Part B (D-SMI) in the 25th month of CDB entitlement.

Since entitlement to CDB cannot begin prior to age 18, entitlement to HI based on CDB entitlement cannot begin earlier than the month of attainment of age 20.

There are two exceptions to the 24-month waiting period. The exceptions are Amyotrophic Lateral Sclerosis (ALS) and End Stage Renal Disease (ESRD). See **DI 45605.001** and **DI 45001.001** for more information on ALS and ESRD cases.

Prior Periods

HI 00801.152

You can use months of entitlement from a prior period of disability (DIB, CDB, or DWB) in counting the 24-month qualifying period provided:

- A prior period of DIB entitlement ended no more than 5 years (60 months) before the month of current onset, **or**

- The prior period of DWB or CDB ended no more than 7 years (84 months) before the current onset; **or**

- The current disability impairment is the same, or directly related to, the impairment which served as the basis for the previous period of CDB entitlement (applies only to individuals whose prior period of entitlement ended <u>after</u> 02/29/88); **HI 00801.152 or**

- The prior period of disability ended for non-disability reasons and re-entitlement is based on the same disability onset date. (This only applies to individuals whose prior period of entitlement ended before 3/1/88), **or**

- A child re-entitled based on a disability may also be re-entitled to HI benefits and be eligible for SMI once the requirements of the law are met. **HI 00801.152**

<u>**EXAMPLE**</u>: Craig was entitled to CDB 11/14 through 10/15. This was 12 months of CDB entitlement. He worked enough to become insured and filed for DIB on his own record. He was approved with an onset date of 07/13/17.

Because this was an application for DIB (not CDB), Craig had to serve a 5 month waiting period (08/17, 09/17, 10/17, 11/17, 12/17). Craig's DIB entitlement date was 01/18.

We count the 12 months of previous CDB entitlement plus the 12 months of current DIB entitlement towards the 24-month qualifying period. For HI/SMI to begin, Craig needs to be entitled to DIB for 12 additional months. Count 12 months starting with 01/18 and we find Craig's HI/SMI begins 01/19 (in the 25th month of disability entitlement).

OBJECTIVE 2:

Identify the evidence, forms, and procedures needed to process a CDB claim.

Development of CDB Claims

DI 11005.016

Forms/Evidence Required

The forms and evidence required are as follows:

- MCS Application or SSA-4 – Application for Child's Benefits (following the rules for obtaining a new application found in **RS 00203.080 B.2**)

- Payee application, if necessary

- Proof of age, relationship, dependency

- SSA-820/821/823 – Report of Work Activity, if necessary

- SSA-3368-BK – Medical History and Disability Report

- SSA-3367-F4 – Disability Report-Field Office

- SSA-827 – Authorization to Release Medical Information to SSA

- E/R and/or MBR on NH if unable to use EC

- Certified E/R on CDB's own SSN to document insured status

- Disability determination

Non-Medical and Medical Development

DI 11005.000ff; **DI 11020.000ff**

EDCS

In initial CDB cases, we use EDCS to obtain information about medical sources, education, and disability onset. Always establish EDCS under the claimant's own SSN, even when they are filing under another wage earner's record.

When a new MCS application is required, establish it before creating the EDCS case.

CDB claims in which we do not require a new application (i.e., minor child benefit converting to CDB for continued eligibility and not involving concurrent Title XVI or multiple Title II filings), can be established in EDCS. To establish these types of claims in EDCS, the record of the claimant (BIC) must be established on an existing MBR with specified LAF codes of C, S6, S7, S8, S9, AD, T4 or T6.

Appeals for CDB cases can be established in EDCS, only if EDCS was used for the associated prior level case. **DI 81010.020 A**

Use the EDCS 3367 to notify DDS of the earliest possible MOE, taking into account the rules of retroactivity. This will ensure the disability examiner establishes the earliest onset necessary for entitlement and maximum possible retroactivity, without doing unnecessary development.

NOTE: If using a paper SSA-3368, complete it the same way as a DIB case, except you will write the name and SSN of the NH at the top of the first page.

SSA-827

The CDB claimant must complete and sign a medical release form (SSA-827). Fax the front of one completed SSA-827 into the CEF prior to case transfer. Some offices are also required to mail the SSA-827 to DDS. This depends on your regional operating policy. Please speak to your mentor to determine your local policy.

Earnings Record

Request a certified E/R on the CDB's own SSN to determine if insured status for DIB exists. Again, please check with your mentor as some field offices prefer an application be taken to show a 090 denial. This is not required by POMS, but may be a local policy.

Proofs Needed

Proof required is the same as for any child's claim - proof of age, relationship, and dependency (if not deemed).

DDS

Most CDB claims requiring a disability determination will be sent to the appropriate State DDS. The following are some of the types of claims for which the disability determination will be made by other components:

- Collateral Estoppel rules apply and a prior favorable determination of disability can be adopted by the field office.

- SGA denial is appropriate and completed by the field office.

- NH is career Railroad (RR) – send to GLPSC

Collateral Estoppel

DI 11011.001-.005; **DI 81010.142**; **DI 27515.001**

If the CDB applicant is already receiving Title II HA or Title XVI DI benefits based on an onset before age 22, adopt the previous decision. **GN 04040.020**

The Title XVI medical determination must have been made as a "DI" and not as a "DC." If the decision was made before age 18 as a "DC" and converted to "DI" at age 18 without a medical decision, it does not meet this requirement. Also, the Title XVI impairment cannot be based on blindness. **DI 11011.005**

If the claim does not meet the criteria for Collateral Estoppel, or if retroactive benefits could be paid based on an earlier onset than previously established, a DDS determination is needed.

NOTE: Effective January 17, 2017, collateral estoppel may not be used on claims involving mental disorders or HIV infection if the prior favorable determination, based on the claimant's having met or equaled a Mental Disorders or Immune System Disorders Listing, was decided before January 17, 2017. See (b) (2) for additional details and processing instructions.

Disabled Minor Child

DI 11025.010; **RS 00202.095**; **RS 00203.085**; **GN 00502.075**

Purpose

A medical decision for a child as young as 15½ can be made for the purpose of continuing young spouse's, mother's, or father's benefits.

If approved, the benefits to the parent will continue after the child reaches age 16, based on having a disabled child-in-care.

Actions Needed

- Establish a SSA-3368 in EDCS and obtain signed SSA-827s for the child, following the same procedure as for any other CDB claim for which you do not need to take an MCS application. No MCS application is necessary because entitlement already exists. Notify DDS on the Capability/Remark screen of the 3367 stating the following, "This is a claim for (spouses, mother's or father's as appropriate) benefits only. First possible month of entitlement (MOE) for parent is (MMYY)."

- Complete an SSA-795 (Statement of Claimant) with the parent's allegation of control and responsibility and/or personal services. After the parent signs the form fax into EDCS or retain in paper folder as appropriately.

- If the parent alleges both mental and physical impairments for the child, enter the remark "Child in Care" on the 3367. This alerts DDS a mental impairment must be identified even if it is not listed as a primary or secondary diagnosis. We use this information to determine if the parent meets the child in care requirements.

- If a claim cannot be processed in EDCS, prepare an SSA-831, as is usually done for a disabled adult child, and enter the remarks shown in first bullet above in item 11, if appropriate. Then forward the paper medical folder to DDS. (**DI 11020.045**)

- Notify the PSC via the Paperless Processing Center or MDW that a childhood disability determination is pending. Annotate the paperless routing sheet or MDW with the following message: "Childhood Determination Pending. Handle per **RS 00202.095B**". With this message the Payment Center will place the parent in suspense when the child reaches age 16 or if benefits have been terminated. Benefits will not be reinstated until the child is found disabled and in the parent's care.

- Create a Special Message on the Master Beneficiary Record (MBR) showing that a DMC claim is pending and the date the case was sent to DDS.

- Control the case on the Modernized Development Worksheet (MDW).

If DMC (Disabled Minor Child) approved:

- Determine if child-In-care criteria are met using the SSA-795 previously filled out and following **DI 11025.010F**.

- Use the Paperless Barcoding system and choose "CLAIM INIT CDB-Initial Claim – CDB/DAC" under Select Document Type.

  - Annotate the coversheet with the following remark: "CDB claim decision to continue (Spouse's/Mother's/Father's) Benefits and establish Diary to mature when DMC reaches 17 1/2 to determine if direct payment should be developed. Date of Onset for DMC is MM-DD-CCYY."

- The spouse's/mother's/father's benefit is continued due to having a disabled child–in-care as long as the requirements in **RS 01310.000ff** are met.

- The disability determination is posted to the MBR so the DMC will be converted to CDB status at age 18.

Even if the DMC is approved, Medicare coverage cannot be given until the month the CDB attains age 20 (unless the disability is End Stage Renal Disease or amyotrophic lateral sclerosis (ALS - also known as "Lou Gehrig's disease").

If DMC (Disabled Minor Child) is denied:

Process as a manual Denial, which is discussed in the DIB Adjudication lesson.

Claims Processing Considerations

GN 01010.000ff, **DI 11020.000ff**

CDB vs. Student Benefits

RS 00203.090

If it appears a child could be entitled as a student or as a CDB, we must develop entitlement to both benefits. The advantages are:

- CDBs do not terminate due to age 19 or non-FTA status.

- CDBs get Medicare after 24 months of entitlement.

- Student benefits can be paid while the medical determination is being made.

- A spouse, mother, or father, may be entitled to benefits for having a CDB or DMC in-care.

Adjudication

In most cases, you can process CDB claims through EC. However, you cannot use the non-medical completion procedure on CDB claims. To process the claim through EC, follow these steps:

- Review the DICL and the BECF screens.

- Code the BECF screen with Miscellaneous Factor 6 for Windfall Offset if SSI is involved.

- Complete the DECI screen.

- Process the claim through EC using 2/21 on the MCS Main Menu.

When other family members can be awarded benefits while the CDB's medical decision is pending and the FMAX is involved, show the CDB as a delayed claimant. This will prevent payment of the entire family maximum amount before the CDB decision is made, and will avoid an overpayment.

If you're unable to process the claim through EC, prepare an A101 or an EF101 if it is an award.

CDB allowances are sent to ODO or the PSC servicing the NH's SSN.

If the CDB claim is a disallowance and cannot be processed through EC, process the manual denial via the MACADE Denial screens. This process is discussed in the DIB Adjudication lesson.

OBJECTIVE 3:

Compute a CDB benefit, including a dual entitlement benefit, and identify nonpayment and termination events for CDB.

CDB Benefit Rate

RS 00203.025

50 Percent / 75 Percent

Compute the CDB benefit like any other child's benefit.

- Auxiliary = 50 percent of NH's PIA, subject to the family maximum.

- Survivor = 75 percent of NH's PIA, subject to the family maximum.

Dual Entitlement

RS 00615.742-.778; **RS 00203.060**; **GN 02401.030**

CDB / DIB

The computation becomes more complex when the CDB is entitled on their own account as well.

Even if the entitlement to CDB began first, the entitlement on the CDB's own SSN becomes the primary benefit. If the CDB is higher, reduce the CDB rate by the amount of the child's own RIB or DIB, and issue two separate payments to the individual.

Medicare will be established under the beneficiary's own SSN. (If the beneficiary was entitled as a CDB first, the Medicare entitlement will switch to his or her own SSN.)

EXAMPLE:

$300   CDB Benefit

- 250   RIB or DIB PIA

$ 50   CDB Benefit Payable

Exhibit 1 is an example of an MBR showing a dually entitled CDB.

The DE DATA field indicates he is entitled to his own HA benefit and the amount payable. This field shows both the SAMBA and the LEMBA. If you review the HISTORY field, you will see he is only getting the LEMBA amount paid on this SSN.

Exhibit 2 is an example of the CDB's own HA MBR.

The DE DATA field indicates he is entitled to CDB benefits on the other SSN. It also shows the other PIA, the LEMBA, and SAMBA. A review of the HISTORY field shows he is receiving only the SAMBA amount on this SSN. Medicare data is also shown on this MBR.

HA Higher

If the HA benefit is greater than the CDB benefit, payment will be received on the HA SSN. The CDB benefit record will show technical entitlement only.

FMAX

Adjust for the family maximum before the reduction for RIB or DIB entitlement. If the RIB or DIB entitlement reduces the CDB to $0, the child still has technical entitlement but is not due any cash payment.

Parisi

As the result of a 1999 court decision (Parisi By Cooney v. Chater), all dually entitled beneficiaries will now be processed in the same manner as

simultaneously entitled children, effective with benefits payable 10/99 or later (**GN 02603.045**, **RS 00615.768**, (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) (b) (2)(b) (2)

Parisi Case Characteristics:

- Two or more auxiliaries are entitled on the record, and
- At least one of the auxiliaries on the record is dually entitled, and
- The FMAX is exceeded

Reduce the other beneficiaries on the record only by the amount actually payable to the dually entitled beneficiary. (The amount actually payable is before any age reduction, government pension offset, or workers' compensation offset.)

EXAMPLE: Jenny is the number holder drawing disability benefits. Her PIA is $1200 and the Family Max on her record is $1800.

The beneficiaries on the record are Jenny, the number holder (HA), Dennis, the first child on the DIB record (HC1), and Sheryl who is a CDB and the second child on the DIB record (HC2).

The benefit rates are $1200 for Jenny (HA) and $300 for each child, Dennis (HC1) and Sheryl (HC2).

If Sheryl becomes entitled to DIB on her own record of $250, her CDB amount is reduced to $50 ($300 - $250).

When reducing benefits for the maximum, the PIA and the partial payment to the CDB must be subtracted.

$1800 FMAX	$600
- 1200 PIA	- 50 partial payable to HC2
$600	$550

The amount payable to Dennis becomes $550 (this is less than 50% of the PIA); Sheryl will receive $50 as a CDB and $250 on her own record.

IMPORTANT NOTE: If there are both dually entitled and simultaneously entitled beneficiaries on the same record, the dually entitled individuals never benefit from Parisi. Simultaneously entitled individuals may be due a benefit increase.

Rules Prior to 10/99

Prior to 10/99, as long as the dually entitled child remained technically entitled, the benefits of other auxiliaries or survivors could not be increased, even if less than the maximum was being paid.

Highest Benefit Payable

When a child is entitled to auxiliary or survivor benefits on more than one SSN, the CDB is generally paid on the SSN which yields the highest original benefit. The CDB would be technically entitled on the other SSN. We combine the family maximums to a Combined Family Maximum. The combination may allow the auxiliaries or survivors to receive higher monthly benefits. **RS 00615.772**

Nonpayment/Deduction Events

RS 00203.030

Nonpayment Provision

The usual nonpayment provisions (e.g., deportation, non-resident alien, prisoner suspension, etc.) apply to CDBs.

Work

A CDB is subject to the SGA and TWP provisions like other disability beneficiaries. For this reason, we do not impose AET rules against a CDB because of the child's own work.

Work deductions incurred by a RIB NH, due to the AET, will reduce the benefit of the CDB just as it would any other auxiliary on the same RIB record.

SGA suspension incurred by a DIB NH will cause suspension of the CDB just as it would any other auxiliary on the same record.

Termination Events

RS 00203.035; **DI 10115.050**

Termination

Following is a list of events which terminate a child's benefit:

- NH's entitlement ends (except because of death).

- Cessation of the CDB's disability (either due to medical recovery or due to SGA).

- Marriage by the CDB, unless the CDB is marrying another Title II beneficiary who is not entitled as a minor child or student child.

- Death of the CDB.

  EXAMPLE 1: Regina has been entitled to CDB since 05/11. Today she calls to report she got married last month. Her husband, Chris, is also entitled to CDB. Benefits for both Regina and Chris will continue.

  EXAMPLE 2: Jeremiah has been entitled to CDB since 08/98. On 11/12/18, he notified us he got married on 11/02/18. His wife, Sarah, has been receiving SSI payments for two years. Jeremiah's CDB benefits will terminate effective 11/2018.

EXHIBIT 1: CDB MBR

PAYMENT   PIC-C1 MPA-$0.00 DOC-039 RD-02/22/13 LAP-T SERVICE IND-6

TELE NO   BTN-717-022-7506 BTC1-H CPND-03/2013

PAYEE   <PAYEE NAME> FOR

              PAYEE UPDATED-02/20/2013

ADDRESS   377 SECURITY BLVD., BALTIMORE, MD 21235

              ADDR UPDATED-02/20/2013 SCC-22150 ZDPC-885 SOURCE-R

BANK   RTN-133283162 DAN-S1711113165 BDCD-05/31/12

BENEFIT   BIC-C1 TERESA MARIE<LAST><LAST> DOB-08/14/1985 B DOEI-05/11

              DOEC-05/11 ABN-WTBT LAF-AD RFST-DECOMB MBP-$593.00 DRD-01/31/13

              DOCA-02/13 DUAL/TECH ENT-PAYMENT CODE X MED STAT-INACTIVE RECORD

              CAUS INDICATOR-NO

HIST TOC   TOC-7 START-05/2011 HBAD01 HAP-01 HEDA-05/31/12

BENREF   VALIDATED BOAN-XXX-XX-2909

BENE ENT   START-05/2011 DATE OF FILING-06/29/2011 APP RECEIPT-07/08/2011

              ID CODE-C1 CUR ENT CODE-DISABLED MOE CODE-UNREDUCED BENEF

DIB   DDO-09/01/05 DAC-X DIG-3180 SDIG-3140 DIB DOED-05/2011

              MEDICARE DOED-06/2009 DSD-06/12

CHLD REL   BEGIN-08/14/1985 TYPE-NATL/LEG CHILD PROVEN

RESIDNCY   START-06/24/1999

CITIZEN   START-08/14/1985 COUNTRY-UNITED STATES PROVEN

DEV PYE   SUSPENSE REASON-NOT QUALIFIED SUSPENSE START-02/2013

              RESUME INPUT-02/2013

R PAYEE   DOS-02/2013 YIPS-2012 TOP-SEL CC-PYE GS-N CMC-Y RPN-XXXXX2909

              RPNI-1

ANN RPRT   YOER-10 TOER-A TOW-W EARNINGS-$5034 ARCD-05/31/12

              YOER-11 TOER-W TOW-W EARNINGS-$5285 ARCD-05/31/12

```
SID        SIFT-D SIED-04/13 SISC-Y XIXEC-I SCADI-W SCCR-22130 RZIP-02368

           SILAC-B SIAD-06/12

X-REF      XRTC-O XAN-XXX-XX-2909 XBIC-A

WOD        WIN-D

DE DATA    OTRAN-XXX-XX-2909 A  TOD-1 OTDOE-06/09 DESC-3 OTPCOC-7

           OTPIA-$519.40 LFMBA-$1113.10 OTRIA-$0.00 LEMBA-$593.70

           SFMBA-$519.40 SAMBA-$519.40 OTPIFC-L OTELY-09
```

DED/ADD	COM MTH	UPDATED	TYPE	SOURCE	AMOUNT	START	STOP	ITEM
	02/2013	01/31/2013	MBP	T2	$ 0.00	02/2013		010
	02/2013	01/31/2013	MBP	T2	$ 0.00			999

HISTORY							
	05/11	$ 533.40	$ 0.00	400	A00	DECOMB	$ 533.00
	12/11	$ 552.60	$ 0.00	600	A00	DECOMB	$ 552.00
	12/12	$ 562.00	$ 0.00	000	A00	DECOMB	$ 562.00
	12/13	$ 570.50	$ 0.00	500	A00	DECOMB	$ 570.00
	12/14	$ 580.30	$ 0.00	300	A00	DECOMB	$ 580.00
	12/15	$ 580.30	$ 0.00	300	A00	DECOMB	$ 580.00
	12/16	$ 582.00	$ 0.00	000	A00	DECOMB	$ 582.00
	12/17	$ 593.70	$ 0.00	700	A00	DECOMB	$ 593.00

EXHIBIT 2: HA MBR

```
ACCOUNT    PCOC-7 NOP-01 SEX-F TAC-D LUM-11 LMM-03/13 RCC-5 ERC-09 FLI-M

           CDY-0 SSI INVOLVED  DRAMS READ

PMT CYC    CYI-1 PCEFD-06/25/2010 PCCOM-07/10 PCCR-S

PRIMARY    TERESA MARIE <LAST>    DOB-08/14/1985 LSPA-$0.00

INSURED    CLAIM TYPE-DISABILITY DATE OF FILING-06/24/2010 FIRST MET-10/2008
           LAST MET-12/2011  WAIT PER START-01/2009 NONX NO GMS USED-10/2008
           EXC NO GMS USED-10/2008 20/40 EXCLUSION-TEST NOT MET  20/40 NON
           EXCL-TEST NOT MET AGE24 EXCL-TEST MET  AGE24 NON EXCL-TEST MET
           DIB QC REQUIRE-06  DIB QC EARNED-06  FULL INS EXCL-TEST MET FULL
           INS NONEXCL-TEST MET  FULL QC REQUIRE-06  FULL QC EARNED-06
           CURR QC EARNED-00  HLTHBEN QC EARN-00

PIA HIS    06/09 $ 371.30 L2  FMAX-$  371.30D ELY-08 IME-$ 390 YOC-00

           12/09 $ 371.30 L2K FMAX-$  371.30D ELY-08 IME-$ 390 YOC-00

           01/10 $ 467.10 L22 FMAX-$  467.10D ELY-09 IME-$ 519 YOC-00

           12/10 $ 467.10 L2K FMAX-$  467.10D ELY-09 IME-$ 519 YOC-00

           12/11 $ 483.90 L2K FMAX-$  483.90D ELY-09 IME-$ 519 YOC-00

           12/12 $ 492.10 L2K FMAX-$  492.10D ELY-09 IME-$ 519 YOC-00

           12/13 $ 499.40 L2K FMAX-$  499.40D ELY-09 IME-$ 519 YOC-00

           12/14 $ 507.80 L2K FMAX-$  507.80D ELY-09 IME-$ 519 YOC-00

           12/15 $ 507.80 L2K FMAX-$  507.80D ELY-09 IME-$ 519 YOC-00

           12/16 $ 509.30 L2K FMAX-$  509.30D ELY-09 IME-$ 519 YOC-00

           12/17 $ 519.40 L2K FMAX-$  519.40D ELY-09 IME-$ 519 YOC-00

PAYMENT    PIC-A  MPA-$1112.00 DOC-039 RD-02/25/13 LAP-# SERVICE IND-6

TELE NO    BTN-717-022-7506 BTC1-H CPND-02/2013

PAYEE      <PAYEE NAME> FOR

           PAYEE UPDATED-02/20/2013

ADDRESS    377 SECURITY BLVD., BALTIMORE, MD 21235 ADDR UPDATED-02/20/2013

           SCC-22150  SOURCE-R

BANK       RTN-133283162 DAN-S1711113165 BDCD-08/09/11
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HLD CHK      $1054.00 FOR 02/13 TOH-5 SPM-TAPE RUN DATE-02/21/2013

BENEFIT      BIC-A  TERESA MARIE<LAST><LAST>    DOB-08/14/1985 Q  DOEI-06/09

             DOEC-06/09 ABN-3TBV LAF-C  MBP-$1112.00 DRD-02/22/13

             DUAL/TECH ENT-PAYMENT CODE X LANG-E MED STAT-ACTIVE RECORD

             MED BILLING-3RD PARTY

             HI CONTS PRD-06/2011 SMI CONTS PRD-06/2011

HIST TOC     TOC-5 START-06/2009

HBAD01       HAP-01 HEDA-06/25/10

HBAD02       HAP-02 HEDA-07/18/11

HBAD03       HAP-03 HEDA-08/09/11

BENE ENT     START-06/2009 DATE OF FILING-06/24/2010 APP RECEIPT-06/24/2010

             ID CODE-A  CUR ENT CODE-DISABLED  FULL RETIRE AGE-08/2052

             ANN EARN FRA-08/2052

DIB          DDO-10/01/08 DAC-R DIG-3180 SDIG-3140 DIB DOED-06/2009

             MEDICARE DOED-06/2009 DSD-07/10 DAA-N

CITIZEN      START-08/14/1985 COUNTRY-UNITED STATES PROVEN

HI-DIB       START-06/2011 BASIS-DISABILITY TYPE-FREE FILING-02/2011

SMI-DIB      START-06/2011 BASIS-DISABILITY PERIOD-IEP FILING-02/2011

SMI PREM     START-06/2011 PENALTY-000% CURRENT AMT- $134.00

SMI 3PTY     START-06/2011 CODE-220 CATEGORY-STATE BILLING

DEV PYE      SUSPENSE REASON-NOT QUALIFIED SUSPENSE START-02/2013

             RESUME INPUT-02/2013

R PAYEE      DOS-02/2013 YIPS-2010 TOP-SEL CC-PYE GS-N CMC-Y RPN-XXXXX7809

             RPNI-1

SID          SIFT-D SIED-04/13 SISC-Y XIXEC-I SCADI-W SCCR-22130 RZIP-02368

             SILAC-B SIAD-10/05

X-REF        XRTC-O XAN-XXX-XX-1205 XBIC-C1

DE DATA      OTRAN-XXX-XX-1205 C1 TOD-1 OTDOE-05/11 DESC-3 OTPCOC-A
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OTPIA-$2226.30 LFMBA-$1113.10 OTRIA-$0.00 LEMBA-$593.70

SFMBA-$519.40 SAMBA-$519.40 OTPIFC-L OTELY-10

DED/ADD	COM MTH	UPDATED	TYPXX	SOURCE	AMOUNT	START	STOP	ITEM
	12/2017	11/18/2017	MBP	BRI	$ 1112.00	12/2017		010
	12/2017	11/18/2017	MBP	BRI	$ 1112.00			999

HISTORY							
	12/12	$1054.10	$	0.00	100	01 S	$1054.00
	12/13	$1069.90	$	0.00	450	01 S	$1069.00
	12/14	$1088.10	$	0.00	830	01 S	$1087.00
	12/15	$1088.10	$	0.00	830	01 S	$1087.00
	12/16	$1091.30	$	0.00	300	01 S	$1091.00
	12/17	$1113.10	$	0.00	470	01 S	$1112.00

OFF AIR ACTIVITIES

1. Read the POMS Chapter **DI 11011.000ff** regarding Collateral Estoppel cases. You may wish to save section **DI 11011.005** as a favorite to use for completing the exercises in this chapter and for future claims processing.

2. After reviewing the POMS section shown above, you may wish to know even more about completing a claims path for CDB claims involving Collateral Estoppel. Follow the steps shown below to connect to a useful processing guide:

   - Find the T2 CS Resource Kit.

   - Under Systems Information, click on "MCS EC Claims Workflows."

   - Locate the workflow titled "DIB/DWB/DAC with Collateral Estoppel" Under the DIB Disability Workflows heading

3. Interviewing – Ask your mentor if there are any upcoming CDB appointments. See if you can observe the CDB claims interview. Check with your mentor to see if you can do the interview yourself with assistance from him or her, or another claims specialist (CS).

EXERCISE #1

OBJECTIVE 1: Apply the factors of entitlement for childhood disability benefits (CDB) and determine a CDB's date of entitlement for HI/SMI.

1. Therese R. Green (age 63) has been receiving RIB since 06/2017. On 11/06/18, her daughter, Violet (age 20) became disabled. Violet files for CDB on 01/10/19. If Violet's claim is approved with the onset she alleged, what is her month of entitlement?

2. David Burr has been receiving DIB benefits since 10/2016. His son Tim (DOB 03/12/98) filed in 04/18 for CDB benefits on his father's record. Tim's claim was approved with a DOO of 03/24/18. He has never been entitled to any type of disability benefits before.

   a. What is Tim's date of entitlement to CDB?

   b. What is the date of HI/SMI entitlement?

3. Using the information from question #2, what would the month of entitlement for payments be if Tim's father's date of death were 03/07/18?

4. Candy Barr was previously entitled to CDB benefits from 08/2013 through 10/2014. In 11/2018, she filed for DIB on her own SSN and DDS established Candy's new onset as 10/12/2018. When will Candy become entitled to Medicare?

EXERCISE #2

OBJECTIVE 2: Identify the evidence, forms, and procedures needed to process a CDB claim.

1. Minny Van Gogh is receiving Mother's benefits for having a minor child in her care. Her child, Jimmy, is age 15 and 7 months old and has been disabled since birth. Jimmy is currently receiving benefits on his father's SSN.

    a. Can Minny's benefit continue after Jimmy reaches age 16?

    b. If not, why?

    c. If benefits can continue, what actions are needed to continue the payments to Minny?

2. Beverly has been receiving child's benefits on her father's SSN for 3 years. She will be 18 in 3 months and will be graduating from high school. She has been disabled by cerebral palsy since birth and must use a wheelchair. Beverly's Aunt Sally, who is Beverly's payee, asks if there is any way the benefits may continue after Beverly reaches age 18. What actions (if any) should be taken?

3. Marlon Fisher, age 63, comes into your office and inquires about filing for retirement benefits. He is still working. He also mentions he has a 21-year-old paraplegic son, Harlan. What actions should you take?

4. Mel Lowe, age 48, filed for the LSDP on the account of his recently deceased wife. He stated their 25-year-old daughter has been living in a local group home since the age of 17 due to an intellectual disability. What action(s) should you take next?

EXERCISE #3

OBJECTIVE 3: Compute the CDB benefit amount (including situations in which the CDB is dually entitled). Also, identify nonpayment and termination events for the CDB.

1. Thaddeus has been receiving benefits as a CDB on his deceased mother's SSN since 10/2011 when she passed away at age 59. His mother's PIA is $900.00 and the FMAX is $1,350.00. His MBA on his mother's record is $675. His father is entitled to RIB effective 11/18. His father's PIA is $1010.00 and the FMAX is $1,515.00 (ELY 2018). Thaddeus is the only auxiliary.

   a. On which record(s) will Thaddeus be paid?

   b. How many checks will he receive each month?

   c. How much will the check(s) be each month?

2. Three children have been receiving survivor benefits on their mother's SSN since 07/2018, when she passed away. A fourth child is awarded CDB benefits effective 10/2018, based on an EOD of 10/08/18. The children are not entitled on any other SSNs. The 07/18 PIA is $874.00 and FMAX is $1,311.00 (ELY 2018).

   a. How much are the three children receiving before the fourth child is added?

   b. How much will the CDB receive from this account?

   c. How much will each of the other survivors receive each month once the CDB is added to the record?

3. Two children file for benefits on their father's RIB account. One child is entitled as a minor child. The other child is entitled to CDB. Based on a PIA of $715.00 and a FMAX of $1,072.50 (ELY 2018), how much is the CDB's MBA?

4. Shirley is entitled as an HA and a CDB. Her own HA PIA is $133.00 and her full CDB MBA is $253.00. What is the **total** amount of money Shirley will receive each month?

5. In the following examples, determine if a <u>nonpayment</u>, <u>deduction</u>, or <u>termination</u> event is applicable.

   a. A CDB marries a non-entitled individual.

   b. A CDB returns to work during the EPE and performs SGA level work.

   c. A CDB has medically improved to the point he or she could return to work at the SGA level.

   d. A CDB marries a NH who is entitled to RIB.

EXERCISE ANSWERS

Exercise #1

1. 12/18, the first month throughout which she is disabled. (**DI 10115.025**)

2. a. Date of entitlement to CDB = 04/18.
   b. Date of entitlement to Medicare = 04/20, the 25th month of CDB entitlement. (**DI 10115.015**)

3. Tim's MOE would be 03/18, because there is no 'throughout the month' requirement in a survivor claim. (**RS 00203.005**, **DI 10115.025**)

4. Candy will become entitled to Medicare in 01/2020. She had 15 prior months of entitlement to CDB benefits. She needs nine additional months of entitlement to DIB benefits to fulfill the 24 month qualifying period. She must serve a five full month waiting period on her DIB record. The WP months are 11/2018 – 03/2019. Start counting the nine additional months of entitlement in 04/2019, which takes us to 12/2019. Her Medicare entitlement begins in the 25th month of disability entitlement, 01/2020. (**HI 00801.152**)

Exercise #2

1. Yes, Minny's benefits can continue if Jimmy is found to be disabled and Minny meets the necessary child-in-care requirements. A claim does not need to be taken for Jimmy because entitlement already exists on his Dad's record. However, you must complete an EDCS-3368 and obtain SSA-827s for Jimmy. Remember to include the first possible MOE for the parent on the EDCS-3367. (**DI 10115.010**, **RS 00203.090**, **DI 11025.010**)

2. Beverly needs to complete the necessary medical forms (EDCS-3368 and SSA-827s) to be found disabled. (**DI 11005.016**) An application is not needed as she is already entitled to benefits. DDS must make a medical determination. Capability should also be developed to determine if a representative payee would be needed after she turns 18. (**RS 00203.065**, **GN 00502.000ff**)

3. <u>First</u>, request an ICERS for <u>Marlon's</u> SSN. Provide Marlon an estimate of his monthly benefit amount and whether any payments would be withheld based upon

his annual earnings. Tell him the evidence needed to process a retirement application.

Next, obtain an ICERS for Harlan's own SSN to determine if he is insured. Also, explore eligibility for SSI. If there is any eligibility for either program, handle this as an inquiry and manage appropriately. You will also want to obtain an estimate of CDB payments for Harlan from Marlon's SSN.

Finally, explain all filing options to Marlon. Be sure to include the information regarding Harlan's potential CDB entitlement, but be careful not to disclose information regarding Harlan's record. Also, explain the evidence necessary to process claims (proof of age, medical evidence for Harlan, etc.). (**RS 00203.050**)

4. Take an application for CDB benefits (including EDCS completion, SSA-827s, SSA-821 (if indicated), proof of age and relationship, etc.). Review **GN 00204.003** to determine who should file the application. Capability development should be undertaken. The daughter's own DISCO query should be checked for insured status. Remember to explore possible SSI entitlement. DDS will need to make a medical decision if the daughter has never been entitled to disability benefits. (**RS 00203.040**, **RS 00203.005**)

Exercise #3

1. a. Thaddeus will continue to receive payments from his mother's SSN.

   b. Thaddeus will receive one check each month.

   c. The amount of his monthly check will remain $675. The most he could receive from his father's record is $505. He receives more money from his mother's SSN. He will be technically entitled on his father's SSN. The combined family maximum (CFMAX) will not apply in this situation because there are no other children on either record. (**RS 00203.025**)

2. (**RS 00203.025**)

   a. When three children were receiving benefits from this SSN, each of their benefits was $437/month. $1,311.00 ÷ 3 = 437.00

   b. When the CDB is added to this account, he or she will receive $327.70/month. $1,311.00 ÷ 4 = $327.75 (rounded down to $327.70)

   c. Each of the other survivors will also receive $327.70/month effective 10/18.

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3. The CDB will receive $178.70/month. Benefits are subject to the FMAX. (**RS 00203.025**)

    (FMAX) $1,072.50 – (PIA) $715 = $357.50 divided by 2 = $178.75 dimes down round to $178.70.

4. Shirley will receive a total of $253 each month. She will be paid $133 on her own SSN and an additional $120 ($253 - $133 = $120) as a CDB (**RS 00203.025 B**).

5. The answers are as follows:

    a) Termination (**RS 00203.035**)

    b) Non-payment (**RS 00203.030 A.3**)

    c) Termination (**RS 00203.035**)

    d) Payment continues (**RS 00203.035 A.3**)

TABLE OF CONTENTS

LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Identify and apply the factors of entitlement to DWB

2. Discuss the prescribed period, controlling date, and waiting period; compute the benefit amount

3. Determine when Medicare entitlement begins for a Disabled Widow(er) or Surviving Disabled Divorced Spouse; Discuss deemed DWB for Medicare

4. Complete the MCS screens, EDCS 3367 and EDCS 3368 for a DWB claim and determine case processing

5. Identify nonpayment and termination events

Length of Chapter

14 hours

BACKGROUND AND RATIONALE

Introduction

Social Security survivor benefits provide insurance protection against the loss of support when a worker dies. Congress recognized disabled widow(er)s and disabled surviving divorced spouses, who were not yet age 60, could not qualify for benefits on the basis of age and needed additional protection. Benefits for disabled widow(er)s and disabled surviving divorced wives who are between the ages of 50 and 60 became payable in February 1968. Disabled surviving divorced husbands' benefits became payable in July 1980.

OBJECTIVE 1:

Identify and apply the factors of entitlement to DWB.

Categories

BIC Chart for Disabled Widow(er)'s Benefits

SM 10802.110

	1st claimant	2nd claimant	3rd claimant	4th claimant	5th claimant
Disabled widow	W	W2	W4	W9	WF
Disabled widower	W1	W3	W5	WB	WG
Disabled Surviving Divorced Wife	W6	W7	W8	WC	WJ
Disabled Surviving Divorced Husband	WR	WT			

Requirements for Entitlement

RS 00207.000ff; **DI 10110.000ff**; **DI 11015.000ff**

The relationship requirements and issues involved in DWB are basically the same as for widow's **(D)** and widower's **(D1)** benefits. DWB beneficiaries must meet all of the following criteria in order to be eligible.

Disabled Widow/Disabled Widower

- Widow(er) of NH who died **fully** insured;

- Attained age 50 – benefits are not payable for months BEFORE age 50 even though the impairment may have existed before age 50;

- Unmarried (unless remarried between age 50-60 and disabled at the time of remarriage or entitled to DWB at the time of remarriage);

- File an application;

- Disabled during prescribed period;

- Have served a 5 full calendar month waiting period or be exempt from serving a waiting period; and

- Not be entitled to a RIB which:

  - Equals or exceeds DNH's PIA;

  - Equals the NH's deemed PIA effective 06/78; or

  - Equals the widow(er)'s indexed PIA effective 01/85.

Refer to **RS 00207.002 B.2** when a claimant is also entitled to DIB.

Disabled Surviving Divorced Wife/ Disabled Surviving Divorced Husband

The requirements for entitlement to Disabled Surviving Divorced Wife (**W6**) and Disabled Surviving Divorced Husband (**WR**) are the same as the requirements listed for DWB plus these additional requirements:

- Be finally divorced from the DNH, <u>and</u>

- Have been married to NH for 10 years immediately before the divorce become final.

DWB Entitlement After Mother's/Father's

DI 11015.000ff; **RS 00207.005**; **RS 00207.008**

Mother's/Father's (E/E4) Entitlement Ends

A mother's or father's benefit will generally be higher than a DWB benefit. A mother/father benefit is 75% of the PIA while the DWB is only paid 71.5% of the PIA (both subject to the FMAX). The first month of entitlement to DWB cannot be earlier than the month after the last month of entitlement to mother's/father's benefits.

EXAMPLE: Sarah Johnson, DOB 02/04/1968, has been receiving E benefits since March 2015. Her youngest child attains age 16 in April 2018, and Sarah's benefits terminate that month. She alleges she is disabled. Her W benefits cannot begin prior to April 2018 because her monthly benefit will be higher as an E than as a W.

Normally, a claim for DWB should be filed when the youngest child is approaching age 16 unless there are months in which the E/E4 does not have an entitled child in care, or Medicare entitlement could be obtained earlier (this provision is discussed further in Objective 3).

A new application is not needed, but medical development is required. Proof of age is also needed if not already established.

Medical Determination

Presently, DWB and DIB medical determinations are based on the same medical and vocational factors. For DWB benefits payable before 01/91, a stricter definition of disability applied.

OBJECTIVE 2

**Discuss the prescribed period,
controlling date, and waiting period;
compute the benefit amount.**

Prescribed Period

[DI 11005.050](#); [DI 25501.350 A.3](#)

A DWB must be disabled during the prescribed period. The prescribed period for the DWB is similar to the date last insured (DLI) in DIB claims.

Beginning Date

The prescribed period **BEGINS** with the **LATEST** of:

- The month of the NH's death; or

- The last month of previous DWB entitlement; or

- The last month of entitlement to mother's/father's ("E") benefits on the NH's record.

Review the history field on the MBR shown below. The last month of entitlement for this E beneficiary is 05/15. June 2015 is the first month of non-entitlement on the MBR and reflects T4.

HISTORY	12/10	$1232.40	$0.00 000	01	$1232.40
	12/11	$1282.90	$0.00 000	01	$1282.90
	12/12	$1325.20	$0.00 000	01	$1325.20
	12/13	$1355.60	$0.00 000	01	$1355.60
	12/14	$1404.40	$0.00 000	01	$1404.40
	06/15	$1465.20	$0.00 000	T40	$1465.20

NOTE: If the DWB claimant is entitled to mother's or father's benefits and is in current pay or suspense, the prescribed period has not started because the claimant is still entitled to mother's/father's benefits.

Ending Date

The prescribed period **ENDS** with the **EARLIEST** of:

- The month before the month a widow(er) attains age 60;

- The month before the month a widow(er) attains age 65 in a Medicare only claim; or

- The last day of the 84th month (7 years) following the month the period began; or

- The last day of the 84th month after the claimant was last entitled to mother's, father's or widow(er)'

Example – Mr. & Mrs. Beeson

John Beeson (NH), died 01/04/18. Mary Beeson, born 02/13/62, received E benefits through 09/18 (MBR shows T4 effective 10/18). Mrs. Beeson filed for DWB on 02/11/19 using an alleged onset date of 11/30/17. She had no prior DWB entitlement.

Use **Exhibit 1A** to compute the prescribed period:

Answer:

Prescribed Period Beginning Date

Month of NH's death –	01/2018
Last month DWB –	N/A
Last month of E entitlement –	09/2018
Prescribed Period **BEGINS** latest date =	**09/2018**

Prescribed Period Ending Date

Month before month of age 60   01/2022

Month before age 65 (Medicare only claim) –   N/A

Last day of 84th month (7 years) following
beginning date of prescribed period –   09/30/2025

Prescribed Period **ENDS** earliest date =   **01/2022**

In this example, Mrs. Beeson must be found disabled by 01/31/2022, the month before she reaches 60, to be paid cash benefits as a DWB.

DWB cannot be paid based on a disability which began after the end of the prescribed period. Do not send a case to DDS for a decision if the only possible onset is after the end of the prescribed period.

Controlling Date

DI 11005.050; DI 25501.350 A.4

Definition

The controlling date is the latest onset date DDS can establish without adversely affecting the first month of entitlement. In a DWB claim, DDS does not always start developing medical evidence with the claimant's alleged onset date.

The DDS examiner uses the controlling date as a starting point to develop medical evidence. That date may be:

- The AOD or POD, if different;

- The first day of the fifth month before the first possible MOET (based on other non-disability factors);

- The end of the prescribed period; or

- Date of remarriage, unless a remarriage is deemed to not have existed.

Unlike a DIB claim, the monthly benefit amount for a DWB beneficiary is not dependent upon the date of onset. The monthly benefit amount for a DWB is a set percentage of the NH's PIA. It is not always necessary for DDS to establish the earliest possible onset. DDS uses the controlling date to establish the most advantageous date of onset without using excess resources to develop unnecessary medical evidence.

Determining the Controlling Date

Computing the controlling date requires several steps. In the first part, the computation derives the first possible month the widow(er) could receive benefits considering only non-disability factors.

Disabled widow(er)s' is an exception to the limitation on retroactivity of survivor's benefits for reduced beneficiaries. DWB applications, for benefits prior to age 60, have up to 12 months of retroactivity. This is also true for deemed entitlement for Medicare only.

Example – Mr. & Mrs. Beeson

John Beeson (NH), died 01/04/18. Mary Beeson, born 02/13/62, received E benefits through 09/18 (MBR shows T4 effective 010/18). Mrs. Beeson filed for DWB on 02/11/19 using an alleged onset date of 11/30/17. She had no prior DWB entitlement.

Using **Exhibit 1B**, compute the controlling date:

STEP 1:

12 months retroactive from filing date –	02/2018
NH's month of death –	01/2018
Month widow attains age 50 –	02/2012
Month after last E entitlement –	10/2018
LATEST date above =	**10/2018**

Considering only the non-disability factors, Mrs. Beeson's FIRST POSSIBLE month of entitlement to DWB is 10/2018.

NOTE: For deemed DWB Medicare only claims where the widow(er) is also receiving benefits as an aged widow(er) (D beneficiary), the filing date should be the date of entitlement to "D" benefits.

STEP 2:

1st day of 5th month before the date selected above –	05/01/2018
Alleged onset date (or Potential onset, if different) –	11/30/2017
LATEST date of above dates =	**05/01/2018**

STEP 3:

Date prescribed period ends –	01/31/2022
Earliest date of Step 2 and Step 3 =	**05/01/2018**

05/01/2018 is the Controlling Date.

Illustrations of Controlling Date

While determining the controlling date can be complex, here are several illustrations of its importance to DDS:

EXAMPLE 1:

Jane, who never worked, has been disabled since age 40. She files for DWB upon her husband's death when she's age 51. There is no reason for DDS to develop medical evidence back to age 40. The controlling date will be 5 full months before her husband died and the DWB could start with the month of the NH's death.

EXAMPLE 2:

Luke died when his wife, Susan, was 53 and not disabled. She became disabled at age 56, but didn't file for DWB until she was 59. The controlling date will be 17 full months before her filing date. There is no reason for DDS to develop medical evidence back to either age 53-when Luke died-or age 56, Susan's AOD.

EXAMPLE 3:

James died when his wife, Jennifer, was 37. She received E benefits until age 41. She becomes disabled at age 47 and files for DWB when she's 50. The controlling date will be 7 years after her last entitlement to E benefits, which is also the end of the prescribed period. She MUST be found disabled by that date to be paid DWB at age 50.

Remarried DWB

RS 00207.003 A.1

In the case of a remarried widow(er), follow POMS **DI 11005.050 C** "Guide for Determining Prescribed Period and Controlling Date," to determine the controlling date.

These claims may require an earlier controlling date to determine if the remarriage can be disregarded.

In a remarried widow(er)'s claim, the controlling date must be established as of the date of remarriage, if the remarriage occurred after the attainment of age 50 but occurred underlined earlier than the controlling date that would otherwise be established.

Claimant at least age 50 but not yet 60

The remarriage of a claimant at least age 50 but not age 60 applying as a disabled widow(er) or disabled surviving divorced spouse may be disregarded if:

- The remarriage occurred after age 50, and

- He or she was disabled at the time of the remarriage.

EXAMPLE:

Sue's first husband died when she was 47. She became disabled at age 51 and remarried at age 52. At age 55, she files for DWB. In this example, the controlling date would usually be 17 months before filing date.

In Sue's case, since she filed before age 60, the controlling date will be established as of the date of remarriage rather than 17 months before filing date. This is because we need to find her disabled at the time of remarriage. If approved, she can then be paid DWB beginning 12 months prior to filing date.

Claimant age 60 or older

When the claimant has attained age 60 at the time of filing, we may disregard the remarriage if:

- the claimant was <u>entitled</u> to disabled widow(er)'s or disabled surviving divorced spouse's benefits at the time of the remarriage, and

- The remarriage occurred between age 50-60.

EXAMPLE:

Angie's first husband passed away when she was 55 years old. She became disabled on her 56th birthday, but never filed for DWB. She remarried 6 months before her 60th birthday. On the day after her 60th birthday she comes in to file for Widow's benefits on her first husband's record and mentions she is disabled. The onset date must be established early enough to allow her to be retroactively entitled to DWB prior to the month of remarriage.

Waiting Period

DI 10110.001 G

5 Full Months

Like DIB claimants, DWB claimants must serve a 5-month waiting period. The beginning date of the waiting period is no earlier than the first full month of disability. Unlike DIB claimants the DWB waiting period can begin before all non-medical factors of entitlement are met (see the Davidson example below).

To determine the starting point of the waiting period, list the first day of:

- The 17th month before the month of filing;

- The 5th month before the month of the NH's death;

- The 5th month before the first month of non-entitlement after mother's/father's benefits on the NH's E/R ends;

- The 5th month before the widow(er)'s attainment of age 50; or

- The 1st full month after the established onset date.

NOTE: During the initial claims interview, it is appropriate to use the AOD or POD to estimate the waiting period).

Select the **LATEST** of the above dates as the starting point.

NOTE: The waiting period for a subsequent period of DWB entitlement can be waived if the claimant's second disability begins before age 60 **and** within seven years (84 months) following the month the prior DWB entitlement terminated. In this situation, DWB benefits can begin the first month the claimant is disabled for the entire month.

When a DWB claimant remarries and the remarriage cannot be disregarded, the waiting period can be served during the period of remarriage. Entitlement cannot begin until the DWB is finally divorced.

Example – Mr. & Mrs. Beeson

John Beeson (NH), died 01/04/18. Mary Beeson, born 02/13/62, received E benefits through 09/18 (MBR shows T4 effective 10/18). Mrs. Beeson filed for DWB on 02/11/19 using an alleged onset date of 11/30/17. She had no prior DWB entitlement.

Using **Exhibit 1C**, calculate the beginning date of the waiting period:

Answer:

17th month before filing	09/2017
5th month before NH's death	08/2017
5th month before 1st month of non-entitlement to E/E4	05/2018
5th month before age 50	09/2011

5th month before Widow(er)'s Divorce (for a remarried widow)   __N/A__

1st full month after onset date   12/2017

The waiting period begins on the latest of these dates: **05/2018**

The date that is derived from this exercise is the first month of the waiting period, if the DWB claimant must serve a waiting period.

Example – Mr. & Mrs. Davidson

Mrs. Davidson died 06/15/14. Mr. Davidson, born 07/17/68, drew E4 benefits through 01/17. His benefits were terminated (T4) effective 02/17. He filed for DWB on 10/15/18 with an onset date of 07/28/13.

Using **Exhibit 1C**:

Answer:

17th month before filing   05/2017

5th month before NH's death   01/2014

5th month before 1st month of non-entitlement to E/E4   09/2016

5th month before age 50   02/2018

1st full month after onset date   08/2013

The waiting period begins on the latest of these dates: **02/2018**

SSI/SSP Credit to Reduce Waiting Period

DI 11015.001 C; **HI 00801.154**

Each month beginning with the first month of Supplemental Security Income (SSI) payment or federally administered state supplement payment (SSP) will be counted toward the 5-month waiting period for DWB payments.

The SSI/SSP period that may be counted includes the first month the individual received any SSI/SSP payment AND all succeeding months, up to the month before the DWB MOE. This is applicable whether or not the

individual met the non-medical requirement for DWB entitlement during the period of SSI/SSP (e.g., widowed, age 50, etc.).

All months in the SSI/SSP period may be credited even when the individual was not in pay status. This will include months in which the individual was in SSI/SSP suspension or termination status for any reason.

EXAMPLE:

Terrell died 07/12/2018. His widow, Coraline, has been disabled since 01/01/2017 and has received SSI from that time through the present. The five full months prior to the Terrell's death are counted as the waiting period for Coraline.

The HICL screen is used to code information when the waiting period is reduced by SSI/SSP credit months. **MS 03509.007**

(b) (2)
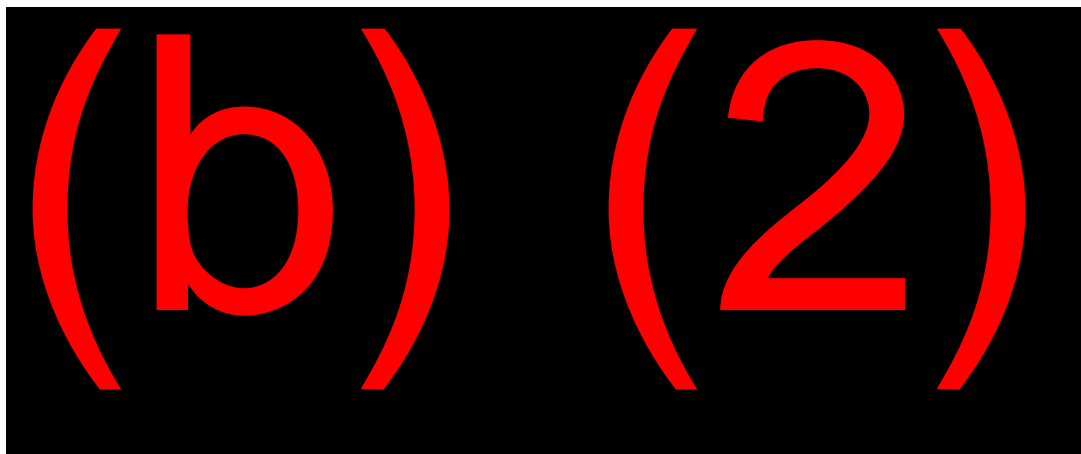
W-DWB DISABILITY AND MEDICARE WAITING PERIODS REDUCED BY SSI/SSP MONTHS SSI/SSP PAY STATUS START MONTH: <u>MM/YY</u>.

In this field you would enter 01/17 because this was the first month Coraline received an SSI payment.

Example of CMPH field:
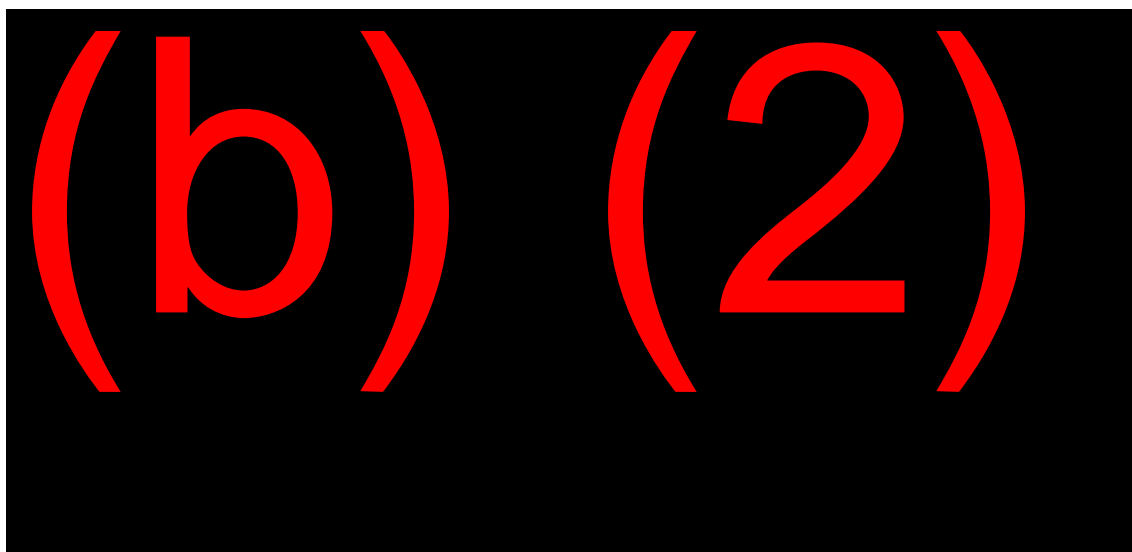
You find the first month of payment by locating the first PS identifier of C01 or M01 in the CMPH line of the Supplemental Security Record (SSR). When this identifier is C01 or M01, with an amount other than "zero" in the payment field (FAM or SAM), the effective month of payment status can be identified on the same horizontal line under the CMPH column. In this case, the PS field shows C01 with a payment of $31480.00 under the FAM field for the month 05/13. Also see **Exhibit 3**.

MOET

DI 10110.001 G

The actual month of entitlement is dependent on the established onset date, waiting period, and all factors of entitlement.

The MOET is the **latest** of the following:

- If a waiting period is required, the 6th full calendar month of disability;

- If a waiting period is not required, the first full calendar month of disability;

- 12 months retroactive from filing date;

- NH's month of death;

- Month widow attains age 50;

- Month after last month of E or DWB entitlement; or

- At least one month before month RIB begins (DWB Medicare-only cases). **DI 10135.010 A**

NOTE: If a case must be forwarded to DDS for a medical decision, the alleged onset should be considered when discussing the month of entitlement with the claimant during the initial claim's interview. The alleged onset should also be considered when coding the DEME screen. The DEME will be discussed in Objective 4.

Example – Mr. & Mrs. Beeson

John Beeson (NH), died 01/04/18. Mary Beeson, born 02/13/62, received E benefits through 09/18 (MBR shows T4 effective 10/18). Mrs. Beeson filed for DWB on 02/11/19 using an alleged onset date of 11/30/17. She had no prior DWB entitlement.

Using **Exhibit 1D** calculate the first month of entitlement.

Answer:

If waiting period required, the 6th full month disabled	05/2018
If waiting period not required, the first full month of disability	N/A
12 months retroactive from filing date	02/2018
NH's month of death	01/2018
Month widow attains age 50	02/2012
Month after last month of E or DWB entitlement	10/2018
At least one month before month RIB begins	N/A

The first month of entitlement for Mrs. Beeson is the **latest** of these dates. The month of entitlement is 10/2018.

Calculating DWB MBA

RS 00615.310 B.1

71.5 Percent

Benefits for DWBs age 50-59 (W/W1) are 71.5 percent of the PIA or share of the family maximum, regardless of when entitlement is established between age 50 and age 60. See **Exhibit 4** for how the DWB benefit is calculated in a family maximum situation.

Disabled surviving divorced spouse's benefits (W6/WR) are never reduced for the family maximum (i.e., they are paid outside of the family maximum). W6/WR benefits equal 71.5 percent of the PIA.

The 71.5 percent equals the age 60 benefit rate for widow(er)'s. This formula applies to all disabled widow(er)'s including those already on the rolls.

EXAMPLE 1:

Mr. Crouse died earlier this year. His widow filed for DWB the month after her 60[th] birthday and is not insured on her own record. The DNH's PIA is $934.10. How much would Mrs. Crouse's DWB be if approved?

Answer:

$934.10 x .715 = $667.8815 = $667.80 (after dime-down rounding)

EXAMPLE 2:

Mr. Wiley died 11/25/18. His widow (DOB 06/04/66) filed for DWB on 12/18/2018 and is not insured on her own record. Mrs. Wiley is approved for benefits based on an onset of 08/04/17. The DNH's PIA is $1143.50. How would you compute her DWB payment?

Answer:

$1143.50 x .715 = $817.6025 = $817.60 (after dime-down rounding)

DIB/DWB Dual Entitlement

Just as in DIB/WIB dual entitlement, we will only reduce the difference between the DIB PIA and the DWB PIA (Deceased NH's PIA) if the DIB MOE is before the DWB MOE.

EXAMPLE 1:

Mr. McMurray died 10/20/18. His widow (DOB 04/30/60) filed for DWB 11/18, with an onset of 06/09/15, and is approved for benefits. His PIA is $812.10. His widow had been receiving DIB on her own record since 12/15 and the PIA effective on her record is $510.80 in the DWB MOE. How would you compute her monthly benefit?

$812.10 (deceased NH PIA)
- 510.80 (own DIB PIA)
$301.30 (excess unreduced W)

Excess Reduced:
$301.30 x .715 = $215.4295 = $215.40 (after dime-down rounding)

$215.40 W Benefit (LEMBA)
+510.80 HA PIA (SAMBA)
$726.20 Combined Benefit

EXAMPLE 2:

Mrs. Tootle died 04/04/18. Her widower, Mr. Tootle, (DOB 01/19/63) has received DIB on his own record since 02/16 (onset 08/19/15 and PIA at DWB MOE = $848.40). He files and is approved for DWB in 04/18. Mrs. Tootle's PIA is $1412.20. How would you compute his monthly benefit?

$1412.20 (deceased NH PIA)
- 848.40 (own DIB PIA)
$563.80 (excess unreduced W)

Excess Reduced:
$563.80 x .715 = $403.117 = $403.10 (after dime-down rounding)

$403.10 W Benefit (LEMBA)
+848.40 HA PIA (SAMBA)
$1251.50 Combined Benefit

OBJECTIVE 3

Determine when Medicare entitlement begins for a Disabled Widow(er) or Surviving Disabled Divorced Spouse; Discuss deemed DWB for Medicare.

Medicare Entitlement

RS 00207.000ff; **HI 00801.152**; **HI 00801.155**; **DI 10110.000ff**; **DI 11040.000ff**

25th Month

All beneficiaries entitled to a DWB for 24 months will automatically be entitled to HI beginning with the 25th month of entitlement. SMI entitlement begins the same month as HI unless SMI is refused.

EXAMPLE:

NH DOD:	06/10/17	DWB EOD:	11/10/17
DWB DOF:	01/19/18	DWB WP:	12/17 - 04/18
DWB MOE:	05/18	HI/SMI MOE:	05/20

NOTE: A DWB diagnosed with ALS will not have to serve the 24-month Medicare waiting period per **DI 10110.001 G.3.**

Reducing the Qualifying Period

Prior Periods of T2

HI 00801.152

Months of entitlement from a prior period of DWB, CDB, or DIB can be used in counting the 24-month qualifying period for Medicare provided that:

- The prior period of DWB or CDB ended no more than 7 years (84 months) before the current onset; or

- The prior period of DIB ended no more than 5 years (60 months) before the current onset; or

- The current disabling impairment is the same as, or directly related to, the impairment that served as the basis for the previous period of DWB, CDB or DIB entitlement.

NOTE: A person does not have to be re-entitled to the same type of disability benefit for these rules to apply.

EXAMPLE:

Elizabeth was previously entitled to CDB from 12/16 - 01/18. Her CDB benefits terminated when she got married. Her husband, Jeffrey, passed away unexpectedly in 12/18 and she filed for DWB in 12/18. Her DWB MOE is 12/18.

The first month of her Medicare entitlement is determined as follows:

CDB – 12/16 - 01/18 = 14 months towards the Medicare qualifying period. Begin counting with the DWB MOE 12/18 for an additional 10 months of the qualifying period – 12/18 - 09/19. Medicare entitlement begins in the 25th month of entitlement, 10/19.

SSI/SSP Eligibility

HI 00801.154; **DI 11015.020 C**

To calculate months that may reduce a DWB's Medicare qualifying period, count each month in the period beginning with the first month of Supplemental Security Income (SSI) and/or Federally Administered State Supplement (SSP) payment.

For the countable SSI/SSP period, we include the first month the individual received any payment and all succeeding months through the month before the DWB MOE (or deemed MOE for Medicare purposes only) whether or not the individual also met the non-medical requirements

for DWB entitlement during the period of SSI/SSP (e.g., widowed and/or age 50). This also includes any month for which the SSI/SSP was terminated or in suspense after the first month of eligibility.

The period of SSI/SSP, previously used as part of the 5-month waiting period, can also be used as part of the 24-month Medicare qualifying period.

NOTE: For the Medicare qualifying period, we exclude SSI/SSP months concurrent with T2 entitlement since these months are already credited under T2.

Document the SSI/SSP information on both the RPOC and HICL screens in MCS.

EXAMPLE:

MaryAnn is entitled to DWB effective 01/2019.

HI/SMI DOE without SSI/SSP = 01/2021

Remember this is due to the 24-month Qualifying Period for Medicare.

We can use SSI/SSP months to reduce that qualifying period.

She had SSI eligibility from 06/17 through 04/18. **All** months from the first SSI payment month of 06/17 through the month before the DWB MOE, 12/18, are credited **despite the fact she was not in pay status part of the time.** Count 06/17 through 12/18 towards the Medicare Qualifying Period= **19 MOS.**

Months needed for the Qualifying Period =	**24**
Countable months from prior SSI =	**-19**
Months still needed for Qualifying Period =	**5**

Months of DWB used towards Qualifying Period: 01/19 - 05/19

HI/SMI DOE with SSI/SSP = 06/19

Exhibit 3 shows how to find the start date of the SSI payment for this purpose.

HICL Screen

[MS 03509.007](#)

(b) (2)
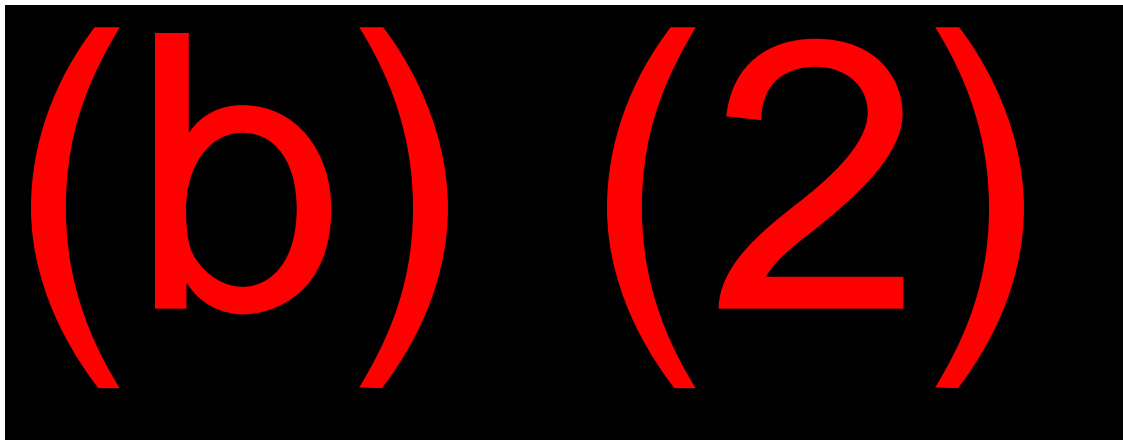
Use the HICL screen to input the earlier start date for Medicare based on a prior period of DIB, DWB or CDB or based on SSI/SSP months.

In the Disability for Medicare Period section, enter the ONSET date for the prior period of T2 entitlement. To complete the START (MMYY) field, first determine the correct start date for Medicare considering all prior periods of entitlement, then enter the month and year two years earlier than that date.

EXAMPLE:

Elizabeth had a prior period of CDB which will count toward her Medicare Qualifying Period. Her onset date for that period was 11/15/16, with entitlement from 12/16-01/18. On the HICL screen, we will enter 11/15/16 in the ONSET field. In the START field, we will first determine the correct start date for her Medicare entitlement. In an earlier example we calculated her Medicare should begin 10/2019. Now subtract 2 years and input 1017 in the START field.

To record the SSI/SSP payment on the HICL screen, enter the first month the claimant received an SSI or SSP payment in the **W-DWB DISABILITY AND MEDICARE WAITING PERIOD REDUCED BY SSI/SSP MONTHS** field.

Deemed Entitlement for Medicare

A claimant may be **deemed** to be entitled to DWB for purposes of Medicare and its qualifying period. The purpose of deemed DWB entitlement is so the beneficiary can qualify for Medicare coverage earlier than age 65. Deemed DWB is a "technical" entitlement and is not a claim for cash benefits.

Deemed DWB entitlement for Medicare-only occurs when:

- An age 50 or older disabled claimant is already entitled to E benefits; or

- An age 60 or older disabled D beneficiary is not eligible for DWB prior to age 60; or

- A disabled claimant is entitled to RIB benefits prior to age 65.

Prescribed Period, Controlling Date, and Onset

Determining the prescribed period, controlling date, and onset will parallel the same procedures used in normal DWB claims. The prescribed period can extend up to age 65 for DWB Medicare-only claims.

Although the prescribed period in DWB Medicare-only claims can be up to the attainment of age 65, it is not necessary to consider onset after age 62 years and 7 months if the claimant is required to serve the five month waiting period. This is because the five month waiting period plus the 24 month qualifying period for Medicare would push the MOE after the claimant would be age 65 or older. **DI 11040.001**

In cases where the disabled widow(er) is eligible for reduced RIB, which would be higher than the deceased NH's PIA, we want to make the month of entitlement for reduced D benefits at least one month before entitlement to RIB entitlement. This allows the Deemed DWB for Medicare to continue even though the cash benefits as a D terminate. See **DI 10135.010 A** for details.

What Claim to Take

Take a claim for "deemed DWB for Medicare" if the disabled claimant is already entitled to a higher monthly benefit.

NOTE: If the claimant is filing at or after age 60 and the retroactivity of the claim does not allow an MOE before age 60, then the claim is for aged D benefits, plus "deemed DWB for Medicare."

EXAMPLE 1:

Claudia

- Has been receiving E benefits for having a CDB in her care;
- AOD 04/19/18 (age 54). A medical determination was requested and the claim was approved;
- Her waiting period is: 05/18 - 09/18;
- Her technical entitlement date is 10/18;
- Claudia can be entitled to Medicare effective 10/20 while still being paid as E.

EXAMPLE 2:

Josephine

- Contacts SSA at age 61½ to file for DWB benefits;
- She is <u>more than a year</u> older than age 60;
- She cannot be entitled to cash benefits as a DWB;
- Josephine can be entitled to cash benefits as a D and if DDS determines she is disabled, she can be entitled to deemed DWB benefits for Medicare purposes;
- Her Medicare coverage begins after 24 months of technical entitlement. This allows her Medicare coverage to begin <u>before</u> age 65. Her monthly benefit amount as a D remains unchanged based on the deemed DWB claim.

OBJECTIVE 4:

Complete the MCS screens, EDCS 3367, and EDCS 3368 for a DWB claim and determine case processing.

MCS Application

The application screens completed in MCS for a DWB claim are the same as those completed for an aged widow claim, since both are under the category of surviving spouse. See the applicable screens in **MS 03505.009**.

The IDEN screen contains the question regarding disability. The only way to distinguish a claim for DWB entitlement from a regular WIB claim is for the applicant to answer the disability question yes and provide a date of onset. **MS 03505.059**

The DEME screen is used to code the date of entitlement. Use option "D" and show the first payment month in the "date" field. When determining the first payment month, consider SSI/SSP credit months, waiting period based on claimant's alleged onset date, date of the NH's death, and date of divorce for a remarried widow(er). After considering all these relevant factors, up to 12 months of retroactivity may be granted on a DWB claim. **MS 03505.025**

SSA-10

The paper application is the same for both aged and disabled widow(er)'s benefits. The questions about disabling conditions are unique for DWB. Answer the question regarding SMI for DWB claimants whose SMI MOE would be within 6 months or for a retroactive SMI MOE.

Medical Information

DI 11005.000ff; **DI 81010.020**

DWB claims requiring a new application on MCS must have the initial claim established on the mainframe before you can create an EDCS case.

DWB claims not requiring a new application (widow(er)/young parent conversions or DWB after WIB for Medicare purposes), can be created in EDCS if a record of the claimant (BIC) is already established on an existing MBR with specified LAF codes. DWBs under age 60 require a LAF on the MBR of C, E, S6, S7, S8, S9, D (any number), AD, T4, or T6; DWBs over age 60 requires a LAF of C, S6, S7, S8, S9, or AD.

EDCS is <u>always</u> established under the <u>claimant's own SSN</u>.

EDCS-3368 Folder

DI 81010.025 B

Input medical information in the 3368 screens for a DWB claim just like in a DIB claim.

NOTE: If it is necessary to use a paper SSA-3368-BK, write the name and Social Security number of the deceased number holder across the top of the front of the paper SSA-3368 BK.

EDCS-3367 Folder

DI 81010.025 A

The screens in the 3367 folder contain a section to record information needed to determine prescribed period and controlling date. Advise the DDS of the prescribed period and controlling date before sending the case for medical development and decision.

From the 3367 "Miscellaneous, DWB, and Prior Filing Information" page, click on the NH's SSN in the DWB Information section to view the "Title II Disabled Widow(er) Controlling Date" page. Most of the information on this page is propagated from MCS or other places in EDCS. There are a

few fields you can edit if you need to change the prescribed period or controlling date.

DWB Case Processing

DI 11015.000ff; **DI 11011.000ff**; **GN 01010.000ff**; **DI 81010.142**

Aged D and DWB Filed Concurrently

If a widow over the age of 60 alleges a disability and entitlement is not possible prior to age 60:

- Establish the claim in MCS;

- Trigger the D claim. Include a paragraph in the notice about the pending decision on the disabled widow(er)'s claim;

- <u>After</u> the MBR is established begin EDCS processing. Complete the 3368 and 3367 in EDCS (or SSA-3367 and SSA-3368 for paper folders). Obtain SSA-827s (and SSA-820/821/823 and EDCS/SSA-3369 as appropriate);

- Control the deemed DWB claim on the Modernized Development Worksheet (MDW).

Use the (b) (2)(b) (2)(b) (2)(b) (2) guide entitled (b) (2)(b) (2) for specific processing instructions.

Deemed DWB When No Application Required

In cases where an individual may be deemed entitled to DWB only to establish Medicare and an application is not required (currently receiving D or E benefits):

- Complete only an EDCS-3367, an EDCS-3368 and SSA-827s (no application in MCS). Also complete the SSA-820/821/823 and EDCS-3369 as appropriate. Establish in EDCS as a MCS Exclusion. Use a Modernized Development Worksheet (MDW) to control the claim.

- In paper claims, caption the SSA-3368-BK "Application for Medicare purposes only" and enter the prescribed period and controlling date on the SSA-3367-F5.

Insured Status

Obtain an ICERS to document non-entitlement on the claimant's own SSN due to lack of insured status. **RS 00207.007**

Systems and Routing

DWB claims requiring a medical determination are routed to the DDS. These claims are excluded from non-medical completions.

If you have a paper folder, complete the paper SSA-831-U3. For instructions on completing the form, see **DI 11010.205**.

Collateral Estoppel

When a DWB claimant was previously approved for Title II (DIB or CDB) or Title XVI disability benefits, consider collateral estoppel. If collateral estoppel applies, you can adopt the prior decision for cash benefits or Medicare entitlement, and no DDS decision is required. Based on the rules of collateral estoppel, a prior favorable determination/decision made by SSA or the courts must be adopted for the same period on the new claim unless the prior favorable determination can be reopened under the rules of administrative finality. **DI 11011.001**

Remember:

- A prior favorable medical decision made after January 17, 2017 based on the claimant's having met or equaled a Mental Disorder or Immune System Disorder Listing cannot be adopted due to changes in the rules for these listings. **AM-18029**

- The prior onset must be before the end of the prescribed period. **DI 11011.005**

If the prior onset is after the controlling date but within the prescribed period, adopt the determination and award benefits, but send to DDS after adjudication for a possible earlier onset.

Follow **DI 81010.142** for establishing a certified electronic folder (CEF) for cases where the field office can adopt the medical decision from a prior claim.

Deferred Development

The deferral of non-medical development applies to DWB claims; follow normal deferred development procedures. In a claim for DWB where insured status, age, or relationship is unresolved, obtain necessary evidence and hold the medical file until the issue is resolved. Do not refer the file to DDS without prescribed period data entered.

Jurisdiction and Routing (DWB)

When DDS makes the medical decision, they close out EDCS and establish an action item on the EDCS Actions page alerting the FO of the decision.

DDS enters the medical decision information on the DICL screen. Once the case returns with a DDS decision, code the BECF screen with SSI windfall information, and enter any SSI/SSP credits months on the HICL screen (if applicable).

Code the DECI screen with the decision information. Awarded claims route to the PSC that has **jurisdiction of the deceased number holder's SSN**. The FO can usually trigger an allowance through EC. Claims that will not clear through EC will require preparation of an A101.

NOTE: A claim with Deemed Medicare entitlement requires an A101. Include the remark "SSI/SSP months for DWB, see RPOC in MCS" on the BCRN (Remarks) Screen of the A101.

Most denied claims process through MCS. Code the DECI screen and trigger the decision through EC. Claims that will not process through EC must be processed through MACADE by completing the 3428 Disallowance MACADE screens. When this MACADE action processes, the MBR will update with the denial information. There is a MACADE Denial processing guide in the (b) (2)(b) (2)(b) (2) under Systems Information called, (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2).

Jurisdiction and Routing (Deemed DWB)

When DDS makes the medical decision, DDS closes out EDCS and establish an action item on the EDCS Actions page alerting the FO of the decision.

When a Medicare-only claim is allowed, the FO completes a SSA-3601. On the SSA-3601, check the boxes for ACTION REQUIRED and UNPROCESSED with REASON, "Deemed DWB Claim: See eView for SSA-831 and supporting medical." Fax the form to the appropriate payment center for action.

If a DDS denial on a Medicare-only claim is received, process a MACADE denial and retain any paper folders for six months in case an appeal is filed.

Reminders

Note the following items in processing DWB claims:

- Develop DIB and DWB claims simultaneously **RS 00207.010**;

- If there is no application on MCS, use an MDW to control the deemed DWB claim;

- Process the DWB claim using EC, if possible;

- When an A101 is needed, review the disability information propagated to the BENE screen and correct, if necessary.

Other Procedures

DI 11015.005; **GN 01010.140**

There are special provisions that uniquely apply to DWB claims:

- If an application for disabled widow/widower benefits includes a claim for the LSDP, the application may be adjudicated as a LSDP only claim. Diary for the DWB decision. If not LISH, the LSDP can only be paid if approved for DWB; hold the lump sum application for the medical decision.

- If other claimants can be awarded and the FMAX is involved, award their benefits and show the DWB as delayed to prevent an overpayment. Keep in mind a disabled surviving divorced spouse is not subject to the FMAX.

- If an E beneficiary files a deemed DWB claim for Medicare purposes only, follow the regular POA procedures and document that the deceased NH was fully (rather than just currently) insured.

Examples of EC Exclusions include:

- Claims involving any of the basic EC exclusions;

- Claims involving Special Enrollment Periods for DWBs;

- Claims involving SSI/SSP months.

OBJECTIVE 5

Identify Nonpayment and Termination Events

DI 13010.000ff; **RS 00207.002ff**

Nonpayment and termination events for an aged widow(er) and for DIB both apply to DWB.

Nonpayment events:

- Total GPO;

- Failure to satisfy the prisoner or fugitive felon provisions;

- Issues relating to the alien provisions;

- Refusal to cooperate in a continuing disability review (CDR).

Termination events:

- Entitlement of DWB to a RIB which equals or exceeds the deceased NH's PIA. If the DWB was entitled to "W" benefits before the first month of RIB entitlement, the DWB remains technically entitled for Medicare purposes;

- Cessation for medical recovery reasons. In this case, entitlement ends the second month following the month the disability ceases, and Medicare entitlement will also end;

- Death.

TWP/EPE vs. Annual Earnings Test

The TWP and EPE provisions apply to disabled widow(er)s in the same manner as to disabled workers. Further details of the TWP/EPE provisions are contained in the advanced lesson on CDRs.

Deductions under the annual earnings test do not apply to disabled widow(er)s or disabled surviving divorced spouses under FRA entitled for any month prior to age 60. As with disabled NHs, any work activity by a DWB claimant is subject to investigation.

When DWBs between the ages of 60 and FRA cease due to work activity, the DWB could choose D benefits but may possibly lose Medicare coverage before 65.

EXHIBIT 1A: PRESCRIBED PERIOD

PRESCRIBED PERIOD

_____   Month of NH's Death

_____   Last Month of Prior DWB Entitlement

_____   Last Month E Entitlement On NH's Record

Latest Date _____ = Prescribed Period Begin Date

_____   Month before Widow(er) Attains Age 60

_____   Month before Month Widow(er) Attains Age 65 (Medicare Only)

_____   Last Day of 84th Month Following Month PP Began

Earlier Date _____ = Prescribed Period Ending Date

EXHIBIT 1B: CONTROLLING DATE

The CONTROLLING DATE is the latest date the onset can be established without affecting the first month of entitlement.

To determine the CONTROLLING DATE, complete these steps:

STEP 1:

_____ 12 months retroactive from filing date as "W" (or "D" entitlement if past age 60 and filing for Medicare entitlement) or N/A

_____ NH's month of death

_____ Month widow attains age 50

_____ Month after last month of E (or prior DWB) entitlement

Select Latest Date Above: _____

STEP 2:

_____ First day of 5th month before date selected in **Step 1** above

_____ Alleged Onset Date (or Potential Onset Date, if different)

Select Latest Date Above: _____

STEP 3:

_____ Date Prescribed Period Ends from EXHIBIT 1A

STEP 4:

Select the Earlier of the Dates in **Step 2 or 3**: _____

STEP 5:

In a remarried widow(er)'s claim, indicate the date of remarriage; otherwise, leave blank. _____

STEP 6

Indicate the earliest of **Step 4 or 5** above: **_____**.

STEP 7

Add this Step ONLY if Claimant Received E Benefits in the 12 Months Before Filing for DWB:

_____   17th Month before Filing Date as DWB

If this date is earlier than the date in **Step 6**, make this date the CONTROLLING DATE **if it will allow for earlier Medicare entitlement**. Do not use this date if earlier than onset date.

EXHIBIT 1C: WAITING PERIOD

WAITING PERIOD

_____   17th Month before Month of Filing

_____   5th Month before Month of NH Death

_____   5th Month before 1st Month of Non-entitlement To E/E4 On This
               E/R

_____   5th Month before Widow(er) Age 50

_____   5th Month before Widow(er)'s Divorce (for a Remarried Widow)

_____   1st Full Month after Established Onset Date (or Alleged Onset Date
               if speaking with the claimant during the initial interview)

Latest Date _____ = Waiting Period Begin Date

EXHIBIT 1D: MONTH OF ENTITLEMENT

MONTH OF ENTITLEMENT

_____   If a waiting period is required, the 6th full calendar month of disability

_____   If no waiting period required, the 1st full calendar month of disability

_____   12 months retroactive from filing date

_____   NH's month of death

_____   Month widow attains age 50

_____   Month after last month of E or DWB entitlement (termination month)
_____   At least one month before RIB begins (DWB Medicare-only cases)

Latest Date _____ = First Month of Entitlement

EXHIBIT 2: DIB/DWB COMPARISON

DIB	DWB
No minimum age requirement. Not eligible at FRA or older.	Not eligible before age 50. Eligible age 60 to 65 for Medicare purposes only.
Must have a medically determinable impairment that prevents engaging in substantial gainful activity.	SAME
Must have become disabled prior to date last insured.	Must be disabled within prescribed period.
Finding of disability based on medical and vocational factors.	SAME
Benefits paid at full DIB PIA, unless prior entitlement to a reduced RIB.	DWB under age 60, the benefit equals 71.5 percent of PIA or share of family MAX (W6/WR is not reduced for family MAX); deemed DWB (for Medicare) age 60 or older, the regular WIB applies. DIB entitlement affects benefit calculation.
Benefits payable after 5 month waiting period.	SAME. Can use SSI/SSP credit months to reduce or eliminate waiting period.
Entitled to TWP.	SAME
Eligible for Medicare after 24 months	SAME. Can use SSI/SSP months to reduce or eliminate qualifying period.
Benefits subject to worker's compensation offset	Benefits subject to government pension offset.
Entitlement subject to continuing disability review.	SAME

EXHIBIT 3: SSI/SSP CREDIT MONTHS ON THE SSID

When you request the SSID, show H in the limit field to get the full history of the CMPH and PMTH fields:

(b) (2)
(b) (2)
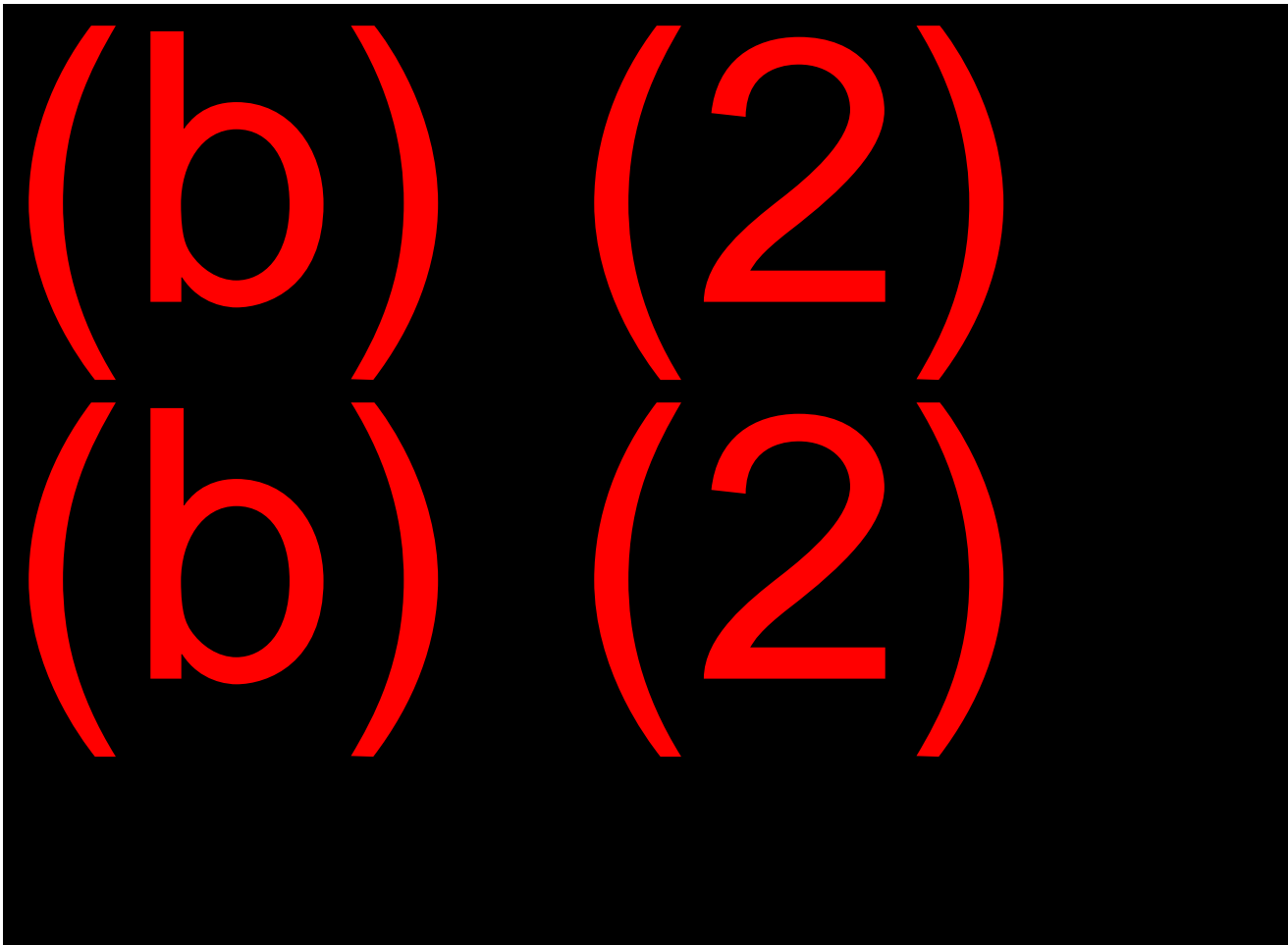
Above is an example of what to look for on the SSID. Look for the PS field in the CMPH line and find the first entry of C01 or M01 in this column. Then look for the earliest date in the CMPH column that has a FAM (Federal amount due) or a SAM (State amount due) greater than zero.   In this case, you see 01/13 is the first date of C01 payment in the FAM. Show 01/13 as the start date for the SSI credit months on the HICL.

EXHIBIT 4: CALCULATING THE DWB WHEN THE FAMILY MAXIMUM IS INVOLVED

Ava Sable (DOB 02/03/1961) filed for DWB on 09/24/18 and DDS found her disabled as of 05/10/2018. Her waiting period is 6/2018 through 10/2018, with the first month of entitlement as 11/2018. She was never entitled to SSI or SSP. Her husband died 09/09/10 (DOB 02/18/1947, ELY 2009). He had never been entitled to Social Security benefits. There are two CDBs currently entitled on the record. Ava was last entitled to E benefits in 11/2015.

Deceased WE's PIA = $1000 FMAX $1500.00

The widow's original rate is $1000.00. The original rate for each child is $750.00. The first step is to prorate the family maximum based on the different original rates.

C1 original rate:	$ 750.00
C2 original rate:	$ 750.00
W original rate:	$1000.00
Total OR:	$2500.00

$$W \quad \frac{1000.00 \times 1500.00}{2500} = \$600.00$$

DWB MBA is 71.5% of the adjusted rate:

$$\$600.00 \times 0.715 \ (71.5\%) = \$429.00$$

W's MBA is $429.00.

$$C1 \text{ and } C2 \quad \frac{\$750.00 \times 1500.00}{2500} = \$450.00$$

Each C MBA is $450.00.

The FMAX and benefit amounts can be calculated using ICF #23 (see input below).
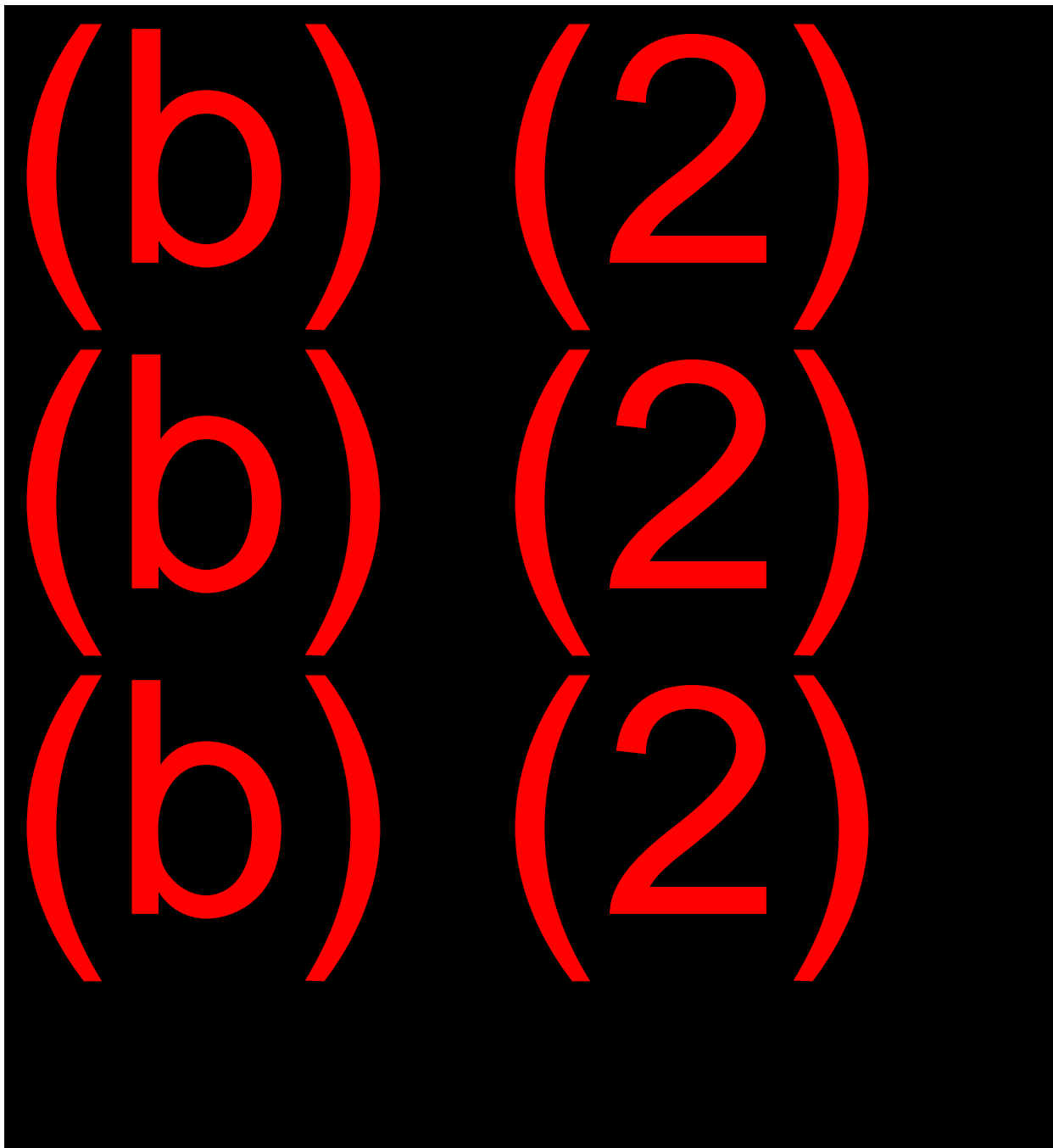
OFF-AIR ACTIVITIES

In PCOM Training, the students should complete the MCS screens for a DWB claim and determine case processing.

Obtain cloned SSNs from the Office of Learning's (b) (2)(b) (2) site for Gary and Kristie Brown to complete the following exercise.

LSDP/DWB Interview

NH Name: Gary Brown   NH SSN: As provided

Claimant Name: Kristie Brown   CL SSN: As provided

Application

Background Information

Widow comes into the office today to file for the LSDP. During the pre-interview, she states she is disabled. She telephoned ahead, so she brought all her documents.

Essential Facts: NH INFO

DOB: Use DOB that propagates from SSN used

DOD: The 21st day of last month

No prior applications (never disabled)

No military service or RR employment

No governmental or non-covered work

No prior marriages; no children

Proven wages of $45,000 in the year prior to death

Alleged wages of $25,000 in the year of death

Essential Facts: CL INFO

DOB: Use whatever propagates from SSN used

No children.

Married to NH since 6/19/86; no prior marriages

No military service or RR employment

No government or non-covered work

Never employed or self-employed

CL DISAB

Rheumatoid arthritis since 02/01/2016

Medical evidence can be released

Application

Review Items

Did you establish a claim for both DWB and the LSDP?

Did you apply the proof of age and citizenship tolerances? If so, were the MCS application screens properly coded?

Did you determine the correct month of entitlement based on her AOD and code that on the DEME screen?

Did you determine the Prescribed Period and Controlling Date and ensure they were properly reflected in the EDCS 3367?

LSDP/DWB Interview Development

Background Information

So you can take the proper development actions, you may wish to begin this part of the exercise by reviewing the application screens for this case. When you finish the claim, access the DW01 to code all relevant issues

and access the PRST to print a copy of the information that will be used to process the claim. Begin processing the claim.

Essential Facts

Today is the application date.

Proof of age, death, marriage, and proof of earnings for the year prior to death were received today.

The benefit estimate shows the NH is insured.

Development

Review Items

Notice the system propagates an issue for the DDS decision. Did you enter an appropriate tickle date for the issue (60-90 days based on office policy)?

Did you review the application output to see what printed?

Conclusion

1. The student should inform the mentor when finished.

2. The student should observe an in-office DWB appointment. After the CS/TE completes the interview, the student (under assistance and observation by the interviewer) should complete the 3367 in EDCS using his or her own PIN. The student needs to include observations of the CL and review the dates for the prescribed period and the controlling date. After the EDCS-3367 has been reviewed by the CS/TE or the mentor, the claim and EDCS should be transferred to DDS.

EXERCISE #1

OBJECTIVE 1: Identify and apply the factors of entitlement to DWB.

1. Which of the following is <u>not</u> a requirement for entitlement to DWB?

    A. File an application

    B. Be at least 60 years-old

    C. Be disabled during the prescribed period

    D. NH must have been fully insured

    E. Serve a waiting period (unless exempt)

2. Sarah Johnson, age 54, files for DWB on her ex-husband, Roger Johnson's, record. Mr. Johnson passed away last week. The Johnsons were married 02/17/02 and divorced 07/02/13. If Mrs. Johnson is found to be disabled 01/22/19, can she be entitled to DWB? Why or why not?

EXERCISE #2

OBJECTIVE 2: Discuss the prescribed period, controlling date and waiting period; Compute the benefit amount.

PART I

Using Exhibits 1A, B, C and D, complete the information for the following two problems. In each example, what is the claimant's prescribed period, controlling date, waiting period, and first month of entitlement? Assume no SSI/SSP credit months. **NOTE:** Use one of the automated calculators to check your answers.

1. Mable Hooper filed for DWB on 10/22/18. Her DOB is 01/15/63. Her husband died on 09/13/11. She drew "E" benefits through 07/2014. T4 effective 08/2014. No prior DWB or SSI entitlement. Date of onset is 03/07/18.

2. Herman Stone, DOB 09/12/66, filed for DWB on 09/24/18. Onset is 12/10/17. His wife died on 08/23/18. He did not draw "E" benefits or have a prior period of DWB.

PART II

3. Robert Eleigh, DOB 04/07/61, filed for DWB on 09/04/18. Onset is established as 04/01/18. His wife died on 06/29/14. He has not received any benefits prior to DWB and is not insured on his own record. His wife's E/R shows a PIA of $750. What is his MBA?

4. Ed Ward died 08/07/16. His wife filed for DWB 11/10/18. Her DOB is 01/29/64. Established onset is 02/04/18. The deceased NH's PIA is $1121.50. What is her MBA? (She has never received any type of benefit and is not insured on her own record.)

EXERCISE #3

OBJECTIVE 3: Determine when Medicare entitlement begins for a Disabled Widow(er) or Surviving Disabled Divorced Spouse; discuss deemed DWB for Medicare.

1. Why would a widow(er) request a medical decision at age 62?

2. Calvin Chase has a 9-year-old child in his care and has been getting father's benefits since 11/2015. On 10/15/2018, he filed for DWB for Medicare purposes only. His date of birth is 06/14/1967 and the NH's date of death was 11/17/2015. If the date of onset is established as 02/10/2017, when will Mr. Chase's Medicare entitlement begin? (Assume no prior entitlement to eliminate qualifying period.)

EXERCISE #4

OBJECTIVE 4: Complete the MCS DADE screens, EDCS 3367 and EDCS-3368 for a DWB claim and determine case processing.

Indicate whether the following statements are true or false.

1. We do not want to delay forwarding a DWB claim to DDS pending the widow(er)'s DOB development. If the MCS application, EDCS-3367, EDCS -3368 and SSA-827s are completed, forward the claim to DDS if you are certain the age requirement will be met.

2. Mrs. Hall files for DWB and tells you she has never worked. Her signed statement on her application or an SSA-795 is sufficient documentation that she is not insured.

3. Mrs. Daniels files an application for DWB at the same time as she files surviving child applications for her 16-year-old twin daughters and her 17-year-old son. You should hold the children's claims in the FO until the DDS decision is received.

EXERCISE #5

OBJECTIVE 5: Identify nonpayment and termination events.

1. Which of the following is a terminating event for a disabled widow(er)?

    A. Confinement in prison because of a conviction for a felony

    B. Pending continuing disability review

    C. Entitlement to a retirement benefit which exceeds the deceased NH's PIA

2. Mrs. B has been receiving DWB since she was 52 years old. It is determined her disability ceased in March this year because her condition improved to the point that it is no longer disabling. When does her entitlement end?

3. If Mrs. B in the question above turns FRA on May 17 this year, when would her entitlement end?

EXERCISE ANSWERS

Exercise #1

1. B **RS 00207.001**

2. Yes, she meets all of the factors of entitlement, including the 10-year duration of marriage requirement. **RS 00207.001ff**

Exercise #2

PART I:

1. Mable Hooper

   PRESCRIBED PERIOD

MONTH OF NH'S DEATH	09/2011
LAST MONTH OF PRIOR DWB ENTITLEMENT	N/A
LAST MONTH "E" ENTITLEMENT ON NH'S RECORD	07/2014

   LATEST DATE   07/2014   = PRESCRIBED PERIOD BEGIN DATE

MONTH BEFORE WIDOW(ER) ATTAINS AGE 60	12/2023
MONTH BEFORE MONTH WIDOW(ER) ATTAINS AGE 65 (<u>MEDICARE ONLY</u>)	N/A
LAST DAY OF 84TH MONTH FOLLOWING MONTH PP BEGAN	07/2021

   EARLIER DATE   07/2021   = PRESCRIBED PERIOD ENDING DATE

CONTROLLING DATE

STEP 1

12 MONTHS RETROACTIVE FROM FILING DATE AS "W" (or "D" Entitlement if past age 60 and filing for Medicare entitlement)	10/2017
NH'S MONTH OF DEATH	09/2011
MONTH WIDOW(ER) ATTAINS AGE 50	01/2013
MONTH AFTER LAST MONTH OF "E" (or prior DWB) ENTITLEMENT	08/2014
SELECT LATEST DATE ABOVE	**10/2017**

STEP 2

FIRST DAY OF 5TH MONTH BEFORE DATE SELECTED ABOVE	05/01/17
ONSET DATE	03/07/18
SELECT LATEST DATE ABOVE	**03/07/18**

STEP 3

DATE PRESCRIBED PERIOD ENDS	07/2021

STEP 4

SELECT THE EARLIER OF THE DATES IN STEP 2 OR 3	**03/07/18**

STEP 5

IN A REMARRIED WIDOW(ER)'S CLAIM, INDICATE THE DATE OF REMARRIAGE; OTHERWISE, LEAVE BLANK.	**N/A**

STEP 6

INDICATE THE EARLIER OF 4 OR 5 ABOVE	**03/07/18**
CONTROLLING DATE:	**03/07/2018**

WAITING PERIOD

17TH MONTH BEFORE MONTH OF FILING	05/2017
5TH MONTH BEFORE MONTH OF NH DEATH	04/2011

5TH MONTH BEFORE THE FIRST MONTH OF NON ENTITLEMENT TO E/E4 ON THIS E/R	03/2014
5TH MONTH BEFORE WIDOW(ER) AGE 50	08/2012
1ST FULL MONTH AFTER EOD	04/2018

LATEST DATE 04/2018 = WAITING PERIOD BEGIN DATE

FIRST MONTH OF ENTITLEMENT

IF A WAITING PERIOD IS REQUIRED, THE 6TH FULL MONTH OF DISABILITY	09/2018
IF NO WAITING PERIOD REQUIRED, THE 1ST FULL MONTH OF DISABILITY	N/A
12 MONTHS RETROACTIVE FROM FILING DATE	10/2017
NH'S MONTH OF DEATH	09/2011
MONTH WIDOW ATTAINS AGE 50	01/2013
MONTH AFTER LAST MONTH OF E OR DWB ENTITLEMENT (TERMINATION MONTH)	08/2014
AT LEAST ONE MONTH BEFORE RIB BEGINS (DWB MEDICARE-ONLY CASES)	N/A

LATEST DATE 09/2018 = FIRST MONTH OF ENTITLEMENT

2. Herman Stone

PRESCRIBED PERIOD

MONTH OF NH'S DEATH	08/2018
LAST MONTH OF PRIOR DWB ENTITLEMENT	N/A
LAST MONTH "E" ENTITLEMENT ON NH'S RECORD	N/A

LATEST DATE 08/2018 = PRESCRIBED PERIOD BEGIN DATE

MONTH BEFORE WIDOW(ER) ATTAINS AGE 60	08/2026
MONTH BEFORE MONTH WIDOW(ER) ATTAINS AGE 65 (MEDICARE ONLY)	N/A
LAST DAY OF 84TH MONTH FOLLOWING MONTH PP BEGAN	08/2025

EARLIER DATE   08/2025   = PRESCRIBED PERIOD ENDING DATE

CONTROLLING DATE

STEP 1

12 MONTHS RETROACTIVE FROM FILING DATE AS "W" (or "D" Entitlement if past age 60 and filing for Medicare entitlement)	09/2017
NH'S MONTH OF DEATH	08/2018
MONTH WIDOW(ER) ATTAINS AGE 50	09/2016
MONTH AFTER LAST MONTH OF "E" (or prior DWB) ENTITLEMENT	N/A
SELECT LATEST DATE ABOVE	**08/2018**

STEP 2

FIRST DAY OF 5TH MONTH BEFORE DATE SELECTED ABOVE	03/01/18
ONSET DATE	12/10/17
SELECT LATEST DATE ABOVE	**03/01/18**

STEP 3

DATE PRESCRIBED PERIOD ENDS	08/2026

STEP 4

SELECT THE EARLIER OF THE DATES IN STEP 2 OR 3	**03/01/18**

STEP 5

IN A REMARRIED WIDOW(ER)'S CLAIM, INDICATE THE DATE OF REMARRIAGE; OTHERWISE, LEAVE BLANK.	__N/A__

STEP 6

INDICATE THE EARLIER OF 4 OR 5 ABOVE	**03/01/18**

CONTROLLING DATE: 03/01/18

WAITING PERIOD

17TH MONTH BEFORE MONTH OF FILING	04/2017
5TH MONTH BEFORE MONTH OF NH'S DEATH	03/2018
5TH MONTH BEFORE FIRST MONTH OF NON ENTITLEMENT TO E/E4 ON THIS E/R	N/A
5TH MONTH BEFORE WIDOW(ER) AGE 50	04/2016
1ST FULL MONTH AFTER EOD	01/2018

LATEST DATE 03/2018 = WAITING PERIOD BEGIN DATE

FIRST MONTH OF ENTITLEMENT

IF A WAITING PERIOD IS REQUIRED, THE 6TH FULL MONTH OF DISABILITY	08/2018
IF NO WAITING PERIOD REQUIRED, THE 1ST FULL MONTH OF DISABILITY	N/A
12 MONTHS RETROACTIVE FROM FILING DATE	09/2017
NH'S MONTH OF DEATH	08/2018
MONTH WIDOW ATTAINS AGE 50	09/2016
MONTH AFTER LAST MONTH OF E OR DWB ENTITLEMENT (TERMINATION MONTH)	N/A
AT LEAST ONE MONTH BEFORE RIB BEGINS (DWB MEDICARE-ONLY CASES)	N/A

LATEST DATE 09/2018 = FIRST MONTH OF ENTITLEMENT

PART II

3. MBA = $536.20 $750 x 0.715 = 536.25

4. MBA = $801.80 $1121.50 x 0.715 = 801.87

Exercise #3

1. To establish Medicare entitlement before age 65. **RS 00207.020**

2. His Medicare entitlement will begin 10/2019, 25th month of deemed entitlement to DWB. The application for Medicare only is restricted to 12 months retroactivity. **RS 00207.020**; **HI 00801.155**

Exercise #4

1. True **RS 00207.007**

2. False **RS 00207.007**

3. False. The DWB claimant should be shown as a delayed claimant. **GN 01010.140**

Exercise #5

1. C – Entitlement to a retirement benefit which exceeds the deceased NH's PIA is a terminating event for a disabled widow(er) . Except Medicare entitlement would continue. **RS 00207.002**

2. May 31 is the second month after the month in which Mrs. B disability benefits ceased. **RS 00207.002 D**

3. Mrs. B entitlement continues as an aged widow because she attained FRA. **RS 00207.002**

TABLE OF CONTENTS

LESSON PLAN

Module Objectives

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

> 1. Identify potential offset situations, determine at what point offset applies, and determine necessary development and documentation.

> 2. Compute the ACE and perform WC/PDB offset computations.

> 3. Properly code MCS Workers' Compensation/Public Disability Benefit screens and process claims involving WC/PDB.

> 4. Use Interactive Computation Facility for WC/PDB offset computations for A101s, EF101s, and for processing of post-entitlement events.

> 5. Use the WC/PDB Online Record Entry Operation (OREO) Program.

Length of Chapter

> 16 hours

BACKGROUND AND RATIONALE

Purpose

> Workers' Compensation (WC) laws were established to provide a satisfactory means for handling occupational disabilities in order to ensure the work-related accident victim a prompt and reasonable income. In addition, the laws were designed to remove the necessity of wasteful litigation to affix blame for the injury.

> Before WC laws were enacted, a well-established rule held that an employer was only responsible for an employee's injury or death if he could be proven negligent. By the close of the nineteenth century, it was apparent this principle was inequitable and in 1908, the first WC law, the Federal Employee's Compensation Act, was passed. This law covered only a small number of employees and was too restrictive to be effective. By 1911, WC laws providing that industrial employers would assume the cost of work-related disabilities without regard to fault were being enacted nationwide.

> Today all States have WC laws. However, there are variations in the provisions of these laws. They differ in coverage, benefit amounts, insurance requirements, and administrative procedure.

Offset Provisions

> Amendments to the Social Security Act contained "offset" provisions under which disability benefits may be reduced by a formula limiting the total amount of monthly income received from Social Security benefits, Federal or State workers' compensation benefits, or certain Federal, State and local disability benefits. These offset provisions require us to consider reducing disability benefits due to the NH's receipt of WC benefits and/or PDB.

> For all initial disability claims filed after 05/27/87, Civil Service (CS) disability payment data will be obtained through computer interface with OPM. This data constitutes verification of the Public Disability Benefit (PDB) since the Office of Personnel Management provides the information. The information is shown on EC and is also passed to the MBR.

Rehabilitation

> The rationale behind the WC/PDB offset is clear when you consider one of the goals of the disability program is rehabilitation. If a disabled worker and the worker's family were to have more income by remaining on the disability rolls than they had when the worker was gainfully employed, the worker would have little incentive to strive for rehabilitation and a return to the work force.

OBJECTIVE 1:

Identify potential offset situations, determine at what point offset applies, and determine necessary development and documentation.

Definition of WC/PDB Offset

DI 52100.000ff

Offset Provisions

Social Security benefits may be REDUCED or WITHHELD if a disabled NH is also entitled to either, or both, State or Federal workers' compensation (WC) payments or certain public disability benefits (PDB). Offset is applied when SSA benefits payable to the NH and any auxiliaries, plus WC/PDB payments, exceed the higher limit of 80 percent of the NH's average current earnings (ACE) OR the total family benefits (TFB) payable to the NH and any auxiliaries.

Key Terms

It is important to understand the various terms and their meanings related to WC/PDB offset. Some of these terms are listed below.

WC

Workers' Compensation (WC) is defined as payments made under a State or Federal plan to a worker who is temporarily or permanently disabled as a result of a work-related injury or occupational illness.

PDB

Public Disability Benefits (PDB) are defined as certain periodic benefits provided for under a Federal, State or local law or plan based on disability paid to disabled persons for temporary or permanent disabilities. The persons receiving the benefits were not necessarily employees of the public entity paying or requiring the benefit. Unlike workers' compensation payments, PDB does not have to be based on a work-related disability.

Offset

Offset is the reduction in SSA benefits to a NH and/or auxiliaries when the total of the benefits plus WC/PDB exceeds the limit provided in the Amendments.

ACE

Average Current Earnings (ACE) is a term used to denote the NH's average monthly earnings. This amount is used in computing the offset due to WC/PDB.

TFB

Total Family Benefits (TFB) is the total of all SSA benefits payable to the family in the first month offset is considered or possible. The TFB is figured after reduction for the maximum or simultaneous entitlement or age but before any deductions.

Application of Offset

DI 52101.001

Currently offset can be caused by WC, PDB, or both. The WC/PDB payments may be made for full or partial disability that is either temporary or permanent. The source of the actual payment may be the employer, an insurance carrier, a State or Federal WC fund, or the Department of Labor (DOL). The WC/PDB payment does not have to be made based on the

same illness/injury for which SSA disability is being claimed to cause offset.

Several types of payments are often confused with WC/PDB. Insurance to which the employee contributed, such as private disability insurance or private employer or union group insurance and payments under an Unemployment Compensation Act do not cause offset. Sick pay from a private employer for a non-work related injury is not WC/PDB.

THE FOLLOWING PROVISIONS APPLY TO BOTH WC AND PDB OFFSET

Offset Begins

Offset is imposed beginning with the first month of simultaneous entitlement to DIB or DIB auxiliary benefits and WC/PDB. Offset applies to any month of simultaneous entitlement, whether the payment is made at regular intervals, intermittently, or in a lump sum. Intermittent or lump sum payments will be prorated over the payment period.

Offset Ends

Offset ends with the earliest of the following events;

- Month of FRA attainment for individuals who attain age 65 on 12/19/15 or later (based on the new law in the 2015 Amendment). For individuals who attain age 65 prior to 12/19/2015, offset ends at age 65. (If DIB onset is prior to 03/01/81, or the month of entitlement is prior to 09/81, offset applies up to the month of attainment of age 62.)

- WC/PDB payments end

- Proration of WC/PDB payment ends

- WC/PDB payment is reduced to an amount that no longer requires offset

- A recognized reverse offset plan applies

- NH's DIB terminates

- NH dies

- NH's benefits are suspended for SGA

Benefits Affected

Offset will be imposed against SSA DIB benefits as well as anyone entitled on the NH's record – not just the NH. The only exception is some divorced spouse benefits (see **RS 00202.035**).

WC/PDB offset will not apply if the State plan requires reduction of the WC or PDB payment due to SSA DIB entitlement. This is called "Reverse Offset" or "Reverse Jurisdiction." The state plan must have been in effect before 02/18/81. A number of states currently have some kind of reverse offset in place. See **DI 52120.000-.280** for a list of the special provisions applied in each state.

PDB Only Provisions

The following types of payments are not considered a PDB for offset purposes and are excluded from causing offset: (**DI 52125.005**)

- Non-disability benefits

- Private disability benefits (i.e., insurance)

- Needs-based benefits

- All Department of Veterans Affairs (formerly VA) benefits

- Union disability benefits

- Federal disability benefit based on SSA covered earnings (including covered military service – see **DI 52130.001**)

- Federal, state, or local disability benefits based on state or local employment all, or substantially all, of which was covered under SSA (see **DI 52125.015**)

- Federal discontinued service pensions

- Railroad disability pensions paid under the Railroad Unemployment Insurance Act (RUIA)

- Black Lung benefits (unless the mining work was not covered under Social Security).

- Radiation Exposure Compensation Act benefits

- Public Safety Officer Benefit Act benefits

- Energy Employee's Occupational Illness Compensation Program (EEOICP) payments

- Any benefit similar to WC that is subject to offset

PDBs do not cause offset if the NH's disability onset is before 03/01/81 and the DIB entitlement is before 09/81.

WC Only Provisions

WC offset was first effective for NHs whose disability onset was after 06/01/65 and DIB entitlement was after 12/65.

For NHs with onset before 03/01/81 or entitlement before 09/81, WC offset only applies beginning with the month after SSA received notice of the WC payments and it ends when the NH attains age 62.

WC vs. PDB

It is important to realize a payment could be either WC or PDB depending on the exact circumstances. Especially with government employees, this can be confusing.

For instance, John Jones, a state employee, is receiving a disability pension based on a work-related illness. His employment was covered under SSA, so this would not cause PDB offset. However, since John's illness is work-related, the payments may be covered under the State Worker's Compensation plan and cause offset as WC.

On the other hand, Sue Smith, a state employee, was denied under the state WC plan (e.g., no direct connection to work activity determined to exist even though Sue believes the illness is work-related) and took a

disability "retirement" pension. In this case, no WC offset would apply since the payment is not WC. However, if Sue's pension was based on non-covered earnings, there would be PDB offset.

Identifying WC/PDB

DI 52140.001

During all points of contact with the NH, interviewers must remain alert to the possibility of WC or PDB and investigate to determine the status of any such payments. If the FO does not identify potential offset situations, many cases involving offset will never be identified, except perhaps by accident, or the offset may be discovered much later causing a large overpayment.

Interviewing

The DISB screen contains questions that ask if the NH has filed for, or intends to file for, WC and PDB, and whether the disability is work-related. However, it is not sufficient to merely ask if the NH was injured on the job. Instead, ask about any form of disability payment the claimant has applied for or received. If a disability claim is currently under appeal, ask about any other disability payment received within the 12 months preceding the first possible month of DIB payment. These questions should be clarified with the NH until the interviewer is satisfied correct information has been obtained.

The interviewer should be aware of the following issues that raise questions of WC/PDB:

- NH states injury or illness is work-related.

- NH states a traumatic injury occurred at work or during normal work hours.

- NH alleges a disability that is compensable under local WC laws such as lung diseases for textile workers or heart conditions, HBP, and other stress-related illnesses for police officers and fire fighters.

- NH is filing for SSA benefits after being out of work for several years due to an illness or injury.

- NH is filing for SSA disability on the advice of an attorney because his "other" benefits have been terminated or reduced.

WC/PDB payments may also become apparent when developing income issues for a concurrent SSI claim or while reviewing E/R gaps with the NH. **NOTE:** the same pension could cause WEP reduction and WC/PDB offset.

If the NH is not clear what type of payment is being received, or if the NH's answers to questions are discrepant or conflict with the general knowledge of the FO, the interviewer should obtain sufficient verification to document the situation.

Documenting the Claim

Information in the Claim is Sufficient

DI 52145.001

No further documentation is needed in the following situations:

- NH states disability is not work-related and no known WC or PDB law or plan appears to apply.

- The WC/PDB periodic payments or lump sum proration ended at least one year prior to the first possible entitlement for the current claim, and there is no appeal pending.

- Certain Reverse Offset situations (see **DI 52105.001**).

The file should be documented clearly, especially if the situation is questionable or confusing. You must document the MCS Remarks Screen (RMKS) when changing the answer from "Filing" to "Not Filing" on the MCS DISB Screen.

Deferred Development

Once we verify the NH is receiving, or has applied for WC/PDB, further development is subject to the deferred development guidelines. However,

obtain enough documentation to determine whether or not offset must be imposed and when.

If deferred development applies and the NH alleges currently receiving WC/PDB, accept the NH's allegation of the WC/PDB rate or use the state maximum rate from the chart in **DI 52150.045**.

A response on the DISB screen that the claimant has filed a claim for WC/PDB will propagate the WPCL, WPAD and WPMU screens, which are discussed in the third objective. These screens record information about the WC/PDB claim.

If the NH alleges a lump sum payment, it will be prorated at the rate stated in the settlement, the previous periodic rate, or the state maximum. Lump sum proration is discussed in Objective 3.

If the NH alleges having filed for WC/PDB, but is not receiving payments because the claim was denied, put the reason for the denial on the RMKS screen. When payments have stopped within one year before the earliest possible DIB entitlement, verification of the reason and date for termination should be obtained. It is important to determine if an appeal was filed or a lump sum settlement agreement made.

On DIB awards involving WC/PDB, an automatic diary (042) will be established by MCS for verification of the WC/PDB issue based on the coding of the WC/PDB screens. The FO does not have the ability to override this diary. If the diary is incorrect, based on the circumstances of the claim, alert the PC to remove the diary.

Verification of WC/PDB

DI 52145.001-.010

If deferred development does not apply, or when the post-adjudicative development is done, verification of the following information is required:

- date of entitlement to the WC/PDB;

- changes in payment rate and effective date;

- date of termination;

- covered employment meeting the PDB exclusion;

- any applicable reverse offset conditions;

- period covered by a lump sum; and

- medical, legal, or related expenses.

Verification is always required, even when offset is not imposed due to a high ACE. If the NH receives more than one WC/PDB payment, each payment must be verified. Re-verification is required when the proof in file is more than two years old.

Initiate concurrent development from multiples sources such as the NH, WC attorney and WC carrier at the same time. This practice saves time and ensures receipt of complete information.

Proofs

The NH should always be the primary source of information and verification concerning WC/PDB. It is very likely the NH has received documentation of the payments. Verification can be in the form of:

- WC/PDB award notice or letter;

- Signed and dated copy of the court order awarding payments;

- Check stub or copy of the check – if it shows the exact periodic rate and the exact effective date, or if payment began before possible DIB entitlement and continues at the same rate (MUST show gross amount);

- Copy of a Lump Sum settlement that shows:

  - exact date entitlement to periodic payments ended;

  - gross amount of the Lump Sum settlement;

  - rate at which to prorate;

  - medical, legal, or related expenses;

- Computer printout or copies of WC/PDB documents;

- Documentation of legal and medical expenses must verify the expenses were/are related only to the WC/PDB condition or claim and were paid by the NH and are not reimbursable by insurance or other (see **DI 52150.050**).

WC/PDB proofs must be permanently retained in file to provide the most comprehensive documentation. Annotating the Evidence Screen (EVID), or coding proof in ICF is not sufficient since WC/PDB verification often involves complex, State-specific forms and documents that routinely involve a certain degree of interpretation (**GN 00301.286E.3.a**). If an Electronic File (EF) exists, fax the documents in to the EF. If there is no EF fax the documents into NDRed.

Attorney

The statement of the NH's attorney can be accepted as verification of the amount of legal fees, but not of the amount of the WC award. However, the attorney can assist the NH in obtaining certified copies of other documentation (see **DI 52145.001**).

SSA-1709

An SSA-1709 (Request for Workers' Compensation/Public Disability Benefit Information) can be used to obtain required documentation directly from the insurance carrier, self-insured employer, or state WC fund when the NH is unable to obtain the necessary verification.

The SSA-1709 is sent to the entity that handled the WC/PDB claim and made the payment. The FO completes Part 1 (front) and the company/ agency completes Part 2 (back). Many states/companies require the signed release from the NH contained in Part 1.

Other Proofs

Other proofs that may be required in connection with WC/PDB offset are:

- Proof of Age – required to document offset does not apply based on attainment of age 62/65/FRA.

- Proof of Earnings – required when actual earnings exceed the maximum taxable for a year that could be used to compute the ACE (discussed in Objective 2).

Possible RIB

DI 52150.030

If a NH is within four months of age 62 attainment or older when either the DIB application is filed or DIB entitlement begins, the option exists of also applying for RIB. Explain and discuss the options with the NH and document the file to show the NH's decision.

The possible advantages of filing for RIB are:

- WC/PDB offset does not apply to RIB – although receiving RIB could cause adjustment of the WC/PDB (the NH will have to contact the entity paying the WC/PDB to determine this).

- The RIB FMAX is probably higher than the DMAX (previously discussed in the computation lesson).

- Medicare entitlement is not affected.

- An ARF would apply at FRA due to DIB technical entitlement.

OBJECTIVE 2:

Compute the ACE and perform
WC/PDB offset computations.

Offset Computations

Usually you are not required to perform the offset computations, as they will be done by EC or ICF. However, as with the other computations we have discussed, it is necessary for you to understand how the computations are done so you can explain them and so you will recognize when the result arrived at by EC or ICF is not accurate. The following sections explain the various parts of the WC/PDB offset process.

Average Current Earnings (ACE)

DI 52150.010

As explained earlier, the combined total of the WC/PDB Benefit and SSA benefits cannot exceed a limit, which is related to the NH's earnings at the time of disability onset.

80 Percent of ACE

One of the possible limits is 80 percent of the ACE. Three methods are considered in determining Average Current Earnings. The highest average is the ACE. The EC system computes all three ACE methods and displays an amount, which is 80 percent of the highest average. However, sometimes it is necessary to re-figure the ACE.

A worker's ACE will be the highest of:

- Average monthly wage (AMW) – the average monthly wage throughout the computation years,

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- High 5 ACE - the average monthly wage of the 5 <u>consecutive</u> years after 1950 with the highest total covered earnings (without regard to statutory maximum), OR

- High 1 ACE - the average monthly wage of the one calendar year in which the NH's covered earnings (without regard to statutory maximum) were highest. Choose the year from the period consisting of the year of the current DIB onset and the 5 years immediately preceding.

In the majority of cases, the High 1 will be the ACE of record.

"High 5" and "High 1" ACEs are computed <u>without regard to statutory maximums on covered wages and SEI</u>. Deemed military wages (DMW) are used to compute ACE even if the DMW causes statutory maximums to be exceeded. All three methods of computing the ACE are based on unindexed earnings. The ACE is never based on indexed earnings. Follow **Exhibit 1** for this illustration.

Illustration of ACE Computation

Tom Chapman became disabled 08/05/17. His entitlement date is 02/18. He receives a weekly state WC payment of $156.40. His 02/18 PIA is $543.80. There were 25 years used in determining his PIA; the total of the highest unindexed earnings for 25 years is $203,416.33. (These may not be the same years used in the PIA.) The highest earnings on his record are:

12 - $16,000   14 - $18,700   16 - $22,000
13 - $16,700   15 - $20,900   17 - $8,000

DIB AMW

To calculate the Average Monthly Wages (AMW) divide the sum of the total unindexed earnings for the computation years (the dividend) by the number of months in the computation years (the divisor).

<u>Dividend</u> = 100 percent DIB AMW
Divisor

25 years x 12 months = divisor of 300

<u>$203,416.33 / 300</u> = $678.05 (round down to $678)

HIGH 5

To calculate the High 5, take the sum of the 5 consecutive years after 1950 with the highest covered earnings and divide it by 60 (number of months in 5 years).

The 5 years, 2012-2016, add up to $94,300

$\dfrac{\$94,300}{60}$ = $1,571.66 (round down to $1,571)

HIGH 1

To calculate the High 1, select the highest yearly earnings from the year of current onset and the 5 previous years and divide it by 12 (number of months in one year).

Highest 1 year = 2015

$\dfrac{\$22,000}{12}$ = $1,833.33 (round down to $1,833)

Highest of the 3 methods above is $1,833 (High 1). The limit to be considered is 80 percent of $1,833.00 or $1,466.40.

Total Family Benefits (TFB)

DI 52150.005

The other limit to be considered is Total Family Benefits (TFB). We would use the TFB if it is larger than the 80% ACE. TFB is the total of all SSA benefits payable to the family in the first month offset is considered or imposed. Auxiliary benefits used are the amounts payable after reductions for the family maximum, simultaneous entitlement, or age but before any deductions, such as Medicare premiums or overpayments, are applied. A divorced spouse is normally NOT included in the TFB. See **DI 52150.005B** for specifics on when the divorced spouse might be included.

A change in the TFB after offset is imposed requires a refiguring of the offset from the initial month of offset, using the new TFB.

EC ACE Computations

The summary MEF (Master Earnings File) used by EC to compute benefits does not store information on earnings over the statutory maximum. Therefore, EC cannot always derive the correct ACE under the High 1 or High 5 methods. The information is available on the DEQY, however, so the correct ACE can be determined when necessary.

When WC/PDB is involved, make sure to check the WRAC screen to see which ACE method was used by EC. If the High 1 or High 5 method is used, and if any of those years have maximum earnings posted, it may be necessary to recompute the ACE. Follow these steps to recompute an ACE:

- From the SSA MAIN MENU, select #7 (TITLE II/INTERACTIVE COMPS)

- Access ICF #28. On the IC25 screen input "1" in SELECT ONE for ACE COMPUTATION.

- ICF will access the MEF and use posted earnings. If any years are over maximum, change the earnings amount on the IC94 to the over-maximum figure so ICF can determine the correct ACE.   ICF also supplies the 80 percent ACE figure.

- After obtaining the correct ACE from ICF, enter the "80 percent ACE" and "ACE Type" at the bottom of the WPCL screen.

Amount of the WC/PDB

DI 52150.035

The amount of WC/PDB used to determine if offset applies is the monthly payment received by the NH, less any excludable expenses (see **DI 52150.050**). Legal expenses are the most common types of excludable expenses as most medical expenses are paid by the WC/PDB entity or insurance.

If the WC/PDB is paid on other than a monthly basis, it should be converted to a monthly amount. EC can perform this operation, but to manually convert a weekly figure to a monthly figure, multiply the weekly

WC/PDB by 13 and divide by 3, then round to the next lower dime to obtain the correct monthly figure.

If a Lump Sum payment is made, it must be prorated as though periodic payments were made. EC will make this adjustment based on entries on the WPLS screen.

If payments for dependents are made to the NH, they are included in the amount of the WC/PDB. If the dependent payments are made directly to the dependent, they will not be included.

The gross amount payable to the NH should be used before any deductions for taxes, health insurance, etc.

If two or more WC/PDB payments are received, the amounts should be added together when determining if offset will apply.

Any change in the amount of countable WC/PDB requires a recomputation of the offset from the initial month of offset using the new WC/PDB amount.

Computing the Offset

DI 52101.001, **DI 52150.020**, **DI 52170.010**

The total of the Social Security disability benefits payable in the first month of offset plus the monthly WC/PDB cannot exceed the applicable limit. The amount of the WC/PDB offset is determined based on the amounts in effect in the first month of offset. The worker is always paid first, and any excess is distributed among the auxiliaries. The steps below will guide you through calculating the amount of offset for a given situation. You can also use a Form SSA-2455 to do these calculations (see **Exhibit 2**).

Steps

1. Determine the higher of the 80 percent ACE or TFB.

2. Subtract the monthly WC/PDB from the applicable limit in #1 to find the remaining benefits payable to the family in the first possible month of offset.

a. If the resulting amount allows full payment of benefits to the NH and any auxiliaries on the record, no offset applies.

b. If the result is zero or less, no SSA benefits are payable.

3. Subtract the NH's MBA from the remaining benefits payable after offset (#2).

a. If #2 is less than the NH's MBA, the difference is the amount payable to the worker in the first possible month of offset. NO other benefits are payable to the auxiliaries.

b. If the #2 amount is equal to or higher than the NH's MBA, the NH receives the full MBA.

4. Divide any remainder in #3b by the number of auxiliaries if their rates are equal. (See **DI 52170.010E.2.g** if the amounts payable to all auxiliaries before offset are unequal, such as age reduction or dual entitlement).

Any changes in the TFB due to family composition changes, a Combined FMAX, changes in deductions, etc., requires recomputation of the offset. Like any other change, this recomputation is done as though the new amounts were in effect the first month of offset, with the new amounts payable effective the month of the change. See **DI 52150.040**.

COLAs

Increases in SSA benefits due to COLAs are not subject to offset. When a COLA occurs after the first month of WC/PDB offset, the difference between the new MBA and the old MBA is added to the benefit payable, if any, after offset as determined above. Often the amount of COLA increase is all that is payable. Form SSA-2455, displayed in **Exhibit 2** will also help you perform the COLA computation. There is an electronic version of the e2455 available in POMS **DI 52170.010 A**.

ICF

In addition to computing the ACE, as previously discussed, ICF program #31 and #32 can be used to compute the offset. Use of these ICF programs will be discussed in Objective 4.

Proration of Lump Sum Awards (LS)

DI 52150.060, DI 52150.065, DI 52170.030

Lump Sum

Lump Sum, for offset purposes, means a final settlement, award, or compromise and release which represents final WC payment due the worker. The LS does not exempt WC from offset. The LS is offset at the periodic rate which would otherwise have been payable. This is called "prorating the LS."

To perform the proration, first determine:

- Gross amount of LS,

- LS starting date or periodic payment ending date,

- Weekly rate at which to prorate, and

- Amount of excludable expenses included in LS.

These facts are usually found in the decision or settlement granting the Lump Sum payment.

LS Start Date

The following order of priority determines the LS start date:

1. The LS is allocated to the period specified in the award.

2. If a date is not specified and periodic payments were previously made, the LS is prorated beginning the day after the day the periodic payments ended.

3. If the LS award does not specify a beginning date and the worker did not receive periodic payments, the LS is allocated to:

- the period beginning with the date of injury for WC,

- the date the worker's employment terminated for occupational disease, or

- the date the illness began for PDB.

Rate at Which to Prorate

LS awards will be prorated at an established weekly rate. The priority for establishing weekly rates is as follows:

1. The rate specified in the LS award. (If the LS award specifies a rate based on life expectancy see **DI 52150.065A**)

2. The periodic rate paid prior to the LS if no rate is specified in the LS award.

3. The implied compensation rate in the award. If the LS award does not specify a rate and the NH received no prior periodic payments, but the language of the LS award implies a compensation rate, use the implied rate.

4. If WC, the State's WC maximum in effect on the date of injury. This figure can be used if no rate is specified in the award and there was no preceding periodic benefit. It can also be used pending post-adjudicative development of the rates specified in 1. or 2. above. See **DI 52150.045** for chart of state maximum rates.

No Excludable Expenses

If there are no excludable expenses, the LS is simply "charged off" from the start date until the gross amount has been accounted for. Once the gross amount is accounted for, offset is removed.

Excludable Expenses

DI 52150.050

Expenses excludable from offset include medical, legal, or related expenses actually paid, incurred, or to be incurred by the worker with the WC/PDB claim.

Types of expenses excludable from offset include:

Legal Expenses

- Must be paid or incurred by the worker in connection with the WC/PDB claim

- Attorney fees paid by the worker in excess of the WC/PDB award specifications are <u>not</u> excluded

Medical Expenses

- Must be paid, incurred, or to be incurred by the worker in connection with the WC/PDB claim

- Verified expenses in addition to the amount shown in the award are excludable

- Future medical expenses are excludable if specified in the WC/PDB award

Related Expenses

- Excludable expenses incurred by the NH related to the settlement of the WC/PDB claim and not specifically medical or legal in nature (e.g. photocopy expenses, transportation costs)

LS with Excludable Expenses

There are three methods of prorating LS with excludable expenses:

Method A:

- Divide excludable expenses by weekly rate, resulting in number of weeks.

- Delay imposing offset for this number of weeks beginning with the date DIB would have been offset.

- Impose offset when the resulting number of weeks expire.

Method A ultimately delays the imposition of offset.

Method B:

- Subtract the expenses from the Lump Sum.

- Divide the result by total Lump Sum.

- Multiply this percentage by the weekly rate.

- Use the new weekly rate determined above to offset the LS.

The result is the reduced weekly rate of offset. This reduces the amount of offset resulting in a higher benefit payable to the beneficiaries.

Method C:

- Subtract the expenses from the Lump Sum.

- Prorate only the balance determined above.

This will make the proration period shorter and end offset sooner.

Advantages of Proration Methods

The system determines the advantage and chooses the proration method based on total SSA benefits payable over the proration period. However, there may be instances when other considerations make it necessary to override the system determined proration method. For example:

- Method A will be advantageous if the NH is close to FRA, since the delay caused by charging the expenses first may last until offset is no longer applicable. Method A is often the best choice when the NH's disability is terminal because offset may not apply before entitlement ends due to death.

- Method B will be advantageous if the reduced weekly rate is low enough offset does not apply.

- Method C will be advantageous if the Lump Sum was paid long enough ago and the shortened proration period results in proration ending before the earliest DIB MOE.

Often, Method B is the most advantageous proration method.

When the proration is done by EC or ICF #31 or #32, most of these factors will have been considered. The options will be shown on the MCS WRLS screen or the WCWE ICF screen. The system will indicate its determination regarding which method is most advantageous, but the CS can override if necessary.

Complex Lump Sum Awards

Certain Lump Sum awards and settlements require additional offset instructions. Specific offset instructions can be found in **DI 52150.065**, in the following situations:

- Life expectancy (LE) awards

- LS awards involving a commuted value of future periodic payments

- LS awards involving advanced payments

- Structured settlements

- Subsequent addendums to LS settlements

Computations for the A101

DI 52155.025

EC

EC can often perform the ACE and Offset computations and propagate them to the A101. If this is not the case, the computations should be done in ICF and saved for incorporation into the A101 by the benefit authorizer when the award is manually processed. Indicate on the A101, ACCT screen, that the computations are stored in ICF. (See Objective 4.)

OBJECTIVE 3:

Properly code MCS workers' compensation/public disability screens and process claims involving WC/PDB.

MCS Screens

MS 00701

When Claim Type "2" (Disability) is entered on MCS, the DISB screen asks if a worker has filed or intends to file a claim for WC/PDB. If the answer is "yes," the system automatically places the necessary screens into the claims path for completion. (The paper equivalent of these screens is the SSA-546, which would only be used with non-MCS claims or post-adjudicative actions.)

The two MCS Application Screens which collect information about WC/PDB are "WC/PDB Claim Data" (WPCL) and "WC/PDB Claim Data Employer/Payer Name and Address" (WPAD). Additional WC/PDB screens will appear in the path as a result of the information provided on these two screens. All the WC/PDB screens in the claims path are common screens and are stored in T2 Shared (#4 from the main menu). They also have excellent "help" screens. If you place your cursor in an item location, then hit the F1 key, you will find help screens.

WC/PDB Claim Data Screen (WPCL)

MS 00701.003
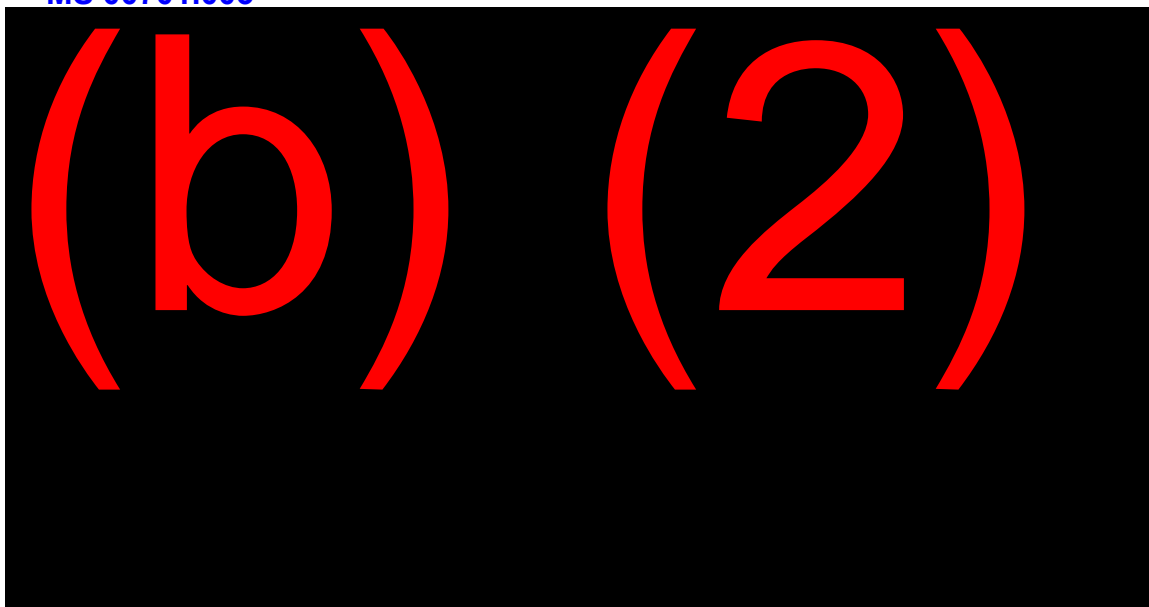
WPCL is a conditional screen about a NH who is a claimant (CL). The questions never pertain to a non-claimant or a CL who is not a NH. If the NH has more than one occurrence of WC/PDB (more than one company is involved or more than one claim has been filed) a separate WPCL screen will be used for each occurrence. At the time of the initial interview, exact information is not always available. Therefore, many of the fields on this screen will permit coding a "?" initially but must usually be completed before adjudication. The WC/PDB claim number line requires an entry. It will not accept a "?". The entry must contain letters, numbers or hyphen. If you do not know the claim number, put an entry in the screen showing you do not know the claim number. The system will accept the word unknown.

The common WPCL screen will be used to either document the status of the NH's claim for WC/PDB or the claimant's intent to file a claim. If the NH is already receiving WC/PDB payments, this screen will collect information necessary for computation purposes.

NOTE: For all subsequent screens, the injury/illness date, source, claim number, and state will propagate to the screen heading and will be protected. It is important to remember you will enter only the data for the particular WC/PDB claim shown in the header on each screen.

Help screens are available for all fields. Place the cursor on the field in question and enter PF1. This will bring up a screen that explains what information is needed and the acceptable entries. Enter through the help screens and back to the screen currently being completed.

WC/PDB Claim Data Employer/Payer Name & Address Screen (WPAD)

MS 00701.004
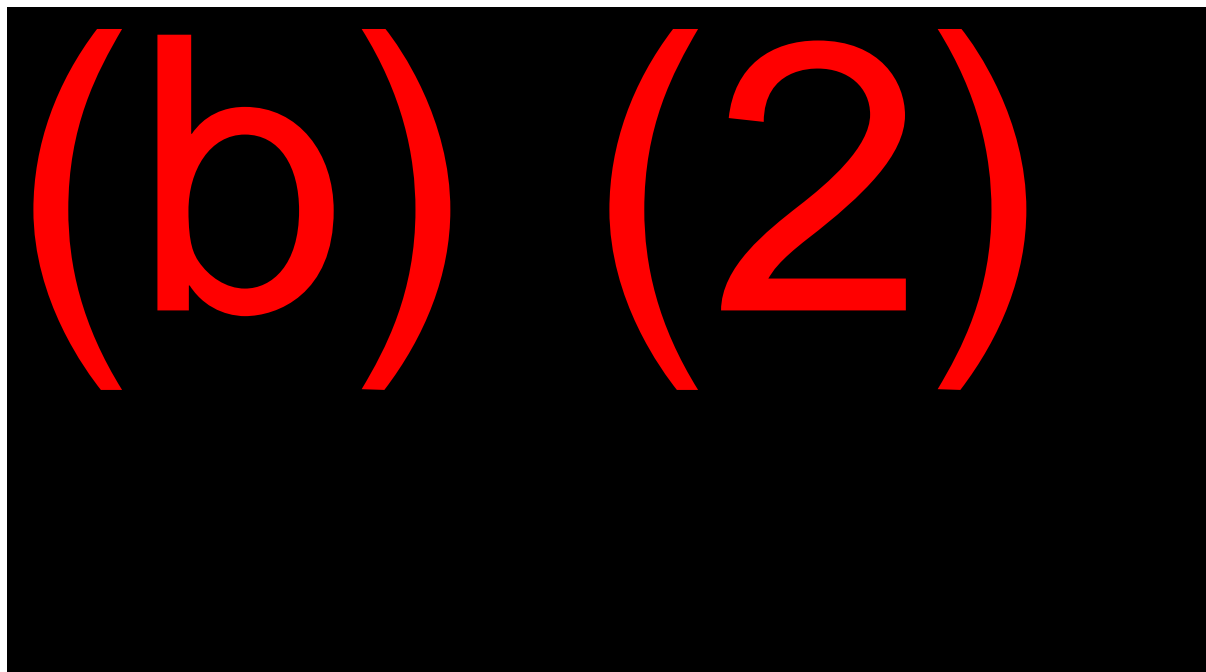
The common WPAD screen will collect the name and address of the WC/PDB employer and payer and the name and phone number of the contact representative. This screen is optional.

Whenever the WPCL screen is completed, the WPAD screen becomes part of the WC/PDB screen path.

WC/PDB Periodic Payments Screen (WPPR)

MS 00701.005

(b) (2)
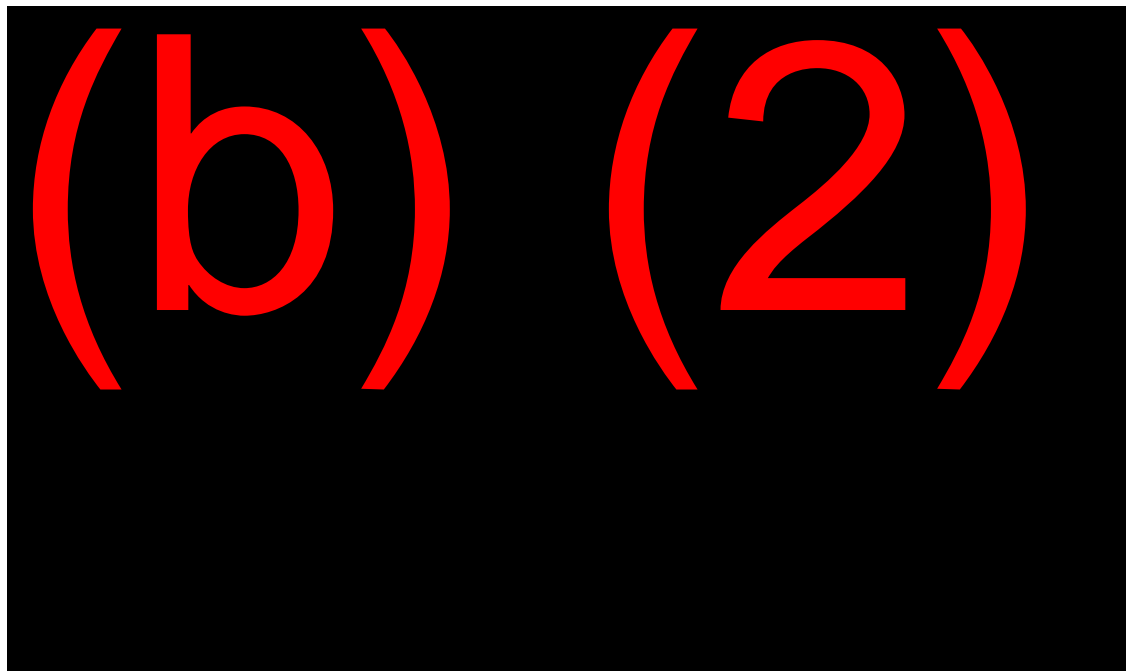
The common WPPR screen is used to collect WC/PDB periodic payment information. A separate screen must be completed for each injury or illness, which involves periodic payments (up to 9 WPPR screens can be entered).

When "Y" is entered in the PERIODIC PAYMENTS AWARDED (Y/N) field on the WPCL screen, the WPPR screen will be generated.

WC/PDB Periodic Payments Ongoing Expenses Screen (WPOX)

MS 00701.006

(b) (2)
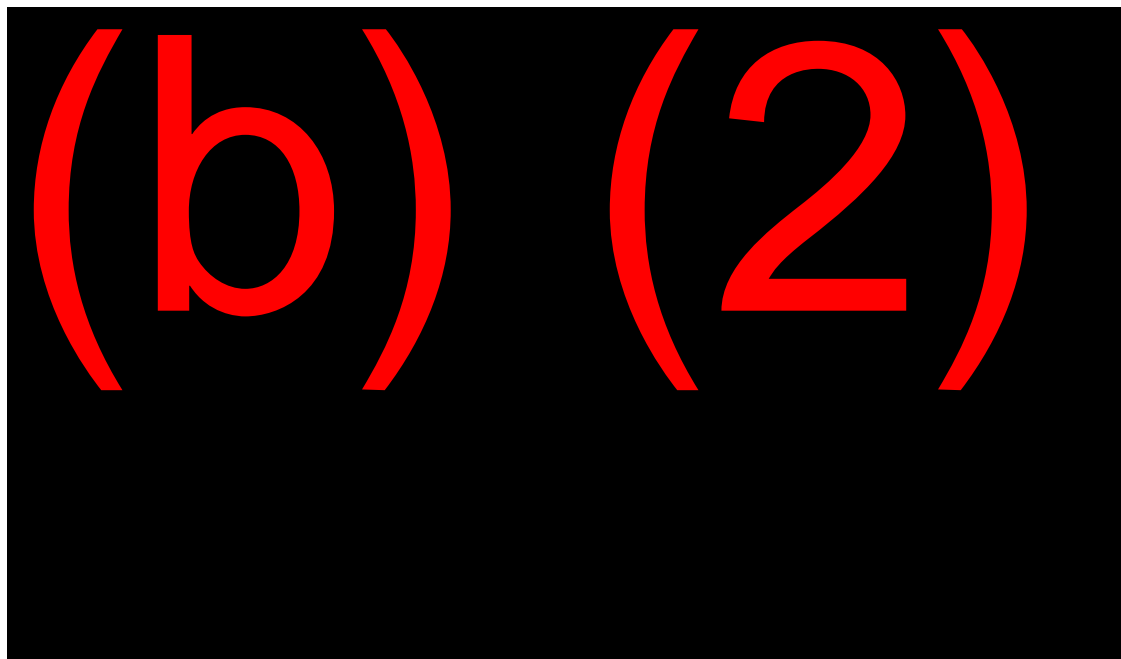
The common WPOX screen documents the specific amount of any excludable expenses (e.g., medical, legal or related expenses) to be deducted, on an ongoing basis, from the WC/PDB periodic payments. If a specific amount of excludable expenses is not provided, then this screen will document the specific periodic payment percentages allocated to excludable expenses.

When "Y" is entered in the ARE ONGOING PERIODIC EXPENSES INVOLVED (Y/N) field on the WPPR screen, the WPOX screen will be generated.

The START and STOP DATES, PERIODIC AMOUNT, FREQ and TYPE PF PAYMENT entered on the WPPR screen will propagate to the WPOX screen. A separate WPOX screen can be displayed for each WPPR screen completed.

One Time Only Excludable Expenses for Periodic Payment Screen (WPEX)

MS 00701.007
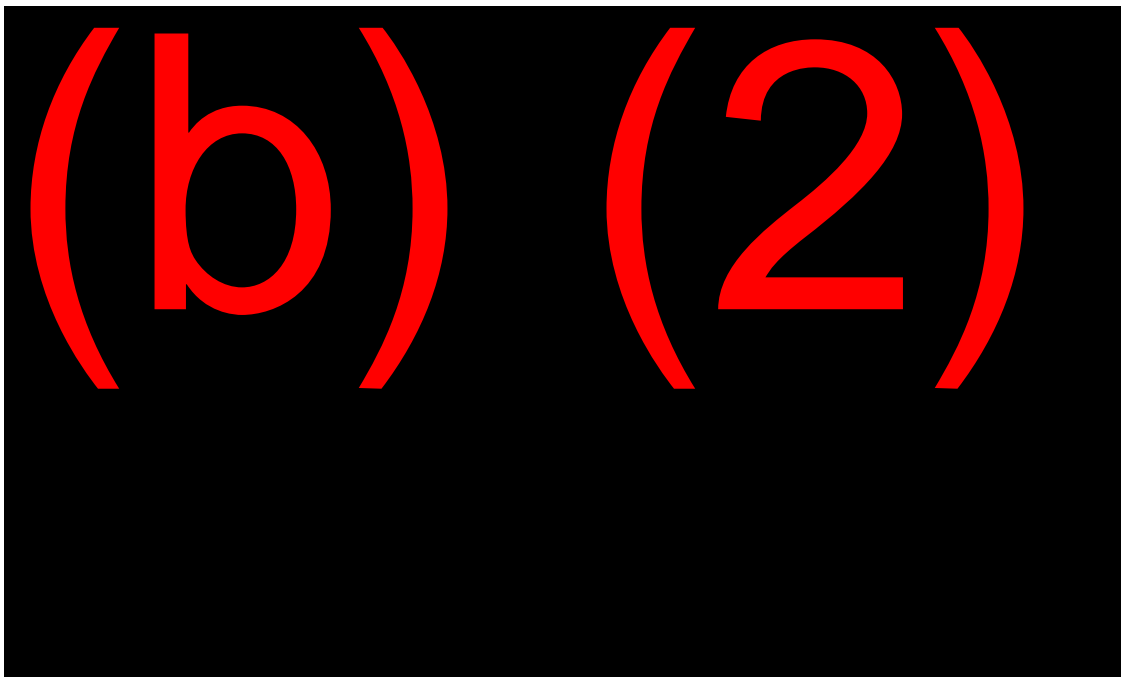
The common WPEX screen will document one-time only excludable expenses. This screen will record the excludable attorney, medical and/or related expenses.

When "Y" is entered in the ARE ONE-TIME EXCLUDABLE EXPENSES FROM PERIODIC PAYMENTS INVOLVED (Y/N) field on the WPPR screen, the WPEX screen will be generated.

WC/PDB Lump Sum Award Data Screen (WPLS)

MS 00701.008
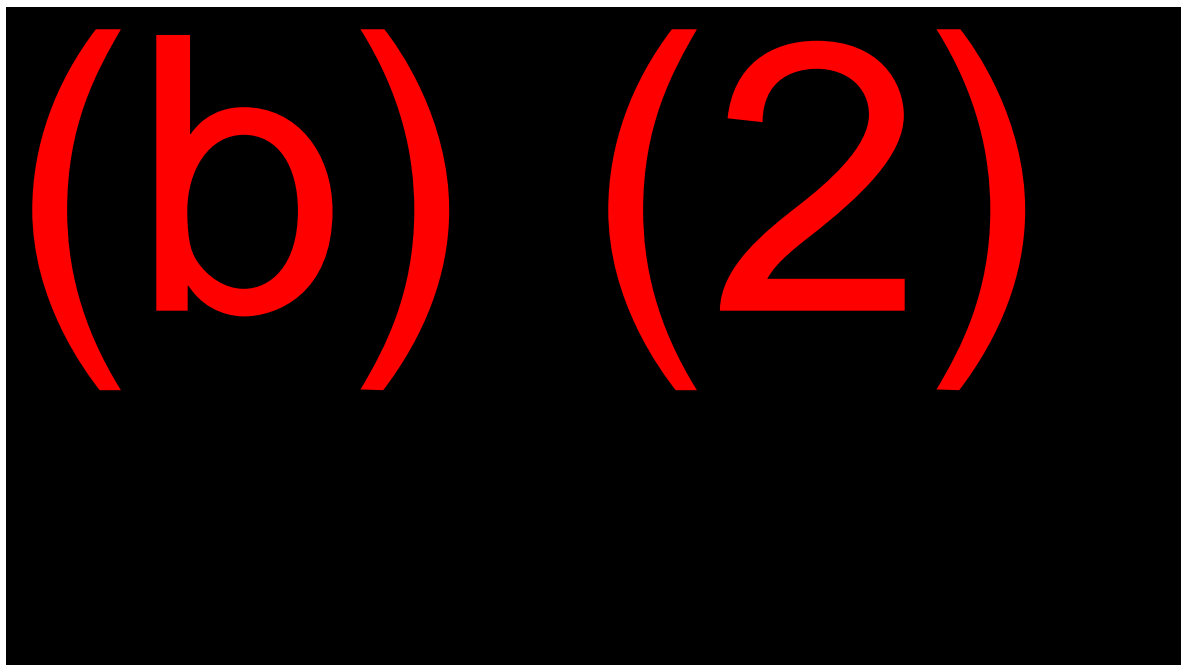
The common WPLS screen will be used to collect WC/PDB lump sum award information. Like the WPPR screen, a separate WPLS screen will be displayed for each illness/injury involving a Lump Sum award.

This screen will also document any applicable excludable expenses. The SPECIAL AMOUNTS TO BE DEDUCTED FROM LUMP SUM is an amount separate and distinct from the lump sum payment made to the NH. The payment amount must be deducted from the lump sum amount before it is prorated. This is not an excludable expense.

When "Y" is entered in the LUMP SUM AWARDED (Y/N) field on the WPCL screen, the WPLS screen will be generated.

Workers' Compensation/Public Disability Benefits Selection Menu Screen (WPMU)

MS 00701.002
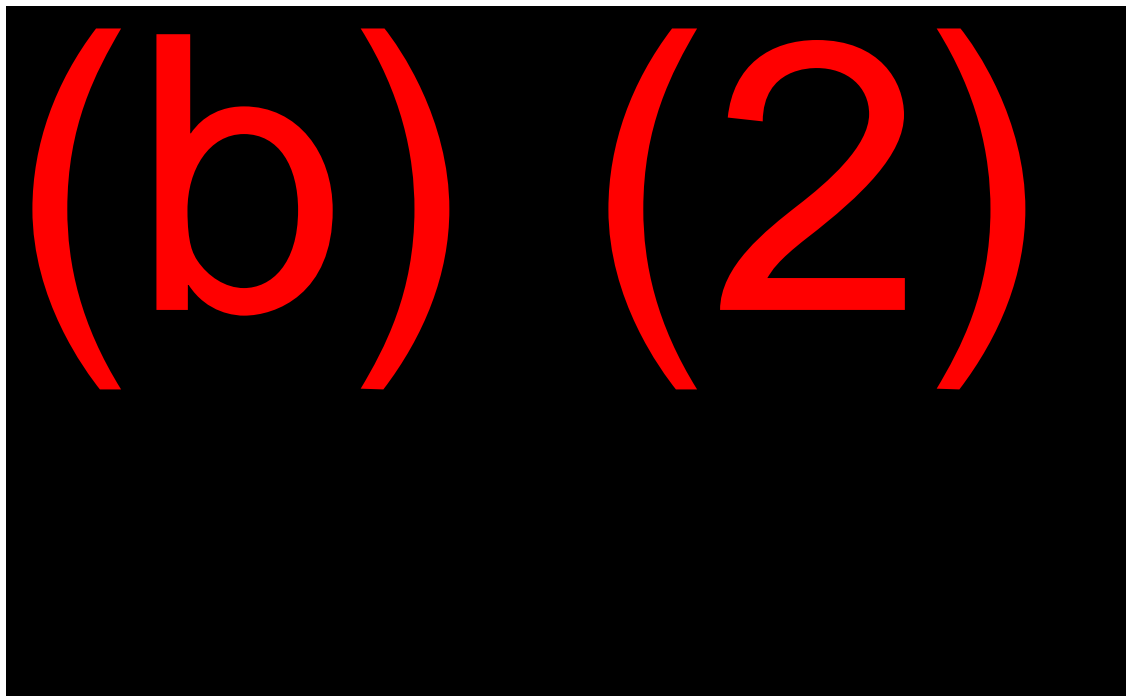
The common WPMU screen will let you select the WC/PDB claim you want to either review or modify. A modification could be a change in the periodic payment, addition of excludable expenses or receipt of a lump sum for an occurrence already established. Also from this screen, you will be able to ADD NEW OCCURRENCE (Y/N) if a new WC/PDB claim should be added. However, there will be a limit of four occurrences (injuries).

If four occurrences of WC/PDB data are present, the ADD NEW OCCURRENCE (Y/N) field cannot be completed with "Y". One of the four injury/illnesses will need to be deleted before adding a new occurrence.

This screen is generated in MCS when injury/illness data exists and the response to question FILED OR INTEND TO FILE FOR on the DISABILITY INFORMATION (DISB) Screen is #3 (WC/PDB).

The WPMU screen initially appears at the end of the WC/PDB mini-path. This will give you the opportunity to add another injury/illness. If you add data for another injury/illness, you must walk the path for that injury/illness until the WPMU screen appears again. This will ensure all data is edited. After the WC/PDB information is loaded, the WPMU is the first screen in the WC/PDB mini-path. From this screen, you can "X" each WC/PDB claim to update information.

EC Processing Screens

EC Provides Computations

Disability claims processed through MCS EC can include WC/PDB information. In nearly all cases, EC will determine the ACE and impose the appropriate offset.

Common WC/PDB screens represent the "output" of the data that was "input" on the WC/PDB input screens. These screens will contain both propagated and systems-generated data.

WC/PDB Offset-ACE Results Data Screen (WRAC)

MS 00702.002

(b) (2)
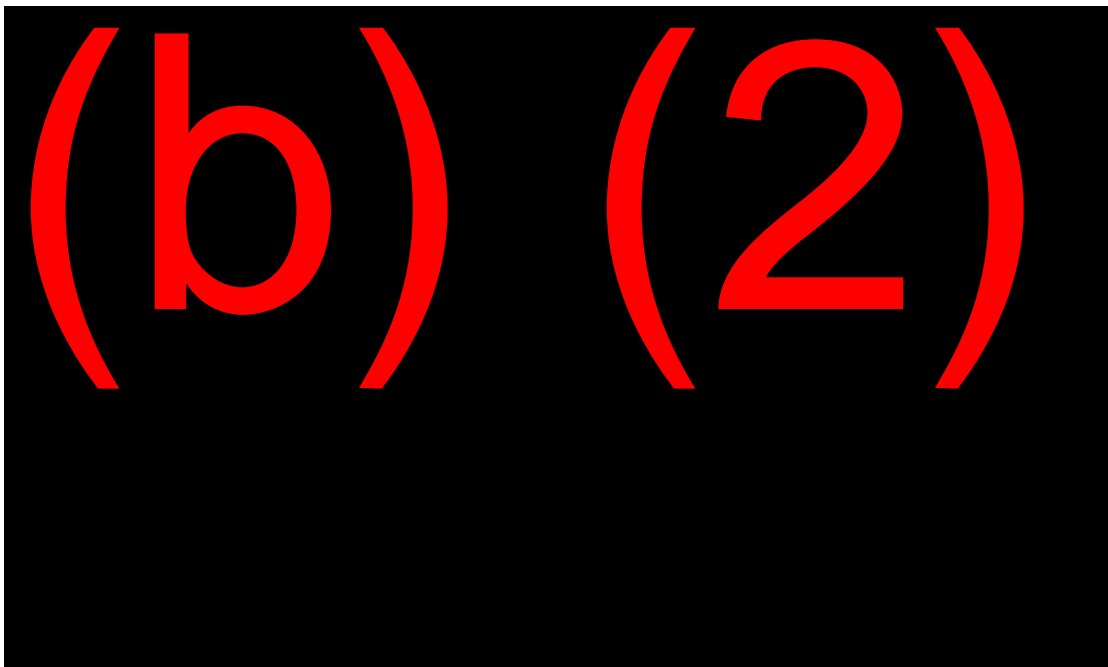
The common WRAC screen provides the results of the ACE determination; the 100% ACE, the 80% ACE, the method used (High 1, High 5 or AMW) and the ACE category (Original, Recomputed or Triennial Redetermination).

WC/PDB Offset-Lump Sum Proration Results Data Screen (WRLS)

MS 00702.003
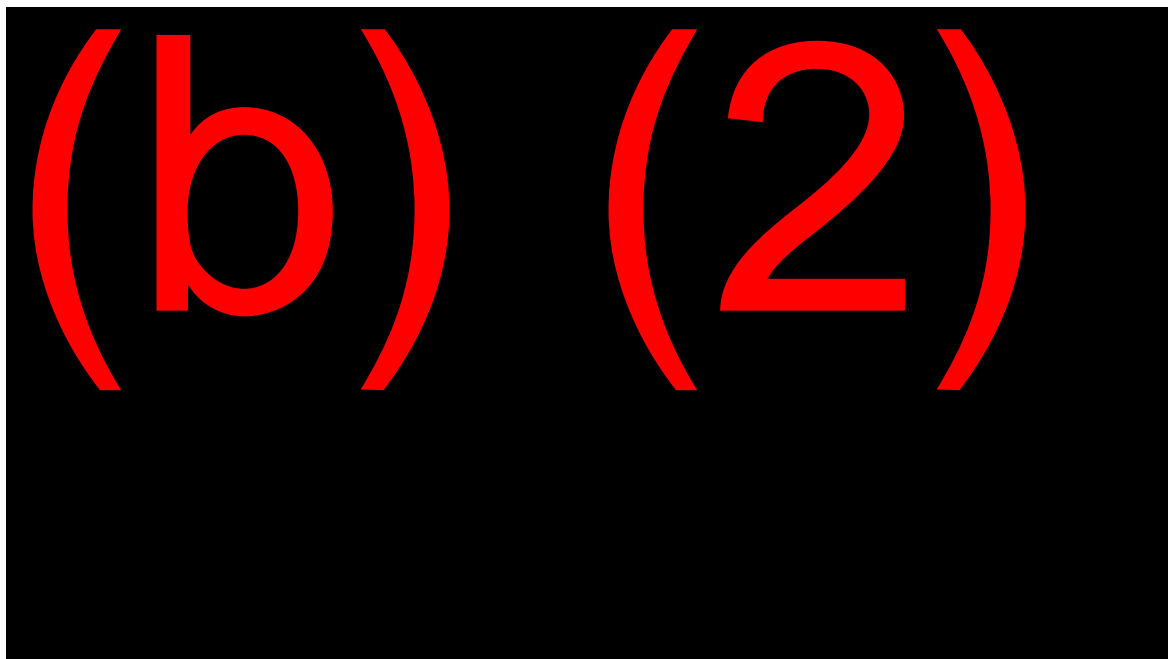
The common WRLS screen will show the lump sum proration results. The system will determine the monthly rate of the lump sum proration and if excludable expenses are involved, the system will determine the most advantageous method of prorating the lump sum.

Up to four WRLS screens can be displayed depending on the number of WC/PDB claims.

WC/PDB Offset-Account Results Data Screen (WRAD)

MS 00702.004
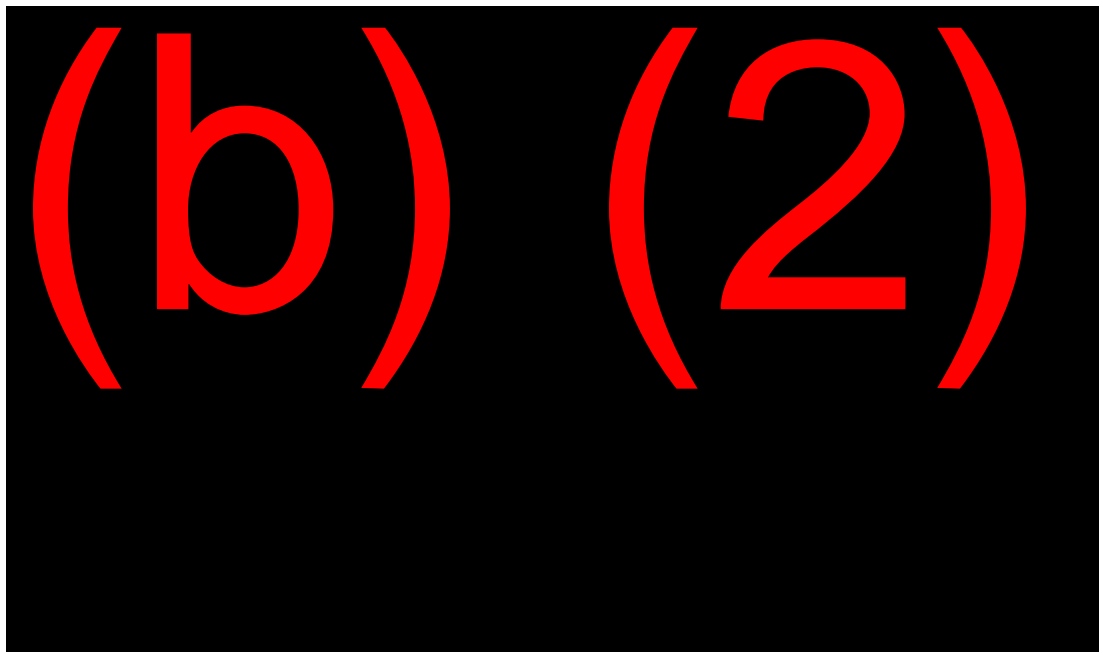
The common WRAD screen will display data such as the date offset is first imposed, the month and year offset no longer applies and the total amount of the WC/PDB monthly payments.

WC/PDB Offset-Results Data Screen (WRBD)

MS 00702.005

The common WRBD screen will show the effect of WC/PDB offset on the benefit amount of each claimant (CL if MCS) or beneficiary (BN) involved. A separate screen will be displayed for each CL or BN showing the benefit amount before and after offset.

NOTE: The WRBD screen title will show the name of the claimant or beneficiary.

Auxiliary Claims

Auxiliary claims involving WC/PDB offset can also be processed via MCS EC if they are in the same segment as the NH.

A subsequent auxiliary claim is an EC processing limitation if the auxiliary entitlement requires an adjustment in the NH's WC/PDB offset (**MS 03601.001**). In these situations, the case must be processed manually. MCS claims screens and all documentation should be completed in the same manner whether the payment will be processed via EC or manually (A101).

This is why some offices obtain the auxiliary claims as part of the initial segment when WC/PDB is involved. Doing so allows processing of the auxiliaries through the automated system rather than by A101.

Propagation

Even in those few cases when EC cannot properly pay a claim involving WC/PDB, EC will usually provide the PIA and ACE computations. When you request an Adjudicative EC and review the computations, the information from the MCS common WC/PDB data collection and results screens propagate to the A101. You should review this propagated information and over key with correct information if needed. However, changes to the A101 WC/PDB results screens do not change the data collection screens, which must then also be updated to reflect the correct current information.

If EC does not propagate the WC/PDB information onto these screens, but does provide a useable PIA, compute the ACE and Offset using ICF #32, as explained in the next objective to transpose the information onto the A101 screens.

If the case is an EC processing limitation and will not generate a PIA, use ICERS or ICF to obtain the PIA and ICF to compute the ACE and Offset. In the unlikely event the case is not on MCS, an EF101 must be completed.

Paragraphs

Many paragraphs are systems-generated. However, there are times when the CS must request specific paragraphs, and many of these require fill-

ins for the appropriate information to be provided to the claimant. See **Exhibit 4** for examples of some frequently used MCS paragraphs, as well as POMS references for MADCAP paragraphs.

WC/PDB Claim Pending

Just as SSA's claim processing and appeals process can cause delays in payment, many Workers' Compensation and Public Disability Benefit claims are subject to periods of nonpayment. Also, the employer or insurance company may challenge the NH's continuing disability and payments may be stopped for periods of time while the issue is resolved.

Options

The NH has two options with regard to SSA payments while not receiving WC/PDB after a WC/PDB claim has been filed. These options apply in both initial claim and post-entitlement situations.

Option 1: Full SSA Payment

Full DIB benefits can be paid while a NH is waiting for further action on a claim for WC/PDB, but is not being paid for one of the following reasons:

- Initial WC/PDB claim is pending,

- A WC/PDB denial is under appeal, or

- Periodic payments have stopped but further payments, or a change in rate, are under appeal or awaiting a Lump Sum settlement.

If the DIB benefits are paid and the WC/PDB is later awarded or resumed retroactively, the DIB payments (which would have been offset if the WC/PDB payments were made when due) will be considered an overpayment. This applies to any auxiliaries, as well as to the NH.

Exception: a NH who has filed, or is already receiving partial payment, under SSI does not have an option, but is required to take the DIB while the WC/PDB is not being paid (**SI 00510.001**).

If a NH requests full payment while awaiting a WC/PDB decision, explain the possibility of an overpayment and obtain the following:

- A written statement from the NH requesting full payment of DIB and the reason;

- A repayment statement from the NH acknowledging the possibility of an overpayment and agreeing to repay any such overpayment;

- Verification the WC/PDB is not being paid; and

- A statement from the NH requesting payment and agreeing to repayment for each auxiliary;

- If the NH refuses to sign the repayment statement, the file must be documented that the possibility of overpayment was explained and the NH refused to sign.

Suggested language for the required statement is in **DI 52140.001 F**. A word document containing the language on a SSA-795 is available at (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)
(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)
You may also want to check the (b) (2)(b) (2)(b) (2) macro which also has pre-filled 795 which can be modified for your individual case. However, you will need to verify the document contains all of the needed language and information if you utilize it in the future. Your office may have a preferred form, so check with your mentor.

Option 2: Offset of SSA Payment

Unless entitled to SSI, a NH has the option to request offset be imposed as though the WC/PDB were currently being paid. If the NH chooses this option, document the file with the NH's request, obtain information concerning the nonpayment of WC/PDB and the amount that could be received, and impose offset as though the WC/PDB were being paid.

Reporting Responsibilities

In either case, it is extremely important you explain WC/PDB reporting responsibilities clearly and completely. Encourage the NH to report any changes, positive or negative, in the status of any WC/PDB claim or payment as soon as possible. The possible effects of late reporting are

overpayment, if offset is not imposed timely, and delayed benefits, if offset is not removed timely. The NH should be reminded the application itself contains a signed agreement to notify SSA about WC/PDB benefits. The Fact Sheet "How Worker's Compensation and Other Disability Payments May Affect Your Benefits" (SSA Pub No 05-10018) can be given to the NH for reference.

(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

SSA Appeal

Whenever a NH appeals a denied SSA DIB claim, you should review and update the WC/PDB information, including status of any WC/PDB claim filed since the file date of the SSA claim. After the appeal is loaded into MCS, the application screens are available for update and an application amendment can be printed and signed by the NH for file documentation.

OBJECTIVE 4:

**Use interactive computation facility
for WC/PDB Computations for A101,
EF101, and for processing of post-
entitlement events.**

ICF Programs #31 and #32

DI 52165.010, **MS 02431.001**

Computations

ICF #31 is used to do Workers' Compensation/Public Disability offset computations for an estimate. The information can also be stored for propagation into a later action. ICF #31 is pre-adjudicative and is for informational purposes only.

ICF #32 is the "adjudicate" mode used for actual case processing to impose, adjust and/or terminate WC/PDB offset. This program is used to annotate proofs when verification is received. Information from the WC/PDB common data collection and results screens from ICF #32 can be propagated for program center use in claims (A101 or EF101) as well as post entitlement situations. It is accessible by claims specialists or claims authorizers.

The field office is responsible for recording post entitlement changes in WC/PDB.   With few exceptions, this will require the CS to secure all proofs and input any change using ICF #32.

ICF #31 and #32 will compute the ACE and the 80 percent ACE. Offset computations can be done involving periodic payments and proration of a lump sum. Entries can be made for auxiliaries and computations will include adjustments for changes in family composition.

Help screens are available. By placing the cursor on the item in question and selecting the F1 key, a help screen appears with information

---

regarding the highlighted entry. The help screens also include procedural references.

Data Collection Screens

WC/PDB Offset - Options Screen (WCPA)

DI 52165.010C.2, **MS 02431.003**
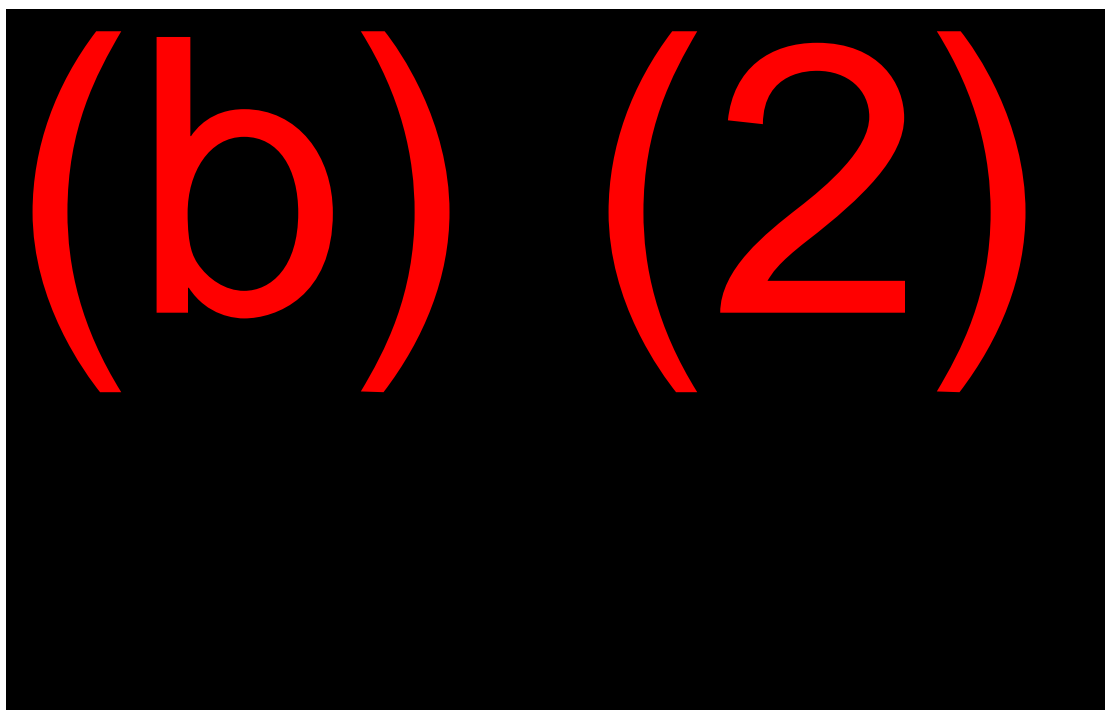
Information from the Master Beneficiary Record (MBR), Master Earnings File (MEF) and Numident (NUMI) will propagate into ICF #31 and #32. From the WC/PDB Offset –Options (WCPA) screen you can request information to be propagated from:

- Pre-adjudicate Record—this would be information previously saved in ICF #31.

- Adjudicate Record—WC/PDB information previously used on an adjudicated MCS claim or processed by a previous ICF #32 post-entitlement input.

- T2 Share Data—WC/PDB information on Common Screens

Any of this previously stored information can be used. There is also a selection to ignore all previously stored information.

If the input is for use in an A101 or EF101 and you have accessed this screen using ICF #32, the question "Is this computation for an A101/Manual Award" must be answered "Y."

WC/PDB Offset Program General Information Screen (WCGI)

DI 52165.010C.3, MS 02431.006
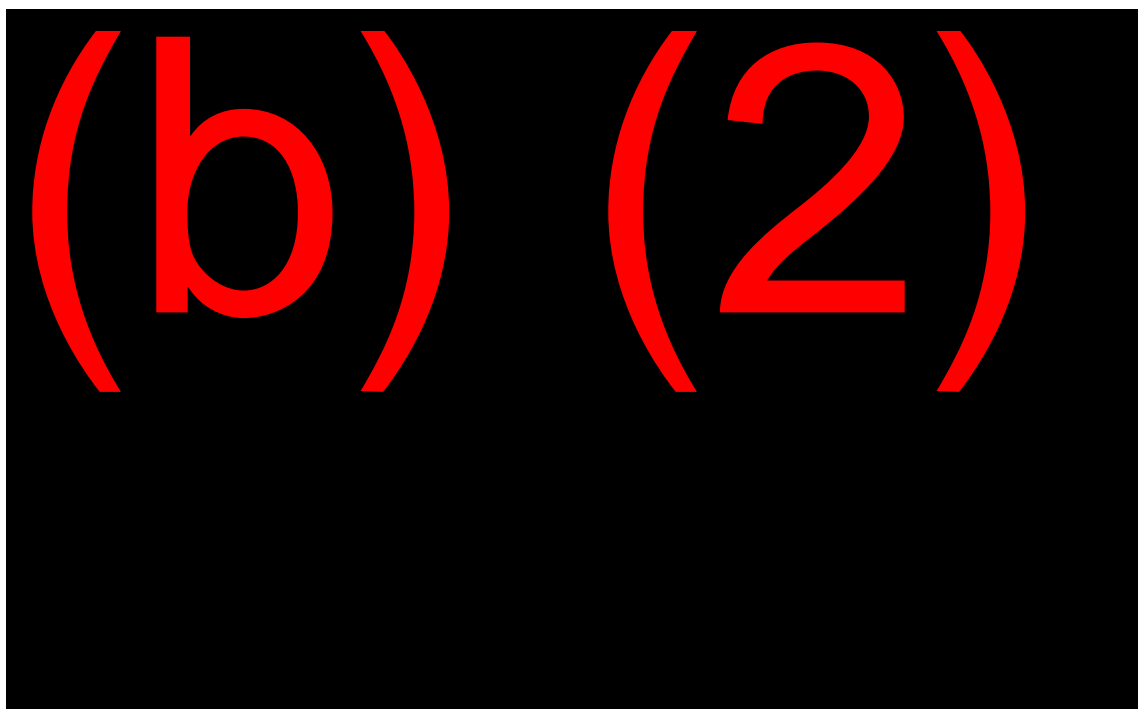
Data propagated to this screen can be overlaid with the exception of the DIB Entitlement Start Date. Information gathered on this page is general information regarding the NH account, not a specific occurrence of WC/PDB. If auxiliaries are being added to the record, a Y must be entered by "Is Spouse Entitled" or "Are Children Entitled" in order for WCCH screen to appear in the path to include the auxiliaries in the computation. An option is given to enter the previously determined ACE or to allow the program to compute the ACE. If the program computes the ACE you will be required to enter the divisor months for the current PIA computation on this screen.

WC/PDB Offset Claims Screen (WCCL)

DI 52165.010C.6, **MS 02431.011**
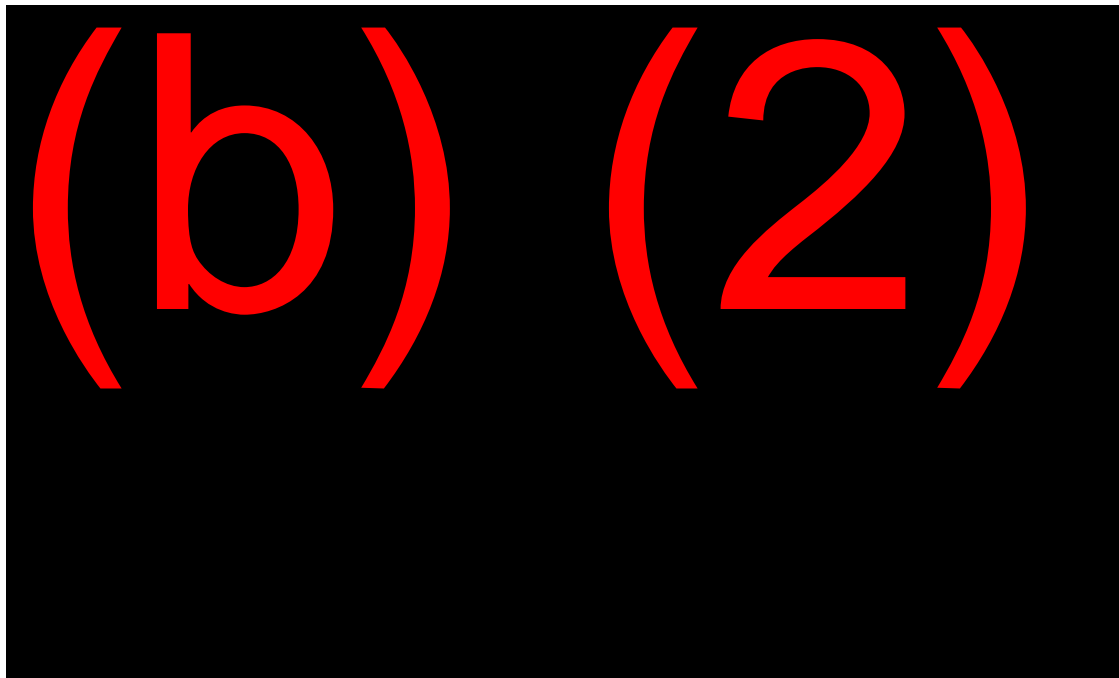
Up to four WC/PDB claim occurrences can be listed. Any listed occurrence, which no longer applies, can be deleted. The remaining occurrences will be considered in the offset computation.

WC/PDB Offset Claim Data Screen (WCCD)

DI 52165.010C.7, **MS 02431.012**
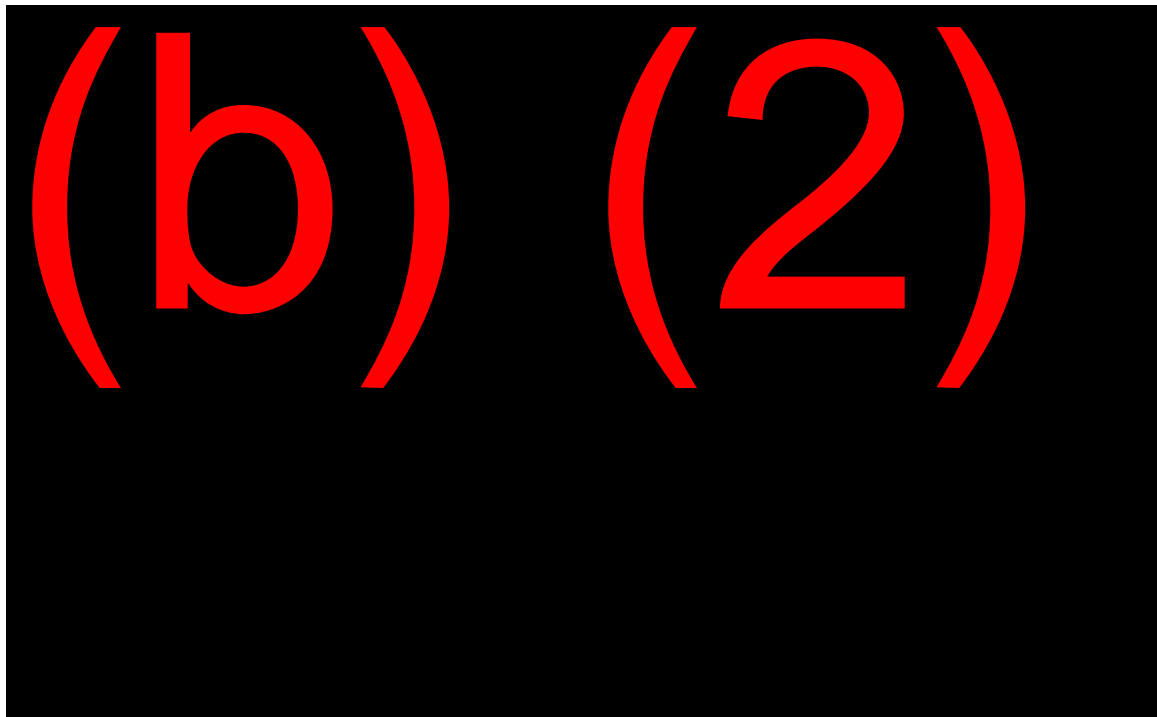
Complete a WCCD screen for each occurrence listed on the WCCL screen. This screen gathers information regarding the employer and who is paying the WC/PDB benefit. Questions regarding reverse jurisdiction, excludable covered service and excludable expenses are specific to the WC/PDB claim described on this screen.

For each WC/PDB claim, the following screens will come into the path as applicable:

WC/PDB Offset – Periodic Payments Screen (WCPP)

DI 52165.010C.9, **MS 02431.014**

(b) (2)
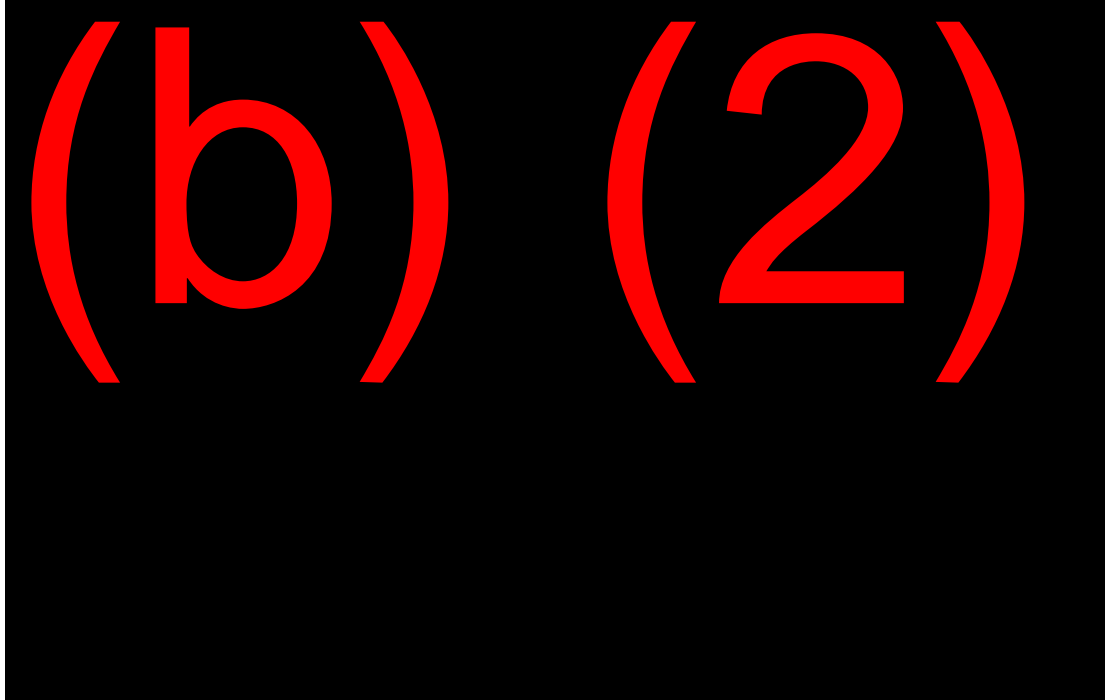
WC/PDB OFFSET – Lump Sum Award Data Screen (WCLS)

> **DI 52165.010C.10**, **MS 02431.015**
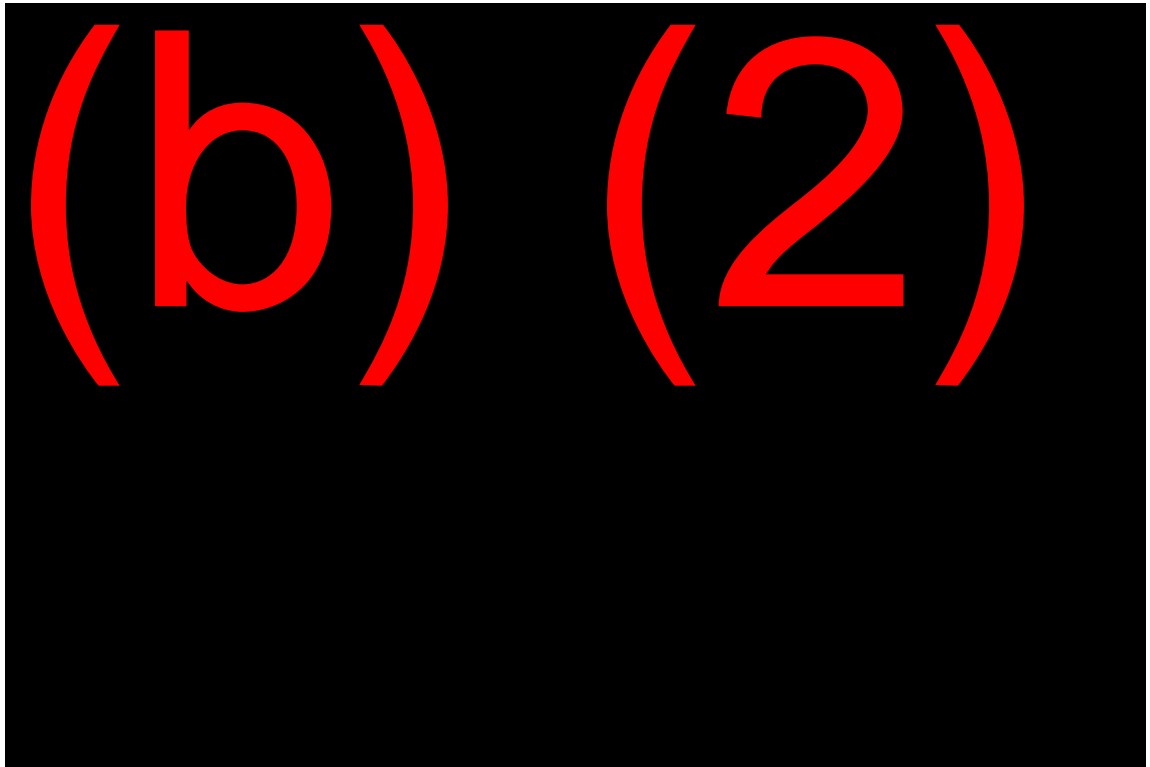
WC/PDB Offset - Periodic Payment Excludable Expenses Screen (WCEE)

DI 52165.010C.8, **MS 02431.013**
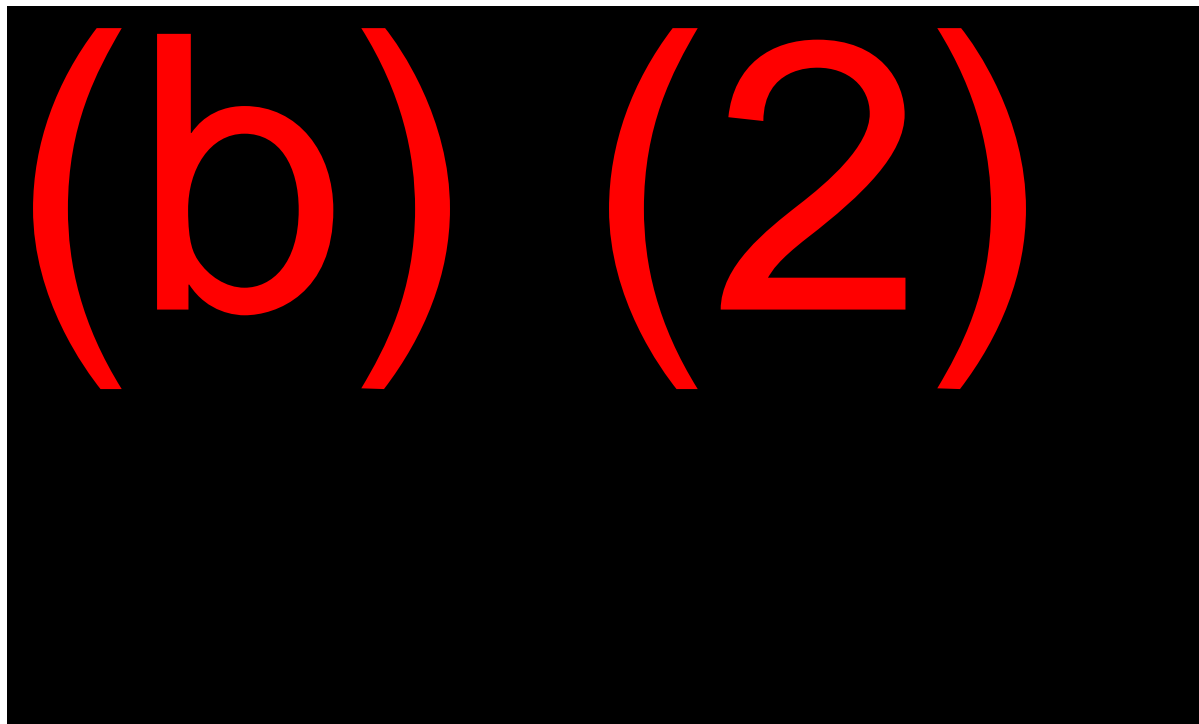
Computation Results Screens

DI 52165.010, **MS 02432.001**

WC/PDB Offset Processing Exception Screen (WCPE)

This screen will appear when ICF #32 cannot process the requested computation. Refer to **MS 02432.002** for a listing of exceptions.

Computation Screens

Computation screens will be displayed for:

ACE Data - WCAC screen

DI 52165.010C.12, **MS 02432.003**

(b) (2)

Lump Sum Proration - WCWE and WCNE screens

DI 52165.010C.13, **MS 02432.004**, **MS 02432.005**

(b) (2)
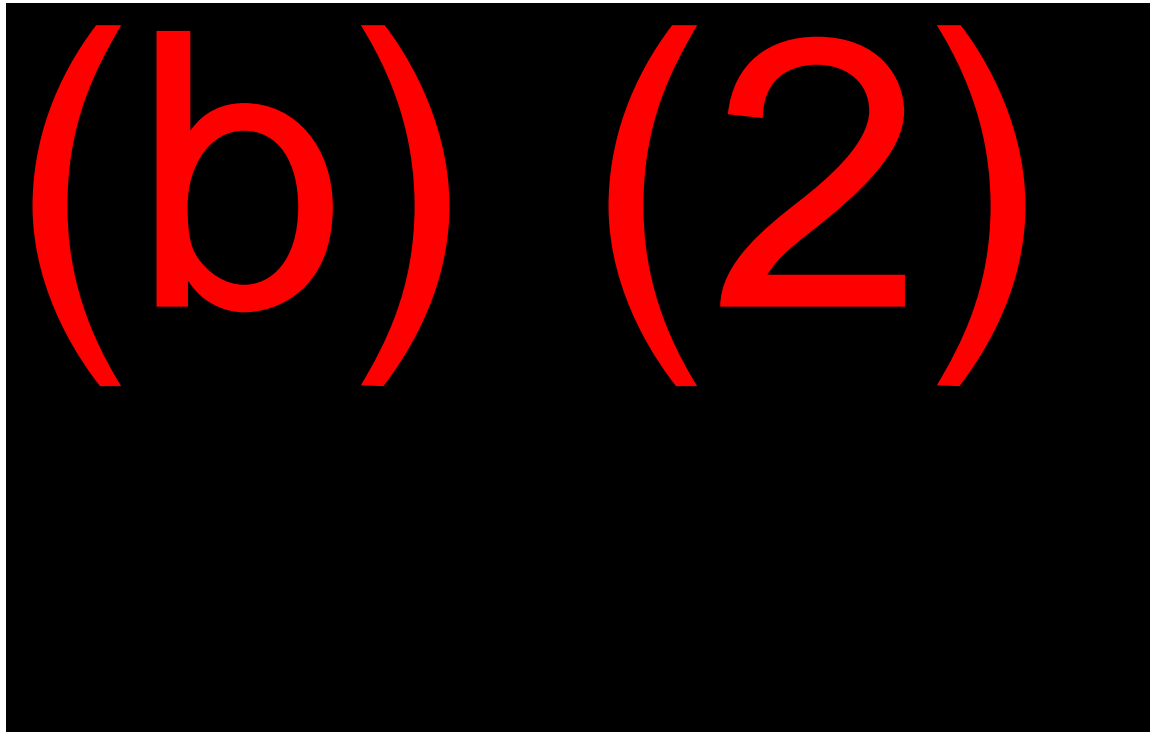
General Offset Data - WCGO screen

DI 52165.010C.14, **MS 02432.006**

(b) (2)
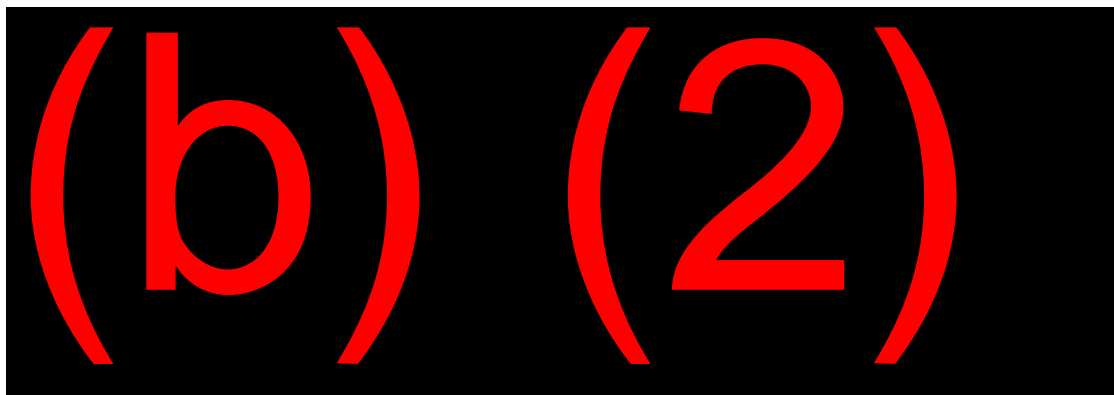
Account Data - WCAO screen (a monthly breakdown of the Total Family Benefit and WC/PDB amounts used to calculate payment after offset)

DI 52165.010C.15, **MS 02432.007**

(b) (2)
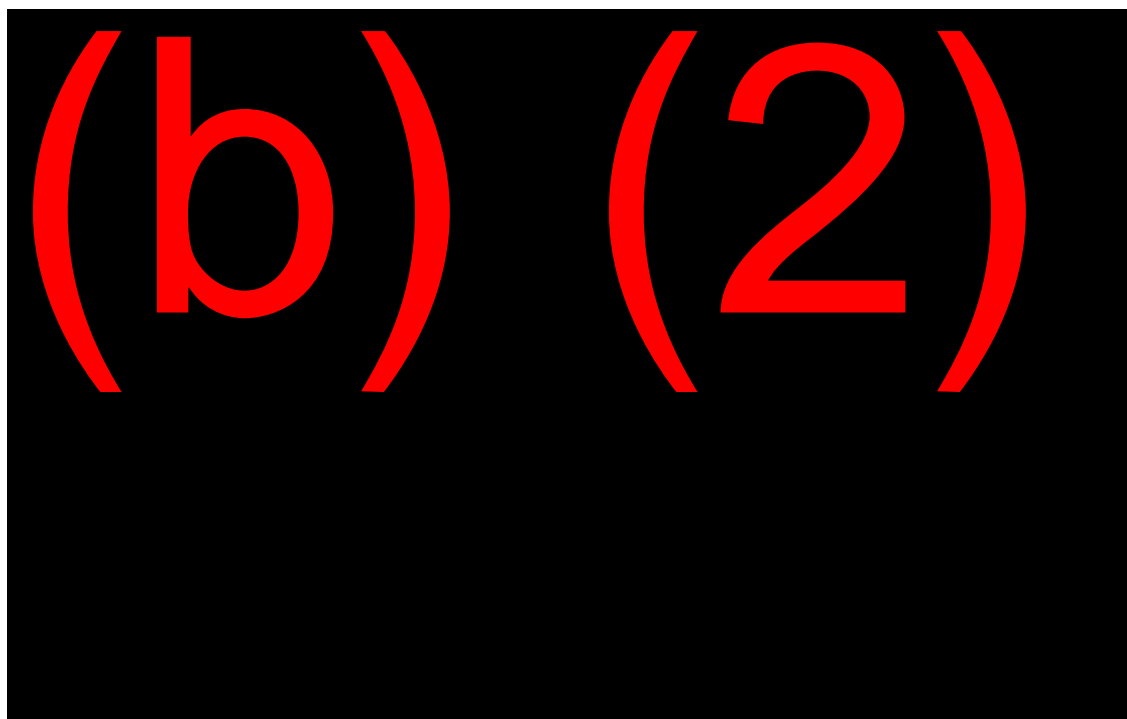
PIC Offset Data - WCPO screen (the monthly amount payable after offset to each claimant on the record)

[**DI 52165.010C.16**](#), [**MS 02432.008**](#)
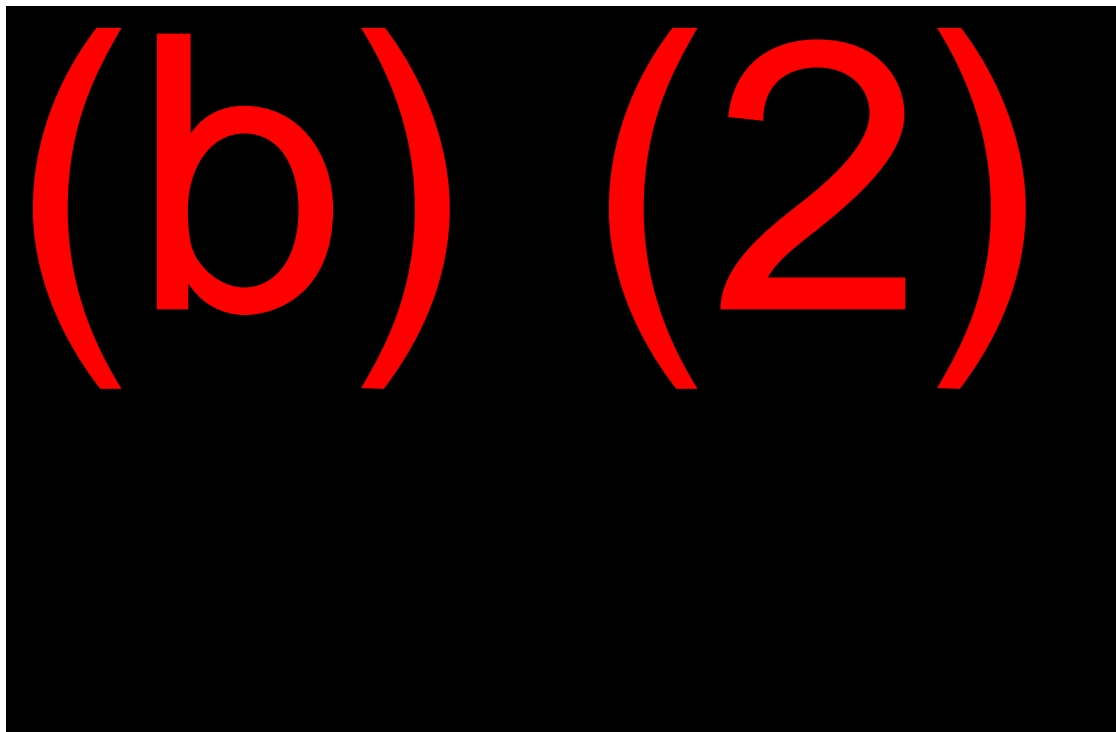
Notice Screens

WC/PDB Offset Notice Menu Screen (WCNM)

[**DI 52165.010C.17**](#), [**MS 02433.002**](#)

Use this screen to select PICs for which a notice should be prepared. Although an option appears to bypass notices, Field Office employees are currently required to provide WC/PDB MADCAP paragraphs for all A101 and post entitlement actions. These paragraphs can be found at (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) , which allows for easy identification of the proper MACADE paragraphs.

WC/PDB Offset Enclosure Notice Block Screen (WCEP)

DI 52165.010C.18, **MS 02433.003**

An enclosure notice block screen is provided for both primary and auxiliary claimants for entry of the MADCAP paragraphs and any necessary dictated language for the individual beneficiary.

Disposition Screens

WC/PDB Offset Remarks Screen (WCAR)

DI 52165.010C.19, **MS 02434.002**

(b) (2)(b) (2)

When certain conditions are met, the program provides remarks regarding additional action that may be required.

From the remarks screen, you are given two options: to save the information or to adjudicate. If neither of these options is chosen, the input information is lost.

WC/PDB Offset Disposition – Pre-Adjudicate Screen (WCDP)

MS 02434.003

Use this screen to save the data to the WC/PDB database. Space is provided to allow for special instructions about the computation.
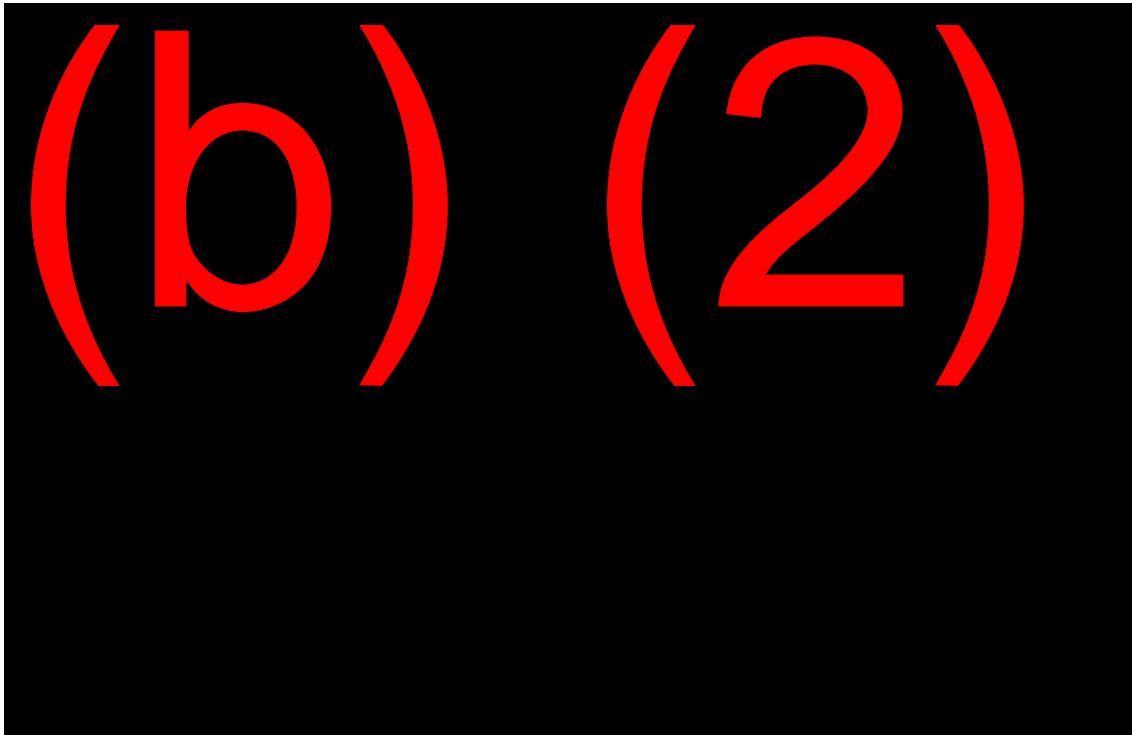
WC/PDB Offset Disposition – Adjudicate Screen (WCDA)

DI 52165.010C.20, **MS 02434.004**
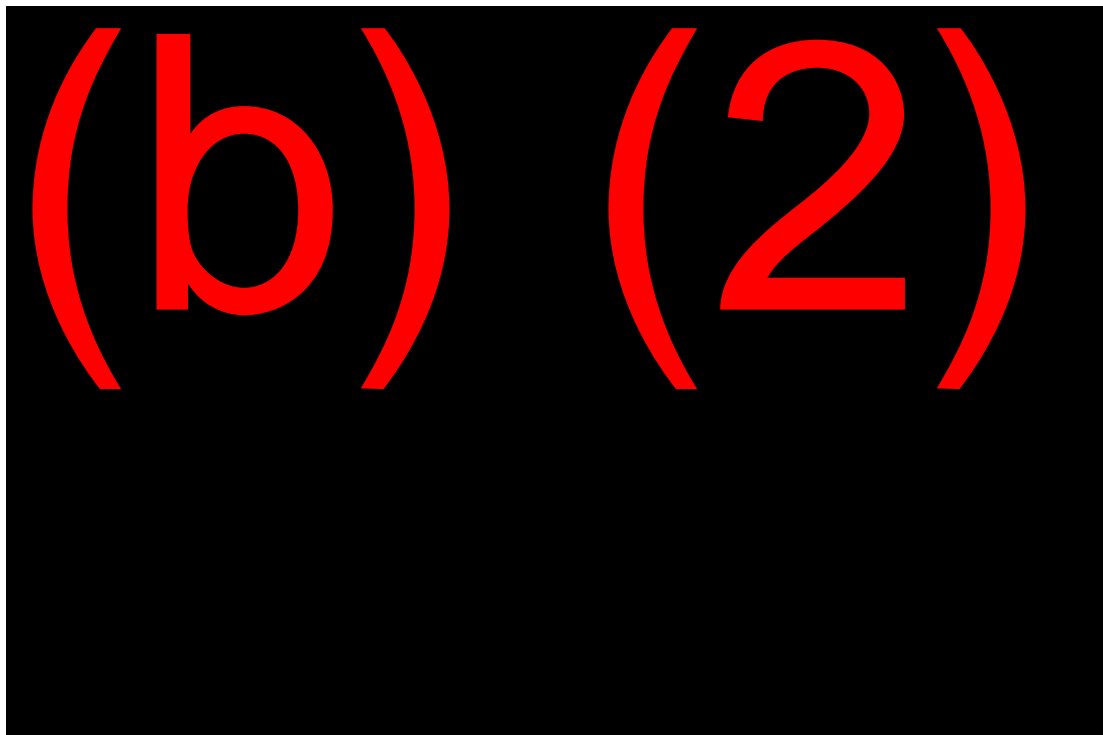
The WCDA can be used to trigger the change in WC/PDB as a post entitlement action. If a "Y" is entered in the ADJUDICATE WC/PDB CLAIM? (Y/N) field, the following will occur:

- The action will be saved to the WC/PDB Database as an "adjudicate" action.

- The input record will be sent to the T2R system for processing. However, this input record will only contain WC/PDB claims data. Account and Benefit data changes are not sent to the T2R system. If you decide not to adjudicate your action, you will be able to save your inputs, results and notice data to a pre-adjudicate WC/PDB record.

- When the FO triggers an action and it cannot process to completion, the input creates a PCACS record for the exception. This PCACS record is directed to the corresponding PSC to process the necessary action to completion. The "adjudicated" information in ICF will be propagated into MACADE.

If the computation is for an A101 or EF101, the information will be propagated by the BA into a MACADE action.

WC/PDB Data File

MS 02431.004

ICF

The latest pre-adjudicative and adjudicative computations will be saved for propagation into ICF. This information can be viewed by selecting ICF #33.

MFQ

A printout of the datasheet from the latest WC/PDB action stored in ICF is available from the MFQ menu by selecting #25.

Selected WC/PDB information is also displayed on the query "Workers' Comp/Public Disability Benefit Data." To view this query, go to the MFQ submenu for Inquiry Response Queries (QRSL, #17) and select "Disability." The query reflects WC/PDB data from the current and three previous injuries.

ORS

All adjudicated ICF actions, as well as Modernized Claims Systems (MCS) and Automated 101 processes with WC/PDB involvement, will also be stored in the Online Retrieval System (ORS). This creates a historical record of all WC/PDB actions.

OBJECTIVE 5:

Use the WC/PDB Online Record Entry Operation (OREO) Program.

WC/PDB OREO Program

DI 52165.020, MS 02436.001

Background

The WC/PDB Online Record Entry Operation (OREO, ICF #34) was developed so that a WC/PDB record could be manually created when the existing #31 (WC/PDB: Pre-Adjudicate Claim) and #32 (WC/PDB: Adjudicate Claim) programs could not be used (e.g., cases involving Combined Family Maximums, dual entitlement and/or technical entitlement). For a complete list of when not to use offset programs #31 and #32, see **MS 02431.001D**.

Access OREO

The WC/PDB OREO program will:

- Allow manual creation of a WC/PDB record by entering both "input" and "results" data into the ICF WC/PDB Offset screens.

- Create the WC/PDB Datasheet, which will be stored on the Online Notice System (ORS).

- Offer the option to propagate data from an existing WC/PDB record into its screens.

- Provide for entry of Notice Data (MADCAP notice paragraphs or dictated notice language).

- Provide a disposition screen which will allow you to adjudicate the action or save it to the WC/PDB database as a pre-adjudicate action.

NOTE: This program will not perform any WC/PDB Offset computations. OREO only provides screens to collect input and results data to create a WC/PDB record for the account. The entire WC/PDB computation must be completed prior to using OREO. In certain situations, ICF #9, #28, #31 or #32 may be used to perform the related computations.

Data Collection Screens

The WC/PDB OREO data collection screens will be the same collection screens currently used in the WC/PDB Pre-Adjudicate and Adjudicate programs. Data may be propagated from the WC/PDB Record (Pre-Adjudicate or Adjudicate) or from T2 Shared (data from the common WC/PDB screens). This selection is made from the WC/PDB Offset - Options (WCPA). If propagated information is incomplete or incorrect, it can be over-keyed with correct information.

HELP (PF1) screens will be available.

Computation Results and Notice Screens

The Results and Notice screens are actually input screens since ICF #34 does no calculations and is solely to collect data. Information can be propagated, over-keyed or entered completely by the CS.

Disposition

After the computation is entered, OREO uses the WCDA (WC/PDB Offset-Disposition-Adjudicate WC/PDB Claim) screen to adjudicate WC/PDB claims.

If "Y" is entered in the ADJUDICATE WC/PDB CLAIM? (Y/N) field on the WCDA screen, the action will be saved to the WC/PDB Database as an "adjudicate" action.

Explain in the SPECIAL INSTRUCTIONS field why you used OREO to process your action. This is mandatory so subsequent reviewers will know why this program was used.

Once you adjudicate the action, the following will occur:

- If the OREO action is adjudicated in a field office (FO), a Title 2 Redesign Exception ACR (Action Control Record) will be established in PCACS (Processing Center Action Control System) at the PC with jurisdiction. A benefit authorizer will input a MACADE action with the changes to WC/PDB.

- If the OREO action is adjudicated in the PC, the claims specialist (CS) will be advised to forward the action to a benefit authorizer (BA) to process the action through MACADE. The BA will then be able to propagate WC/PDB data into MACADE.

If you decide not to adjudicate, you will be able to save your actions to a pre-adjudicate WC/PDB record.

WC ICF Resource

(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) (b) (2)(b) (2) is a centralized, one-stop resource to access when processing WC/PDB claims. The website will tell the FO and PC what currently works and what does not work in the WC ICF programs (#s 9, 28, 31, 32, 33, 34).

EXHIBIT 1: COMPUTING THE ACE

DI 52150.010

The ACE will be the highest of:

A. DIB AMW   -   the average monthly wage (AMW) based on un-indexed earnings, or

B. High 5   -   the average monthly wage of the 5 <u>consecutive</u> years after 1950 with the highest total covered earnings (without regard to statutory maximum and based on un-indexed earnings), or

C. High 1   -   the average monthly wage of the one calendar year in which the NH's covered earnings (without regard to statutory maximum and based on un-indexed earnings) were highest in the period consisting of the year of the current DIB onset and the 5 years immediately preceding.

NOTE: The ACE as used in computing WC/PDB offset cannot be indexed nor can it be based on indexed earnings.

Let's use the following earnings record for our examples of figuring an ACE using these different methods:

2012	$5,824.93
2013	$ 0.00
2014	$7,729.54
2015	$5,626.15
2016	$6,745.81
2017	$7,326.54 Onset

A. Computation of the DIB AMW

<u>Dividend</u> = 100 percent DIB AMW
 Divisor

e.g., $\frac{$15,056.08}{24 \text{ (2 comp years)}}$ = $627.34 = $627.00 (Round to the next lower dollar amount)

B. Computation of the High 5

Add the highest 5 consecutive years from 1951 on.

If posted earnings are maximum taxable, check DEQY for additional earnings.

e.g.,   2013 $ 0.00
             2014 $7,729.54
             2015 $5,626.15
             2016 $6,745.81
             2017 $7,326.54
        TOTAL $27,428.04

(**NOTE:** a year with no posting still counts as a year in determining 5 consecutive years.)

Divide by 60 months (# in five years), e.g., $\dfrac{\$27,428.04}{60}$ = $457.13 (round down to the next lower dollar amount $457.00)

C. Computation of the High 1

Considering the year of current onset and the 5 previous years, divide the highest yearly earnings total by 12 months. If posted earnings are maximum taxable, check DEQY for additional earnings.

2012 $5,824.93
2013 $ 0.00
2014 $7,729.54 - Highest year
2015 $5,626.15
2016 $6,745.81
2017 $7,326.54 - Onset

$\dfrac{\$7,729.54}{12}$ = $644.12 = $644.00 (rounded down to next lower dollar amount)

The above examples give the 100 percent ACE. The final figure in each case must be multiplied by 80 percent (.8) to derive the correct figure for computing offset.

NOTE: If earnings before 1978 are used in the ACE computation and maximum earnings were reached before the 4th quarter (i.e., at least one "gift" quarter is posted), see **DI 52170.035.**

EXHIBIT 2: SSA-2455

(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

OFFSET WORKSHEET – DISABILITY INSURANCE BENEFITS		Social Security Number
PART 1 – OFFSET DATA		

A. PERIOD COVERED BY THIS WORKSHEET	B. MONTH OF ENTITLEMENT	C. FIRST MONTH OF OFFSET

D. FAMILY BENEFIT COMPUTATION	HA	
	HB	
	HC	
	HC	
	HC	
	TOTAL FAMILY BENEFIT (TFB)	

E.	100% AVERAGE CURRENT EARNINGS (ACE) – USE UNINDEXED EARNINGS	
	☐ DIB AMW ☐ HIGH 5 ☐ HIGH 1 YEAR ____ EARNINGS ____	X .8
F.	80% ACE	

PART 2 – OFFSET COMPUTATION

A.	APPLICABLE LIMIT (Higher of (1.D.) or (1.F.)	
B.	MONTHLY WC / PDB (if weekly, $ x 13/3)	☐ VERIFIED
C.	TOTAL BENEFITS PAYABLE AFTER OFFSET (Subtract (2.B.) FROM (2.A.). If (2.C.) is less than HA's MBA, pay (2.C.) to HA. If (2.C.) is more than HA's MBA, pay the MBA to HA.)	
D.	WORKER'S MBA (The PIA unless DIB is reduced for age)	
E.	AMOUNT PAYABLE TO AUXILIARIES (Subtract 2.D.) from (2.C.)	
F.	NUMBER OF AUXILIARIES	
G.	AMOUNT PAYABLE TO EACH AUXILIARY (Divide (2.E.) by (2.F.))	

PART 3 – INCREASES NOT SUBJECT TO OFFSET

A. CLAIMS SYMBOLS		HA			
B. MONTH	YEAR	AMOUNT	AMOUNT	AMOUNT	AMOUNT
C. AMOUNTS PAYABLE FROM ITEMS (2.C.), (2.D.), AND (2.G.)					
D. TOTAL AMOUNTS PAYABLE					

SIGNATURE	TITLE	OFFICE CODE	DATE

SSA-2455 (08-87)
Prior editions may be used

EXHIBIT 3: OFFSET TYPE CODE

DI 52170.005F.1

Enter one of these codes on the WPCL screen to describe the benefit the NH receives (received)

BL   =   Black Lung (Part C)

FC   =   Federal Employees Compensation Act

FM   =   Federal PDB

HW   =   Harbor Workers and Longshoremen

ML   =   Local PDB

SG   =   State PDB

WP   =   Workers' Comp – State payment

Codes you may see on the MBR:

OP   =   Offset postponed. Used, for example, when proration of a lump sum is involved and Method A delays imposition of the offset for some months. Or, the ACE is too high.

PE   =   Offset pending

RJ   =   State law precludes offset – Reverse offset

EXHIBIT 4: WC/PDB OFFSET PARAGRAPHS

MCS EC CASES

NL 00725.470, **MS 04801.001**

WCPR31

Claimant filed for WC/PDB, but claim is under appeal at the time the DIB application is processed and claimant requests full benefits.

WCPR06; WCPR07

Offset amount is based on an estimated ACE (no OEO development pending).

WCPR09

WC/PDB Interim notice, pending ACE determination. Request this notice when benefits are withheld/reduced and a breakdown of earnings has been requested from OEO per **DI 52170.035**.

WCPR15; WCPR16

WC/PDB involved, change in payment amount, SSA benefits adjusted.

WCPR27

Offset based on unverified WC/PDB amount.

WCPR23; WCPR24; WCPR25

Offset involves lump sum proration of WC/PDB.

NOTE: The list on the previous page represents the most commonly used paragraphs. The POMS sections cited should be consulted for other MCS paragraphs.

OFF-AIR ACTIVITIES

1. Review the National Worker's Comp Resource Page at
   (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)

2. Request the James (DOB 02/28/1963) cloned SSN from the Office of Learning website. Using the following information and the cloned SSN, load a claim in the Training Region.

   NH: James Last
   SSN: _____
   DOB: 02/28/63
   DOO: 01/15/2018

   The NH has never been married and has no dependent children or parents. He started working for Metropolitan Electric of Missouri in Kansas City, MO the day after he graduated from high school in June 1982 and has continued to work for them until he was injured at work on January 15, 2018. The day after his injury, he started receiving Workers' Compensation payments of $100.00 per week from Wausau Insurance Company, and they are still continuing. After you have loaded this claim and reviewed the Clearance Screens, the NH comes into the office with a certified court order showing his Workers' Compensation has changed. On 02/15/19, he accepted a settlement from the insurance company. Effective that date, his periodic payments stopped, and he received the following lump sum settlement: Gross amount $100,000, which represents payments of $100.00 per week starting 03/01/19; this included Attorney Fees of $25,000.00.

EXERCISE #1

OBJECTIVE 1: Identify potential offset situations and determine at what point offset applies and determine necessary development and documentation.

1. Joe Jameson contacts the DO on 02/15/2019 and states he was just notified his WC claim was approved with an effective date of 06/22/18. His DIB MOE is 12/18 based on an EOD of 06/22/18. What is the first month offset is considered or imposed?

2. Reginald Rogers filed for DIB on 11/01/18. He had filed for WC, but no decision had been made at that time. He was approved for DIB with an EOD of 09/01/2018. Today, he calls to notify you his WC claim was approved and was awarded retroactively to 09/2018. What is the first month offset is considered or imposed?

3. Susan Stroud filed for DIB on 01/15/19, alleging an onset of 12/10/18. She has been receiving Federal Civil Service (CS) disability payments since 2006, when she retired on disability after 16 years with the Federal government. She had no employment prior to working for the government, and her government wages were non-FICA covered. Despite her disability, she went to work in private industry in 2008 and worked until her current onset date of 12/10/18. Will there be an offset applied?

4. Craig Jeffers files for disability on 03/03/19, alleging an onset of 12/01/18. He stated on the application screens that he receives a military disability benefit. His service dates were 10/30/83 - 06/30/01. Will his Federal PDB cause an offset?

EXERCISE #2

OBJECTIVE 2: Compute the ACE and perform WC/PDB offset computations.

1. The combined total of SSA benefits and WC/PDB benefits is limited to what amount?

2. What are the three methods of determining what average earnings will be used as NH's ACE?

3. What earnings can be used to compute the ACE?

4. What benefits are used to determine TFB (Total Family Benefit)?

5. When an NH stops receiving regular periodic payments of WC/PDB because they made a settlement agreement, does WC/PDB offset end? Explain your answer.

6. Can a NH receive their own SSA benefit when WC/PDB offset applies to their auxiliaries' payments?

7. What can be excluded from WC/PDB when the amount of offset is calculated?

8. When an NH and/or auxiliaries are not receiving payment because of WC/PDB offset and there is a COLA increase, is the amount of the increase offset also?

EXERCISE #3

OBJECTIVE 3: Properly code MCS Workers' Compensation/Public Disability screens and process claims involving WC/PDB.

List the Workers' Compensation/Public Disability screen(s), and the specific fields on those screen(s), which would be completed in each of the following claims situations.

1. Richard files for disability. He was injured on the job two weeks ago while working for Hafee Iron and Metal, Muskogee, OK. He has filed for state WC payments, but has not received any payments to date. He should hear something within 60 days. He does not know the claim number. Lighthouse Life and Casualty is the insurance company handling the claim.

2. Karen files for disability. She was injured on the job exactly six months ago today while working for Lindsey Chapel Services, York, PA. She has been receiving temporary W/C payments of $200 twice a month since the date of injury. Aetna is the insurance company handling the claim. She does not know the claim number.

3. The claim you are working on is an EC processing limitation. It is necessary to code the A101 with the workers' compensation information. What EC screens show the WC/PDB information needed? Is it necessary to copy down the information from EC and enter it on the A101?

4. WC/PDB information was entered on the claims screens, and you determine at time of clearance the earlier information was incorrect. Do you need to completely re-input all the WC/PDB information?

EXERCISE ANSWERS

Exercise #1

1. 12/18 – offset effective with first month there is concurrent entitlement to DIB and WC/PDB. (**DI 52101.001**)

2. 02/19 – offset effective with first month of concurrent <u>entitlement</u> to both WC/PDB and DIB. Based on an EOD of 09/01/2018 and a filing date of 11/01/18, his first DIB MOE is 02/19. The five-month waiting period begins in September because his onset was the first day of the month and ends with January; therefore, his MOE is February. (**DI 52101.001**)

3. Public Disability Benefit offset will be imposed because Susan's Civil Service disability benefit is not based on at least 85 percent covered earnings. (**DI 52130.001**)

4. There will be no offset because military service is covered service after 01/01/57 and is covered under Social Security. Do not offset the military disability benefit if the worker only has military service (MS) after 1956. (**DI 52130.015)**

Exercise #2

1. The highest of either 80 percent of the ACE or the TFB. **DI 52101.001**

2. AMW, High 5, and High 1. **DI 52150.010**

3. Unindexed earnings. For High 5 or High 1, earnings above maximum taxable can be used. **DI 52150.010**

4. Benefits to NH and all auxiliaries, after reductions, in the month offset are considered. **DI 52150.005**

5. No. The amount of money paid in the settlement must be prorated to determine continuing offset. **DI 52150.040**

6. Yes. The amount to be paid after offset is given to NH first. Auxiliaries may be offset when NH is not. **DI 52101.001**

7. Medical expenses, legal expenses, and other expenses related to the WC/PDB injury, illness, and claim that have been paid by the NH. **DI 52150.050**

8. NO. COLA increases are not offset—the amount of the increase is payable to the beneficiary. **DI 52150.055**

Exercise #3

1. **MS 00701.001B & C**
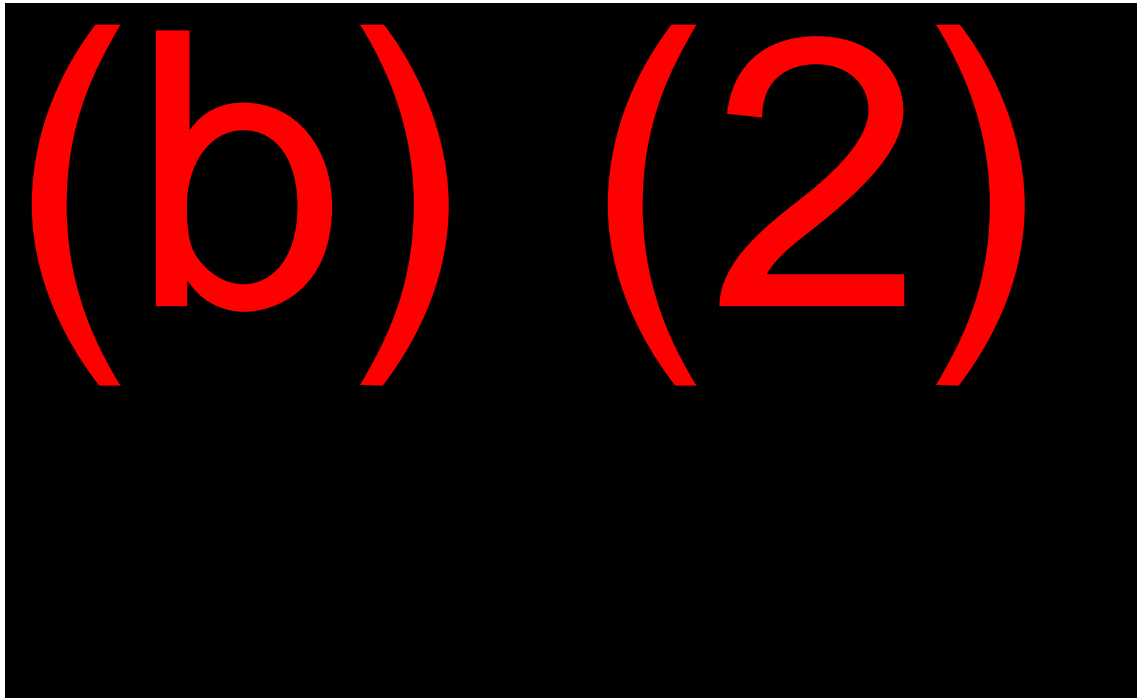
2. **MS 00701.001C**
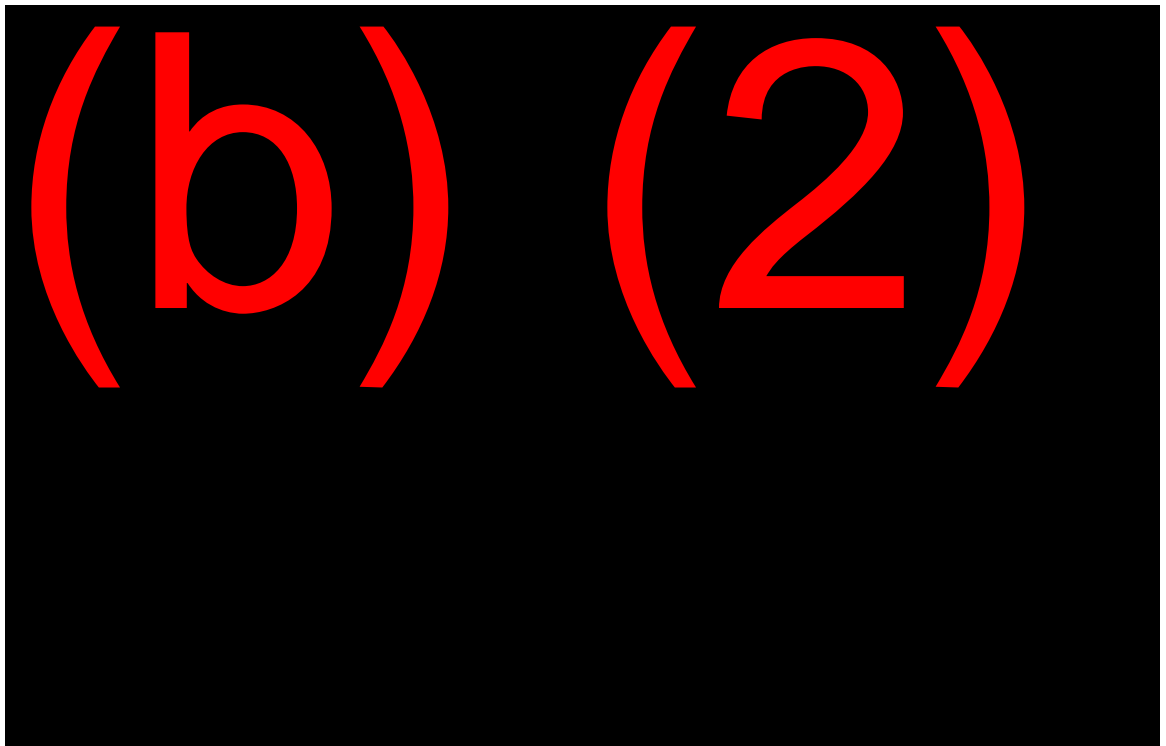
(b) (2)

(b) (2)
(b) (2)

3.   The WC/PDB information is on EC screens **DRMK, WRAD, WRBD**. Requesting an Adjudicative EC, **before using Proc Code A to establish the A101,** propagates the entries to the A101. (**MS 03601.001**)

4.   You should correct any entries made in MCS which are incorrect. You do not need to completely re-input all the WC/PDB information.

TABLE OF CONTENTS

LESSON PLAN

Chapter Objectives

At the completion of this chapter, the students will be able to:

1. Determine the action(s) necessary to adjudicate DIB claims through MCS EC.

2. Determine if a non-medical completion input can be done and determine proper folder processing.

3. Determine the action(s) necessary to manually adjudicate DIB claim allowances.

4. Determine the action(s) necessary to manually adjudicate disallowed and denied DIB claims.

5. Determine the proper processing of an SGA denial.

6. Determine the proper action to be taken in the processing of concurrent RIB/DIB claims.

7. Obtain and Interpret the DDSQ, eView, and PCACS.

Length of Chapter

8 hour

Local Supply

SSA-831

BACKGROUND AND RATIONALE

Definition

Adjudication is the process of making an initial determination about a claimant's entitlement or non-entitlement to Social Security benefits. Adjudicative activities consist of a series of judgments running through the entire development of a claim culminating in the processing of an award or disallowance.

DIB Adjudication

There are two determinations made on disability claims: medical and non-medical.

The non-medical criteria states the NH must:

- File an application;

- Not be full retirement age;

- Have disability insured status;

- Not be working at SGA levels; and

- Serve a waiting period (if applicable).

These factors are usually determined by the FO prior to sending the medical portion of the claim to DDS (Disability Determination Service).

The FO will determine if insured status requirements are met at onset and the DDS will determine if the individual was disabled on or before the date last insured. The medical decision is made by the DDS, but is considered to be made by the Commissioner of SSA. The DDS decision establishes the existence or nonexistence of a disability. The decision is subject to review by the Office of Quality Performance (OQP) in the SSA Regional Offices.

OBJECTIVE 1:

Determine the action(s) necessary to adjudicate DIB claims through MCS EC.

Claims Clearance Menu (CMEN)

MS 03509.004

The application screens in MCS contain information about the claimant, but not all the information needed to process the adjudicative decision on the claim. Clearance screens may be necessary depending on the case characteristics. You have to determine if clearance screens are necessary and which ones to include in the claim. The clearance screens used most often in disability claims are discussed in this objective.

Purpose

The clearance screens are accessed through the system MENU by using the update mode to select FUNCTION 06 (CLAIMS CLEARANCE). The Claims Clearance Menu (CMEN) is a submenu, which allows you access to 13 optional clearance screens.

Initially, you will have to request each individual clearance screen you want to use. Afterwards, you can use the interscreen transfer method to access any previously requested screen. All existing clearance screens for all claimants can be reviewed by entering "0" (BROWSE) in all claimants on the CMEN.

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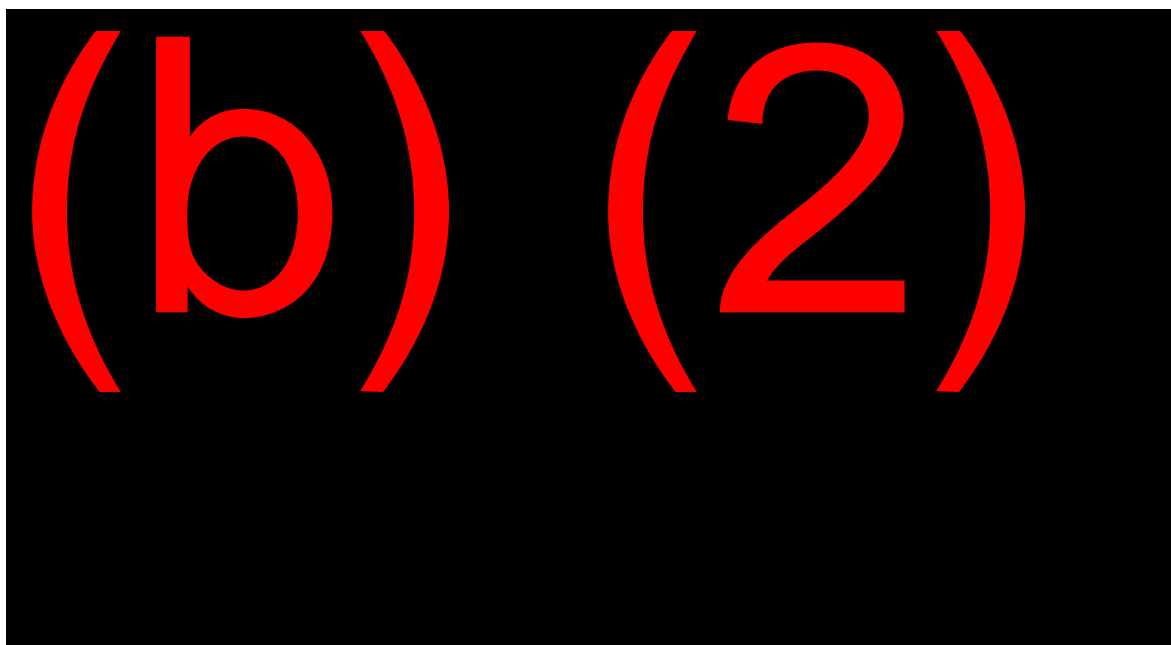
Check/Notice 1 (NOT1) Screen

MS 03509.008

The purpose of the Check/Notice 1 (NOT1) screen is to enter data for:

- Rep payee, and

- Third party notices such as an employer or an insurance company.

NOTE: Use the NOT2 screen for authorized representative data.

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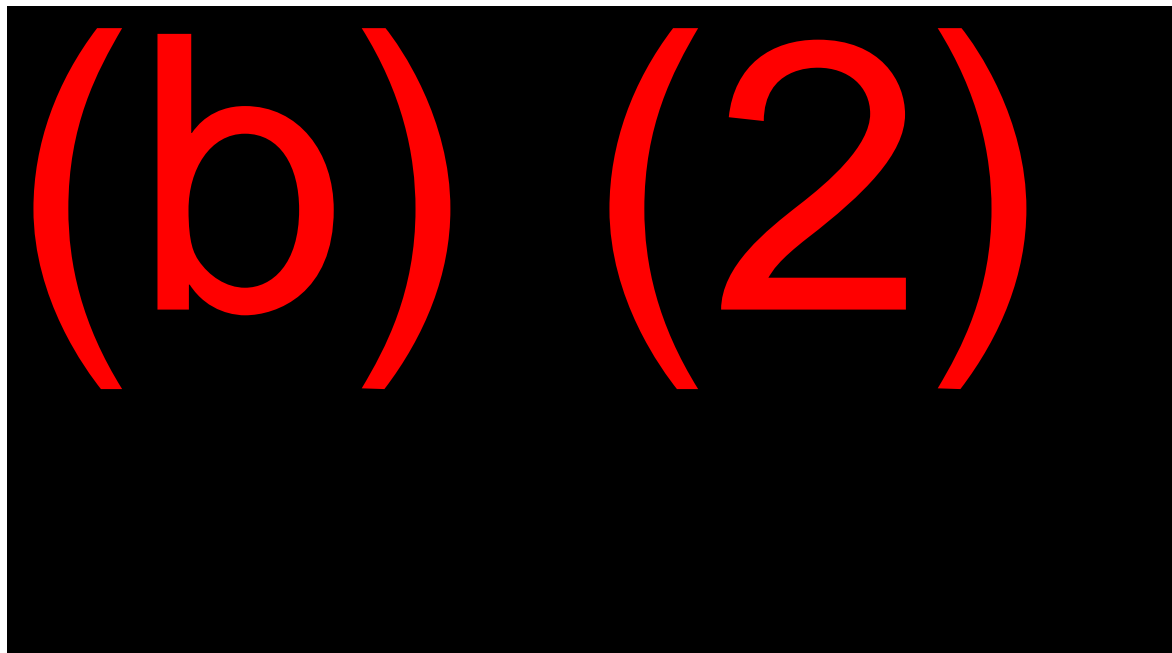
Check/Notice 2 (NOT2) Screen

MS 03509.009

Purpose

The NOT2 (Check/Notice 2) screen contains data to complete and send notices and payments to authorized attorney/non-attorney representatives. The Appeals lesson discusses this screen in detail.

(b) (2)
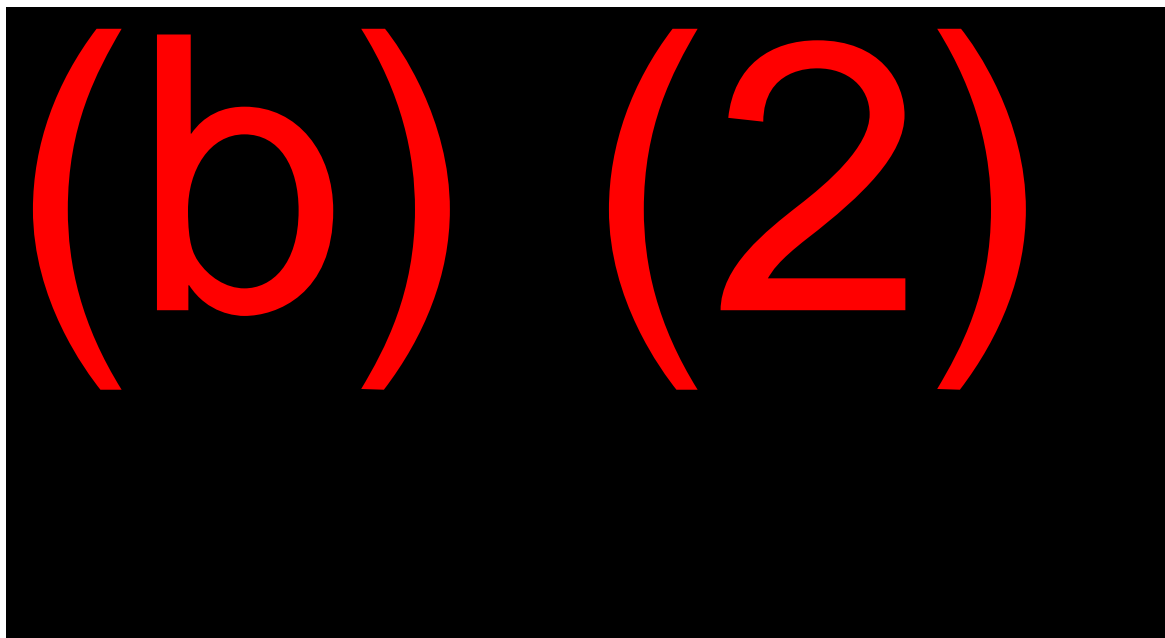
Disability Allowance/Denial (DICL) Screen

MS 03509.005

The Disability Allowance/Denial (DICL) Screen is used to display or record the medical allowance or denial of disability benefits. When DDS inputs the medical decision, and it processes correctly, MCS propagates all disability information to the DICL screen. For a disallowance, the denial basis code propagates to the first field on the DICL screen. Information about a disability allowance decision also propagates to the DICL.

(b) (2)
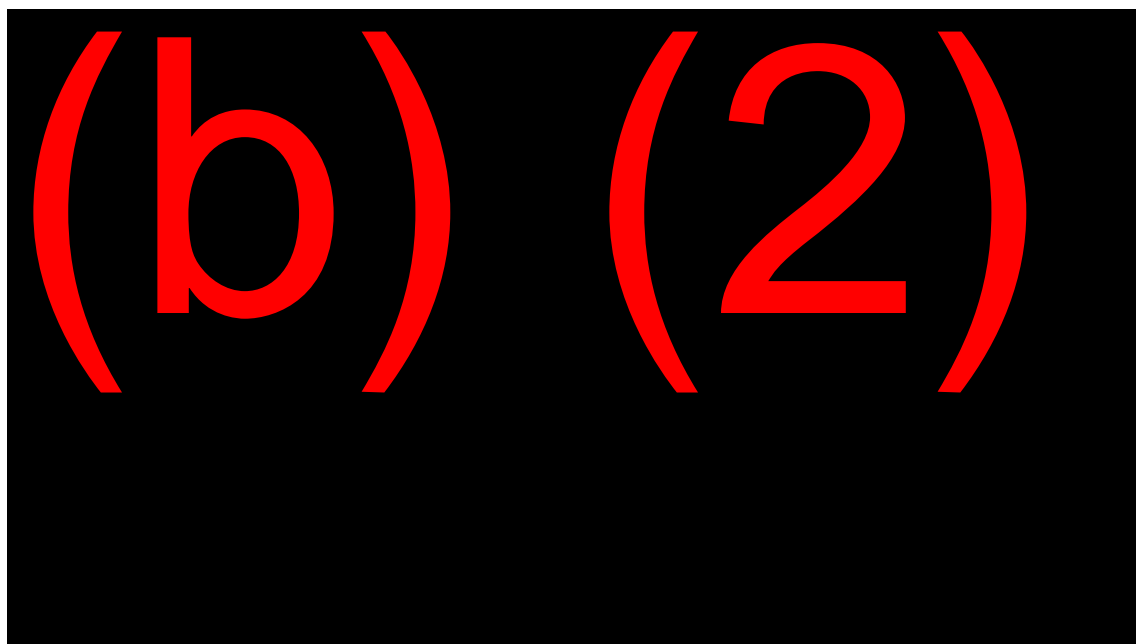
Occasionally, the DDS medical input does not transfer to the DICL screen. When this happens, you must complete the DICL screen.

If the medical decision is a denial, input the denial code from item 22 of the SSA-831 in the "Denial Basis Code" field. Use eView to view the SSA-831.

If the medical determination is an allowance, review the SSA-831 in eView and input the fields on the DICL as follows:

SSA-831	DICL field input
From Item 15A, enter date	Established Onset Date
From Item 17, Diary Type: MRP MRN	Select Severity: #1 – Permanent #2 – Non-Permanent
From Item 16A Item 16B (if listed)	Enter 4-digit Diagnosis Code Enter 4-digit Secondary Diagnosis Code
	Enter Y (yes) to Establish Medical Re-exam
If Item 18 is completed (DDS established claimant is Stat Blind)	Enter Y in the Stat Blind field
If Item 34, Remarks, has the following: DAA is material – (A, D or B, as applicable)	Select Drug Addiction/Alcoholism: #1 = Alcoholism #2 = Drug Addiction #3 = Both #4 = Not Material

DAA Not Material – DAA Condition (X,Y, or Z, as applicable) No evidence of DAA-W	#5 = Not a DAA Condition
From Item 17, MM/YY box	Enter Medical Re-exam Diary date (MMDDYY) For the day – enter 01 **DI 26510.020**
From Item 17, Reason: If Numeric (3, 5, 7) If Alpha	Medical Diary Reason: Leave Blank Enter the Alpha Code
Also from Item 17, Reason	Periodic Review Diary field: #1 = 3 Year (Non-Permanent) #2 = 5 Year (Permanent) #3 = 7 Year (Permanent)
If Item 34, Remarks shows a remark regarding capability	Make the selection applicable to the case.

Benefit Continuity Factors (BECF) Screen

MS 03509.003

Purpose

The Benefit Continuity Factors (BECF) Screen records information MCS needs to set up the benefit continuity fields.

Completing the BECF screen when a disability claim involves:

- Disability denial basis code;

- Processing only the DIB portion of a claim; and/or

- Miscellaneous factors (06 = Windfall Offset).
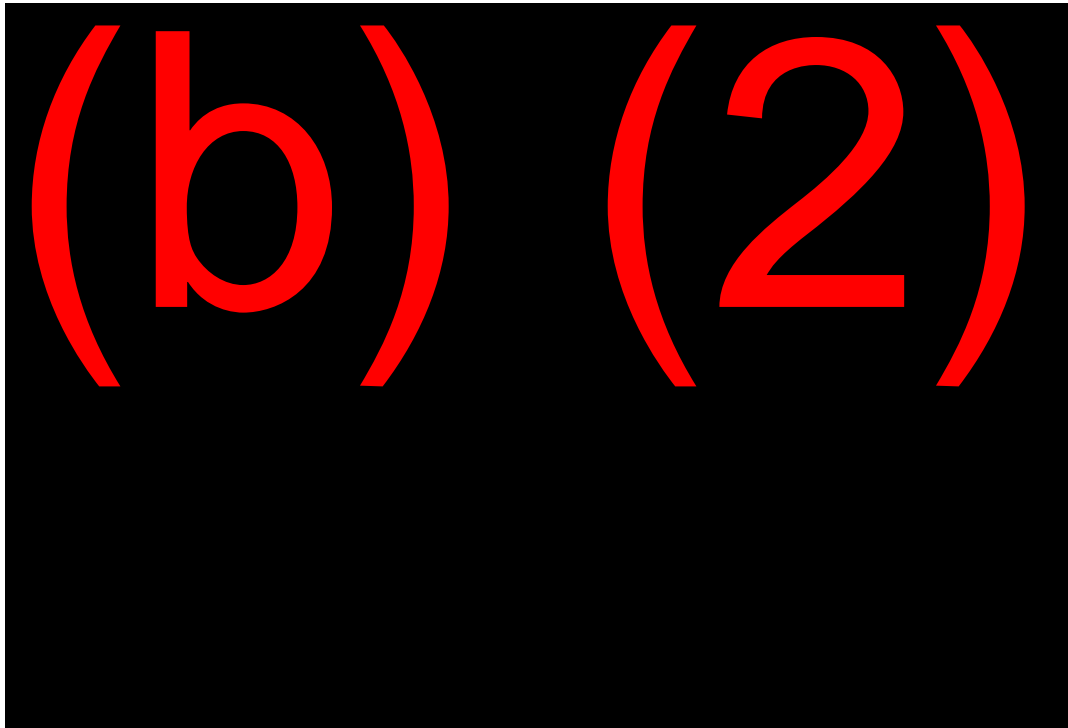
Process Disability Portion of claim (Y/N):

Type Y or N to indicate whether you are processing only the disability portion of the claim if the claimant applied for benefits as a:

- mother/father <u>and</u> disabled widow(er); or

- widow(er) <u>and</u> disabled widow(er); or

- child <u>and</u> disabled child.

Otherwise, leave this blank. **MS 03509.003 E [1-O]**

Disallowance Reason(s)

SM 00380.040; **SM 00380.050**; **SM 00380.100**; **MS 03509.003 E [2-O]**

If you are processing a disallowance, abatement, withdrawal or denial and MCS will not automatically generate the disallowance code, type up to 3 disallowance/abatement/withdrawal/denial codes. Use 2 or 3 characters.

When the claimant does not meet the requirements for entitlement for reasons other than medical, MCS may generate the disallowance code.

These codes are listed in **SM 00380.050**. A specific order of priority for disallowance and denial codes is listed in **SM 00380.090**.

Miscellaneous Factors

This field will be coded for claims which include various factors affecting payment. On disability claims, you must code this screen with windfall offset information (06), if SSI payment is involved. **GN 02610.005**; **MS 03509.003 E [3-O]**

Suspension Events

The Suspension Events screen, as discussed in the retirement adjudication lesson, allows you to adjudicate claimants into a suspense code when their medical determination is an allowance but there are conditions which cause non-payment of benefits. **MS 03509.016**

Access this screen by selecting option #8 on the MCS MENU. The list of functions at the bottom of the screen allows you to request the function applicable to a particular suspension event.

(b) (2)
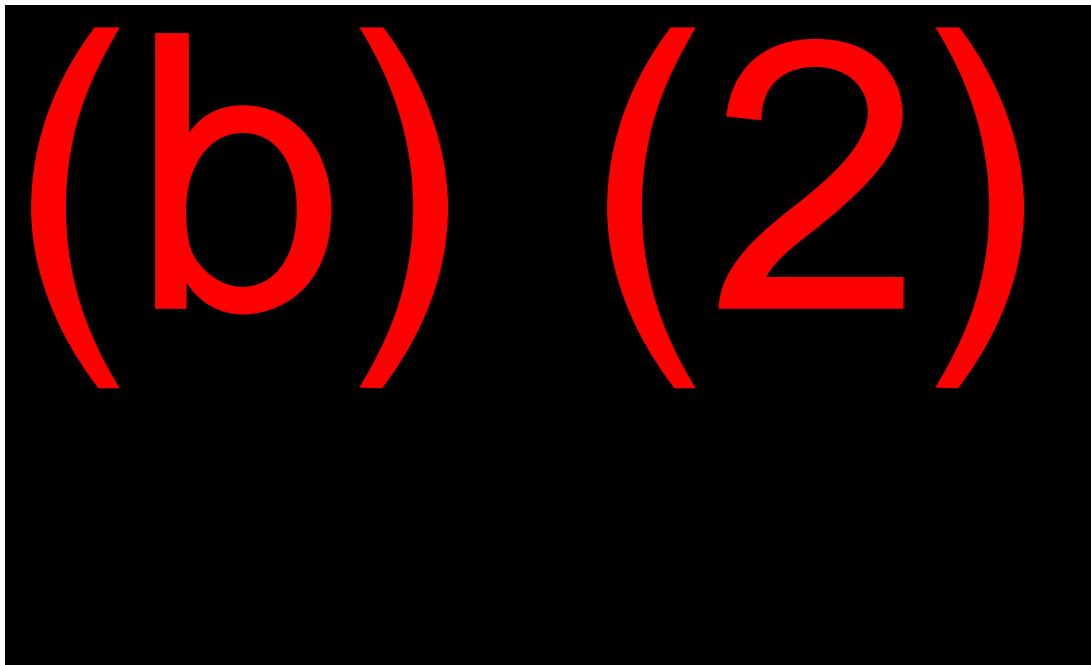
Decision Input (DECI) Screen

File Date Determination (FDDS) Screen

MS 03509.014

As with all adjudication processes the FDDS will be the first of three screens in the DECI screen path. Access these screens by selecting option #23 on the MENU screen.

The PROTECTIVE FILE DATE (PFD)/FIRST CONTACT and the APPLICATION RECEIPT DATE fields on the FDDS screen contain propagated dates that cannot be changed on this screen. If the information shown is incorrect, you must correct it on the DW01 before processing the claim.

The MATERIAL FILE DATE field is pre-filled with the application receipt date. This date is used to calculate processing time on the application.

To skip to the DECI screen without viewing multiple FDDS screens, you will enter Y in the field SKIP TO DECI (Y/N).
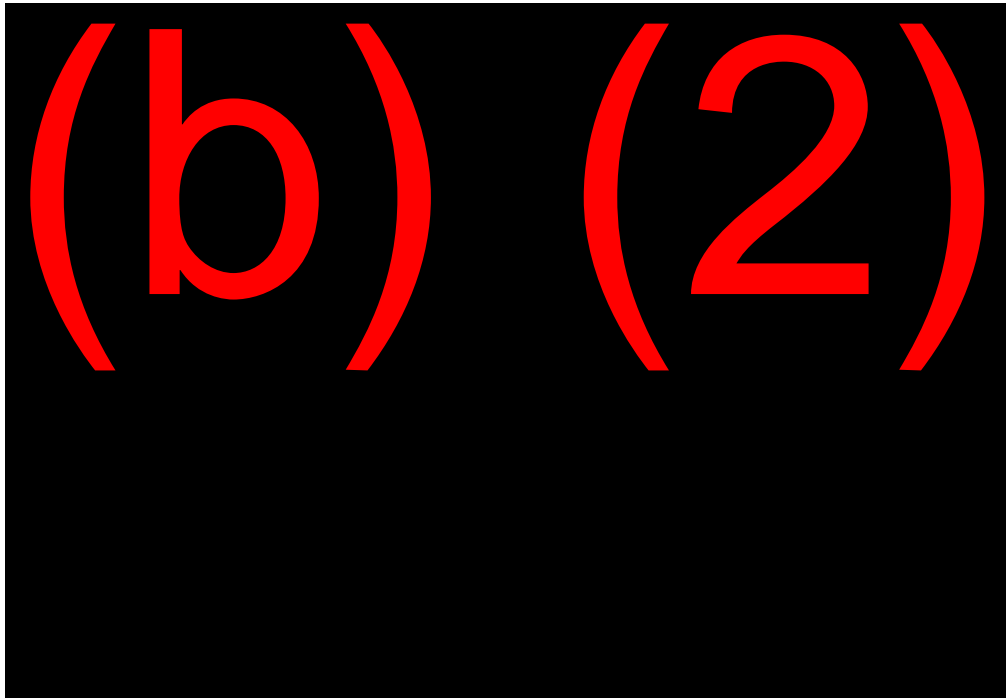
Decision Input (DECI) Screen

MS 03509.013

The date of filing propagates to the DECI screen and cannot be changed on this screen. The date propagated to the DECI is the earlier of the Protective File Date (PFD)/First Contact Date or the Material File Date.

The Decision Input Screen is the place to input your decision for the claim: either an allowance or a denial. The DECI must be completed for all Title II MCS claims.

Inputting the DECI initiates the MCS edit process which determines whether errors were made on the various screens or processing limitations or exceptions apply.
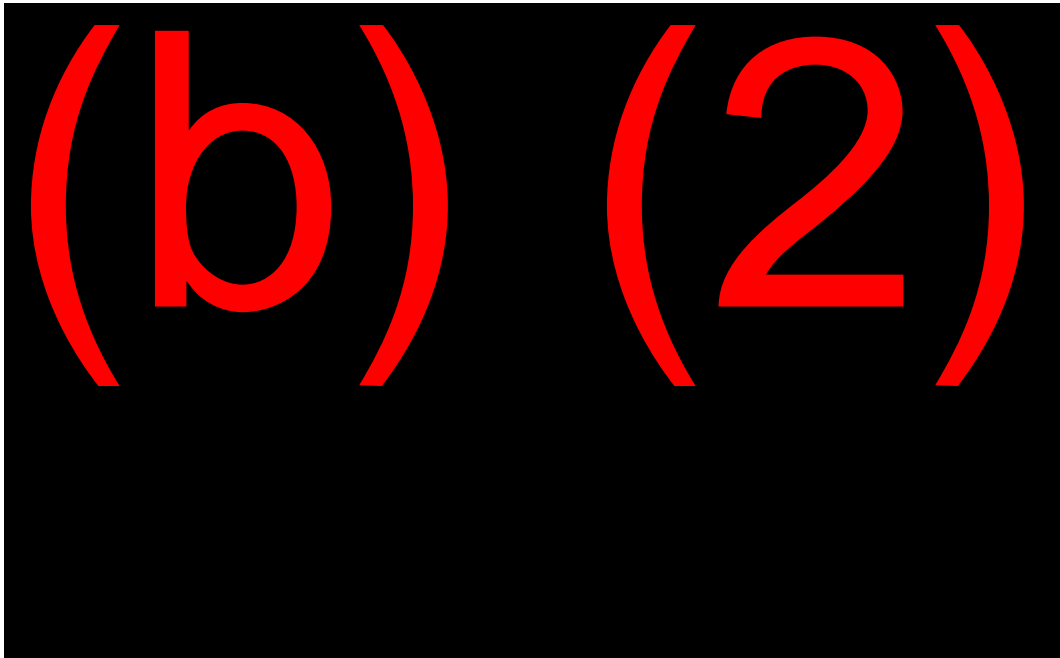
File Date

You can process DIB claims through MCS with a filing date of up to 4 years prior to the current year when only the NH is filing.

If the filing date on a claim is too early, MCS will send the edit message "FILING DATE TOO EARLY," and the claim must then be processed using an A101.

File Date Change (FDC)

MCS records why you changed the date propagated in File Date when the change is due to an open application or re-opened prior claim.

If the file date is earlier than the application receipt date, type one of the following codes to show the reason why:

> B = Open Application
>
> C = Re-opened Prior Claim

Dec Stat

Complete this field only when you are adjudicating a claim. Applicable disability DEC STAT codes are:

- #3 – DIB TECH DIS (DIB technical disallowance)

- #4 – DIB ALLOW (DIB allowance)

- #5 – DIB MED DENY (DIB medical denial)

- #6 – NON-MED COMP (Non-Medical Completion)

- #10 – DIB PARTIAL (DIB allowance partial)

Abatement or withdrawal may apply in a disability claim. A separate module covers processing abatement and withdrawals.

Diary and Listing Codes

GN 01040.010; **GN 01040.100**

If you are adjudicating a claim needing a diary code, type up to four 3-position numbers, using a lead zero when necessary. MCS automatically creates a control on PCACS.

Listings are entered by the FO to identify cases which may need to be controlled and studied in the future.
- Listings are generally used when the case possesses a special characteristic. **GN 01040.100**

PC Jurisdiction

DI 11010.280

MCS initially generates a code in this field based on the area code of the NH's SSN and whether disability is involved.

- If the claimant is 54 years of age or older, enter the respective PC based on their SSN: PC1 – PC6.

- Disability claims where the individual is under age 54 are PC7 jurisdiction.

Over-key this field if it is determined this code is incorrect.

EC Screens

MS 03601.001 - **MS 03601.037**

Access the EC screens by entering #21 (Earnings Comp Request) on the MCS System Menu. MCS displays the Earnings Comp Request (MREQ) screen. The MREQ lets you:

- Request an adjudicative or pre adjudicative EC;

- Exclude some claimants from the EC;

- Consider or ignore possible Dual Entitlement;

- Consider or ignore possible MQGE entitlement.
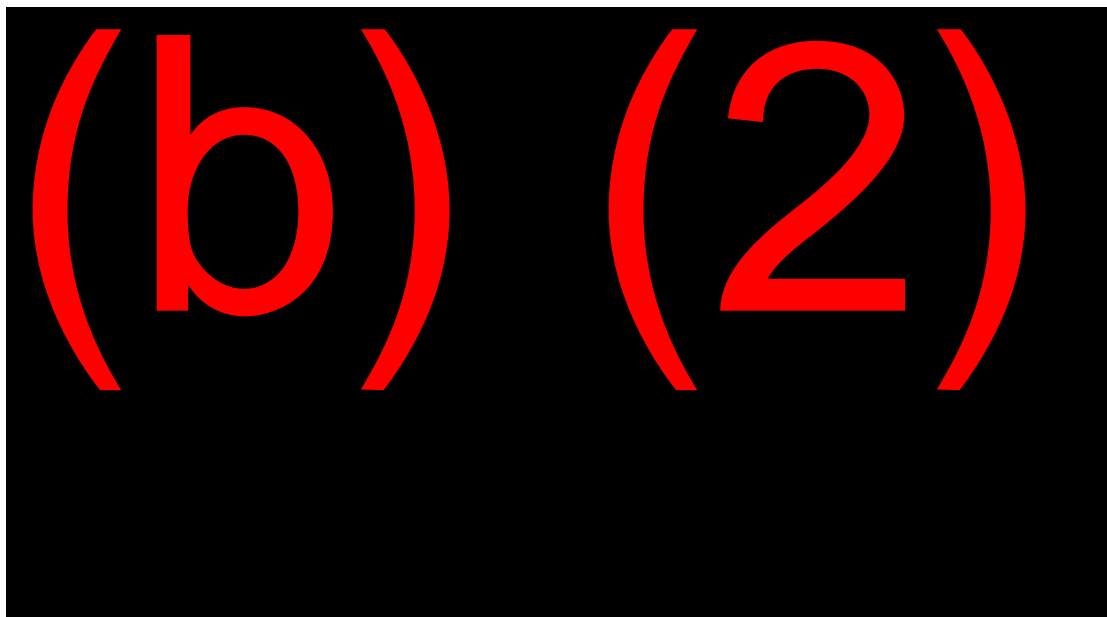
When you request an EC, MCS checks information on the DADE screens and the MEF. MCS verifies information about insured status, the BIC and certain entitlement factors, computes the PIA and the MBA. With EC clearances, all earnings and computation data are displayed online.

MCS checks for processing limitations (PROC-LIMS), exceptions and indications OEO involvement is needed. If MCS finds one of these conditions, it will stop processing and generate a message to either the MENU screen or DRMK screen explaining why it stopped.

If you have a processing limitation message, determine what is causing the PROC-LIM, correct the problem and continue processing your claim.

If you cannot correct a processing limitation, you will need to process the case manually, using an A101 or EF101 for an award, or a MACADE denial input for a manual denial.

EC Approval Screen

DAPP EARNINGS COMP APPROVAL – this is the screen used to trigger the claim. With a "Y" answer, the claim will be locked and jurisdiction is transferred to the appropriate Payment Center. The claim will then process to completion and the MBR will be updated. Entering an "N" on the DAPP screen will cancel the adjudicative request.

(b) (2)

Routing MCS EC Paper Claims

DI 11010.280; **DI 11010.355**

You will forward the initial DIB allowance to ODO (PC7) for claims where the NH is under age 54. If the disabled worker is age 54 or older or is deceased, route the case to the PSC with jurisdiction of the NH's SSN.

Paper DIB denials are retained in the FO during the appeal period.

Notices/Paragraphs

NL 00725.006-.007; **MS 04802.003**

Disability Notices

When a claim is allowed or denied, a notice of decision is sent to the claimant(s) and any representative(s).

- In disability claims in which DDS makes the medical denial, DDS is responsible for preparing and releasing the personalized notice.

- In SGA denials, the FO is responsible for preparing and releasing a personalized notice.

- All other disability notices are computer generated. Specific paragraphs can be provided on a notice using the NOT3 clearance screen.

- In any claim, whether EC or manual, the FO is responsible for ensuring a correct and complete notice is sent to the beneficiary.

OBJECTIVE 2:

**Determine if a non-medical
completion input can be done and
determine proper folder processing.**

Non-Medical Completion

DI 11010.115

Non-Medical Completion (NMC) is the FO adjudicative decision indicating
the non-medical portion of the disability claim is ready for adjudication.
NMC can be used in both initial claims and reconsideration cases. NMC
suppresses the final payment action while waiting for DDS to make a
medical decision. When DDS inputs a medical decision and there are no
processing exceptions, the claim is triggered and processed without
additional input from the FO.

MCS EC Input

To process a non-medical completion:

- Select Function #23 in update mode. Then enter 06 as the Decision
  Status code on the DECI.

- Select Function #21 in update mode. On the MREQ screen show
  Adjudicative Request as Y and process all claimants as Y.
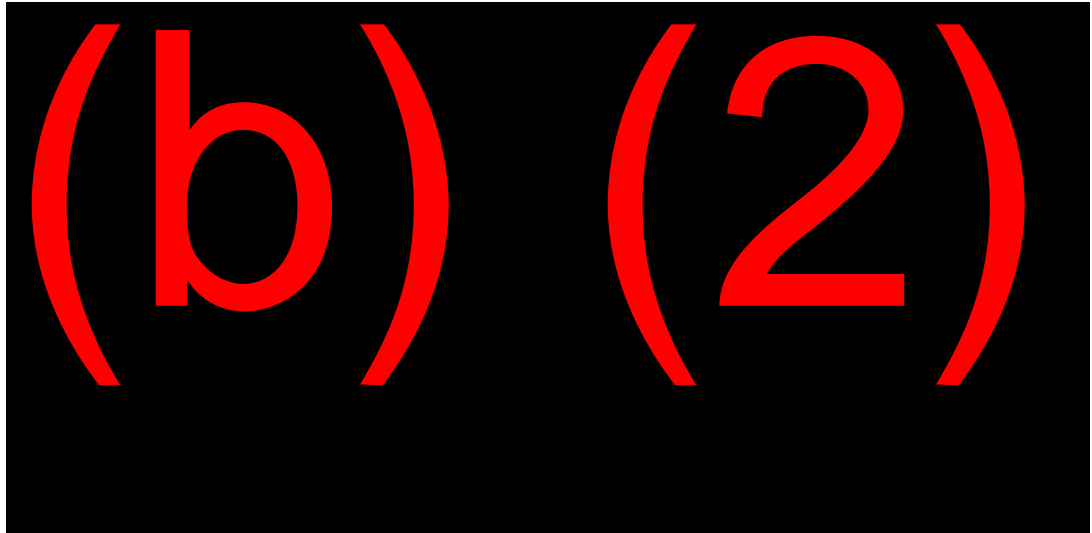
- On the MCR1 screen select Item 7 (APPROVE).
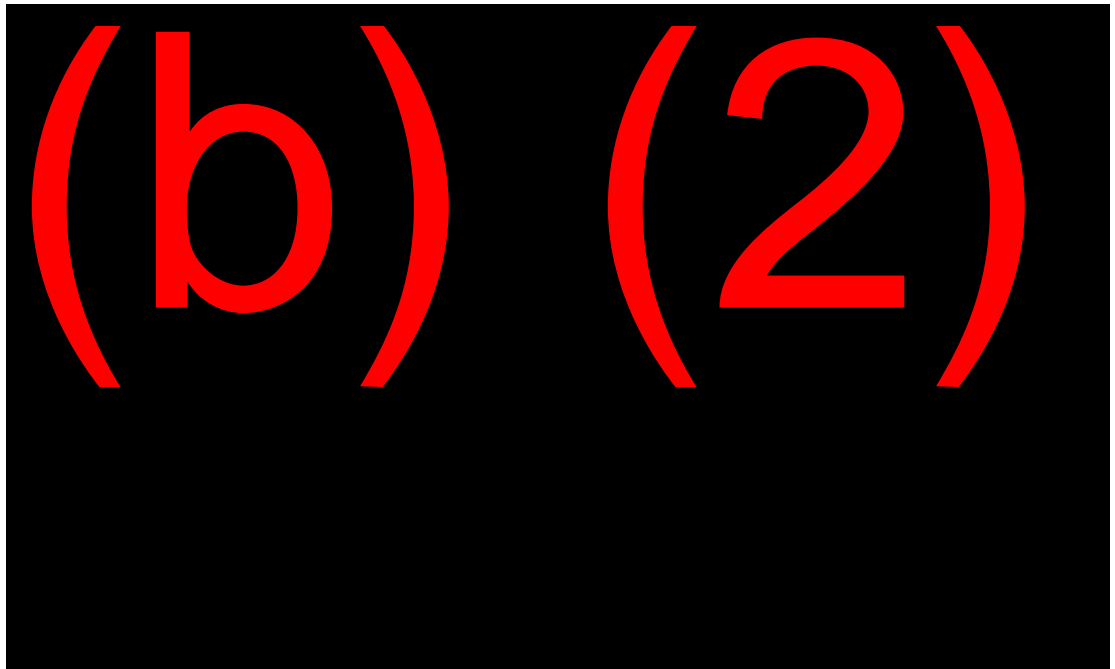
- Enter Y in the NON-MEDICAL COMPLETION field of the DAPP.
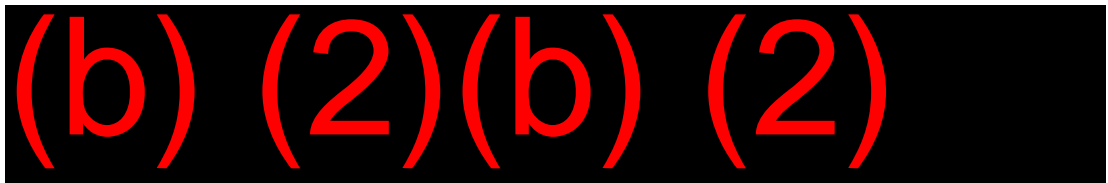
- You are taken back to the MCS system main menu, and in the lower left hand corner, an alert will be displayed that says "NON-MEDICAL COMPLETION PROCESSED" in red.

(b) (2)
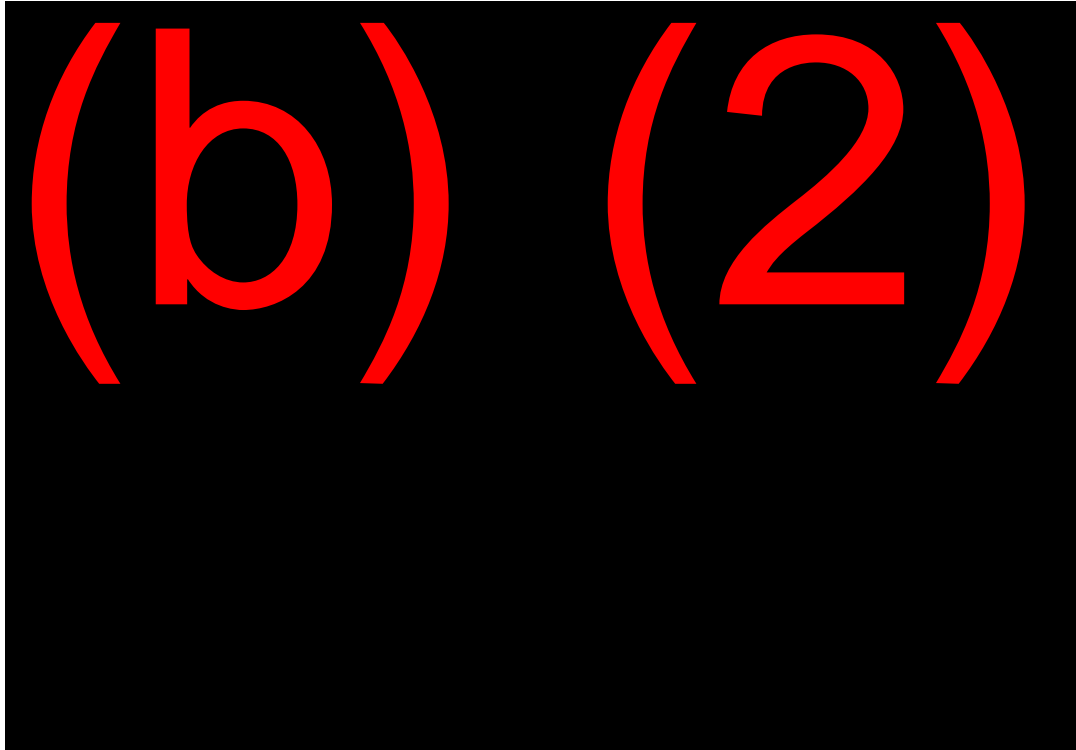
MCS will:

- Lock all screens except the development worksheet screens. This is done to prevent segmentation problems which would occur if auxiliaries were added.

- Await the medical decision input from DDS.

- Update the WMI pending list to show:

  - The date of the input in the NON-MED COMP field; and

  - The code of NM in the "EC" field.

If the medical decision has not been made and you want to update the claim, the adjudicative lock can be removed by:

- Accessing the EC screens by selecting #2 for update and #22 for Earnings Comp Determination.
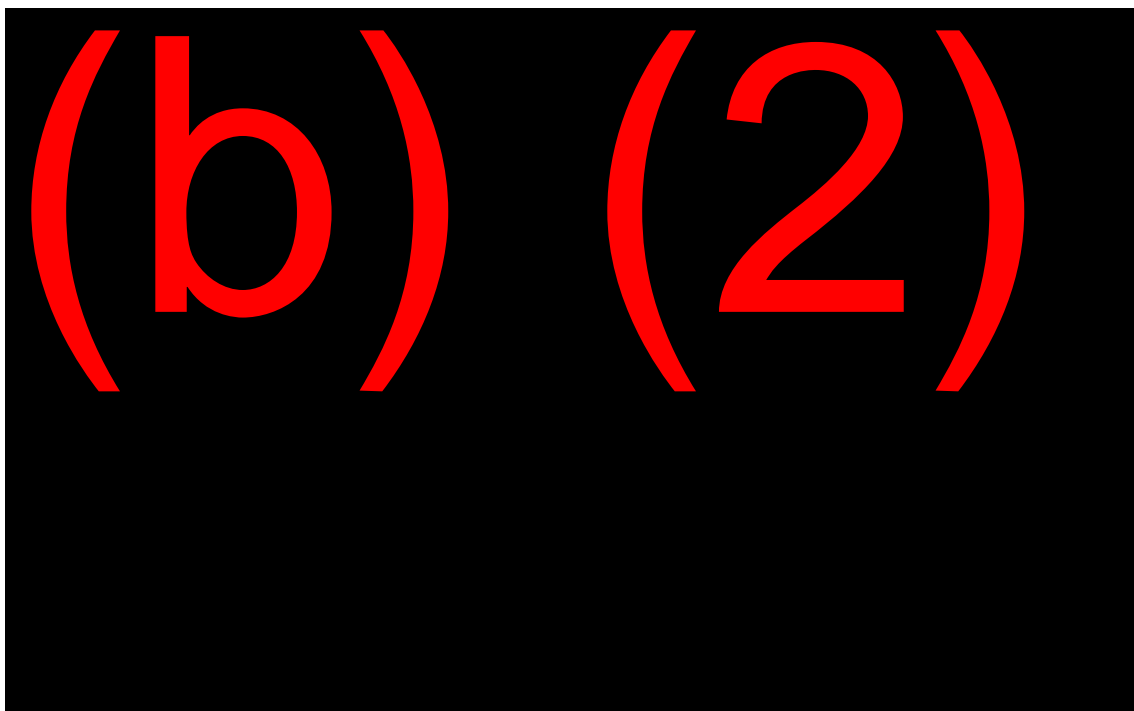
- Enter a "7" to approve the decision on the MCR 1 screen, and press enter.
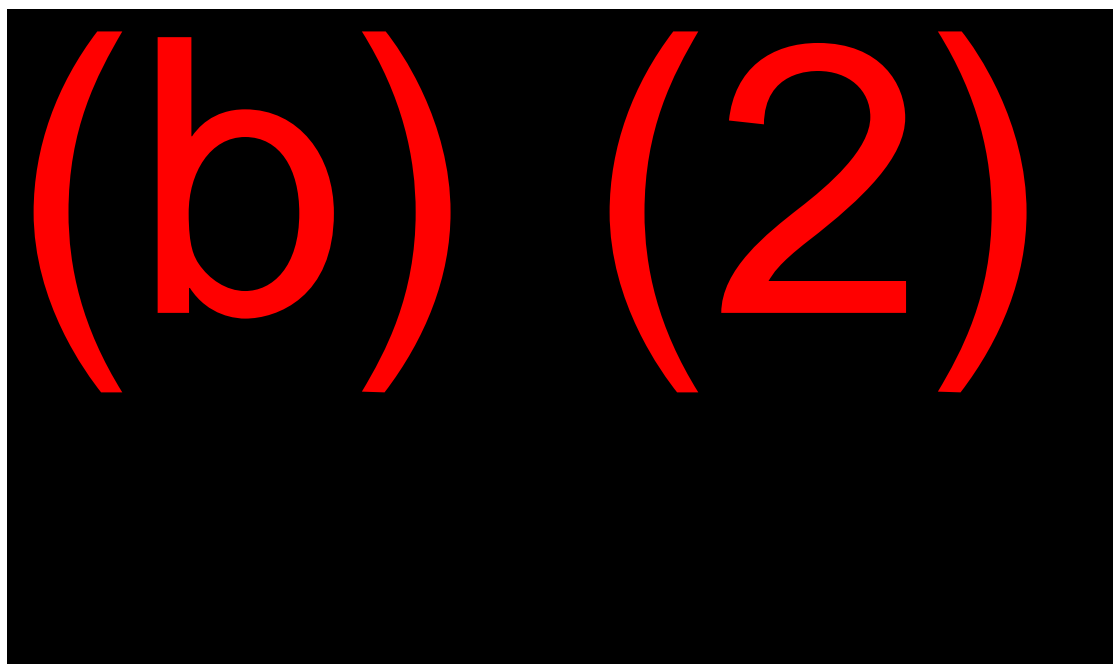
- This brings you back to the DAPP screen where you will enter an "N" this time.

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- This will take you back to the MCS Main Menu, and now the alert on the bottom of the screen reads "NON-MEDICAL COMPLETION REMOVED."

(b) (2)
(b) (2)

- Now you are able to go in and update your claim with the new information.

When the claim has been updated, you may set the non-medical completion again using the instructions shown above for processing a non-medical completion.

DI 11010.115 C&D

Non-Medical Exclusions

There are initial DIB claims which are excluded from using the non-medical completion and must be processed under the normal procedures.

Claims with the following characteristics are excluded from non-medical completion:

- DWB, CDB, and MQGE claims;

- Representative Payee – To assure claimant of due process in selection of payee;

- Non-traumatic onset claims sent to DDS with insured status last met within 1 year of onset—this may result in inappropriate code "090" denial;

- Foreign claims - any case involving a foreign address. Only OIO clears foreign claims using the non-medical completion input;

- Appointed Representative fee claims—month of adjudication is unknown, so this field cannot be coded until the DDS returns the case to the FO;

- SSI Involvement – Cases with SSI offset (Windfall) involvement in which there is outstanding development for proof of age, lag earnings and/or WC which would affect the PIA.

- STAT BLIND - cases where the claimant meets only stat blind insured status. In these cases, the claimant must meet only fully insured status, not 20/40 insured status;

- IRWE Cases sent to DDS for a disability determination when the deduction of IRWE will affect the SGA determination. This was discussed in the SGA lesson. See **DI 10520.020 C.1** for more information.

DDS Input

Once DDS has made the decision to medically allow or deny a claim, the decision is input into their system and it interfaces with MCS.

If the FO has triggered the non-medical completion, and there are no processing exceptions, final award or denial adjudication will take place. If the non-medical completion has not been done at the time of the DDS input, you will need to take action to adjudicate the claim.

DDS can change specific data fields, including date of onset, adjusted blind onset date and capability. After DDS makes a medical decision, a case may be selected for review by the Office of Quality Performance (OQP). OQP has the authority to change a DDS decision and make the final input once their review is completed.

The WMI query system shows if your file was sent to the OQP after the DDS decision was made. You must not adjudicate the claim until OQP has finished their review and transferred the case to your FO.

Systems Indication of Clearances

MS 03508.002; **MS 03703.007**

MCS EC

Once the disability input has been made, the claim will be on the WMI Clearance Listing if NMC was input on the disability claim. If a disability claim appears on this listing, it indicates the case has cleared through the system, notices have been released, and the MBR is set up to reflect the decision.

If an edit occurs when DDS inputs their final decision, MCS EC will alert the FO to these edits. WMI will move the case to the "DDS Review/MCS Exception" portion of the FO Pending list. It is important you recognize these edits on MCS screens, tickle lists and WMI listings so you can correct them.

The DDS edits are:

- <u>DDSRV</u> = DDS Review Conditions –for example: change in onset or capability unresolved. This can occur whether or not non-medical completion was done. Action is necessary by the FO;

- <u>DDS-FL</u> = DDS input resulted in a full processing limitation. DAPP must be completed with "N" to unlock the screens. Process the claim through A101/EF101 as appropriate;

- <u>DDS-PL</u> = DDS input resulted in a partial processing limitation. New EC screens should be displayed with the limitation reason. Correct the condition if possible and trigger the claim through EC.

If it cannot be corrected, process manually through A101/EF101 as appropriate; and

- <u>DDS-EX</u> = DDS input resulted in an exception. New EC screens will be displayed with the limitation reason. Correct the condition if possible and redo the EC request. If unable to correct, process the claim through A101/EF101 as appropriate.

If the EC trigger is not successful, you will need to unlock the claim from the EC process by accessing the DAPP screen and answering "N" to "Non-Medical Completion Y/N". Review the claim, clearance, and EC screens to verify all information is correct, update any necessary information, and then trigger the claim through EC.

OBJECTIVE 3:

Determine the action(s) necessary to manually adjudicate DIB claim allowances.

Manual Adjudication

SM 00380.000; **MS 03514.001**

Most claims, whether allowances or denials, will process through EC. When a case will not process through EC, a manual award must be prepared using the Automated 101 (A101) or, in rare situations, an EF101.

Manual denials are processed through MACADE. MACADE Denial inputs will be discussed in the next objective.

Manual Allowance/A101

A101

MS 03514.001

Take the following steps for allowances which will not process through EC:

- Complete the DECI screen;

- Try an adjudicative EC first – the system will make you do this. This will propagate most information into the A101, saving you time;

- Change the PROC code on the INTE screen to "A". This creates an A101 for the claim;

(b) (2)

- Complete the A101 screens. Review the disability information the system has propagated to the A101 and make any necessary corrections. **MS 03514.001** lists the items which are propagated from the MCS claim;

- Adjudicate the A101 by selecting the Adjudicate option on the M101 and completing the ADJU screen.

(b) (2)

(b) (2)
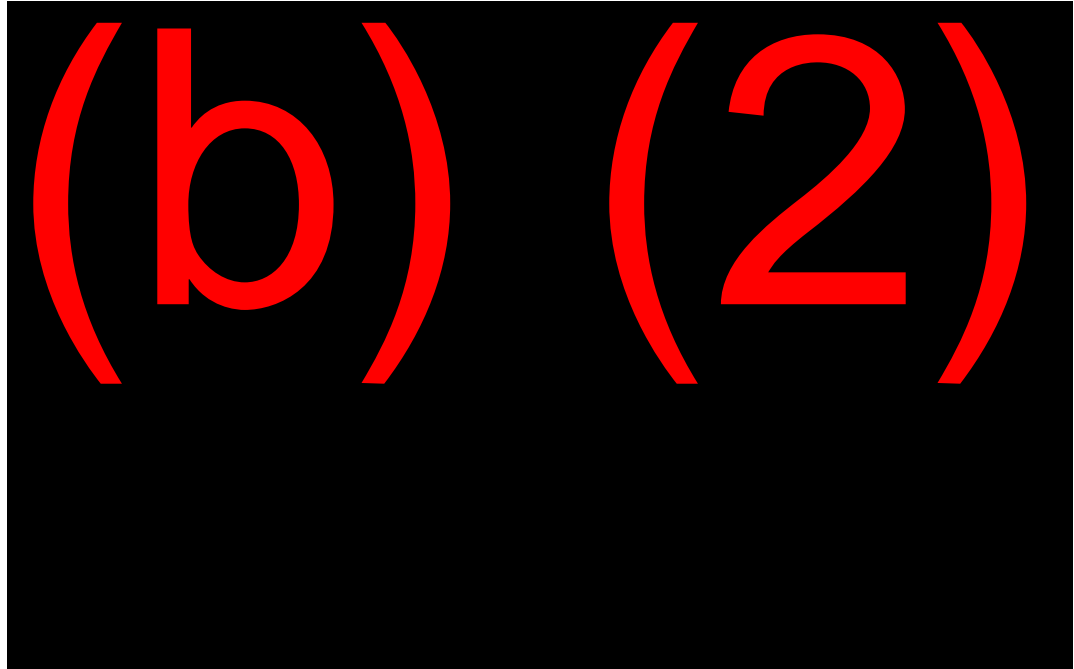
- After you press enter you will return to the M101 screen;

- The next step is to transfer the A101 to the appropriate processing center. Select Transfer on the M101 screen. This brings up the INTE screen where you change the PROC code to "N". Pressing enter locks the MCS screens and transfers jurisdiction of the claim to the payment center for MADCAP processing.

(b) (2)
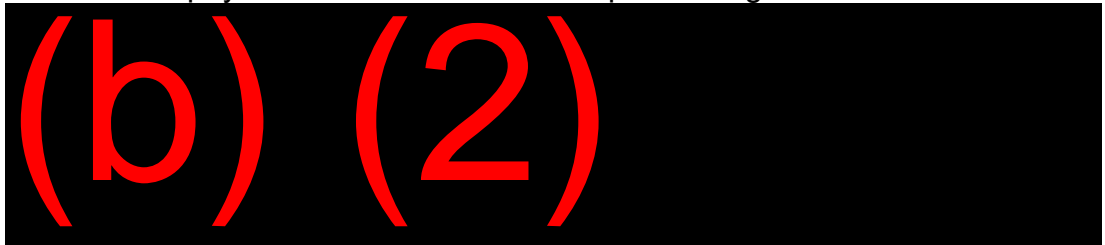
WC/PDB and A101

MCS requires you to run an Adjudicative EC before doing an A101. It also pulls information from EC into the A101. This is useful with WC/PDB offset because EC will do the offset computation and pull the information into the A101. If EC cannot do the computation or if it was done incorrectly, process the ICF #32 input before completing the A101 screens.

On the WC/PDB Offset – ACE Results Data (WRAC) screen in the A101 application path, the question USE RESULTS FROM ICF (Y/N), must be

answered Y. The A101 MBEN screen will be completed without consideration of any offset for WC/PDB. The Y indicated on the ACCT screen will cause the amounts payable after WC/PDB offset to be brought into MACADE for the Benefit Authorizer that will be processing the A101. For subsequent auxiliary awards, the computation should be done in ICF per above and the question WC/PDB OFFSET DATA ON ICF (Y/N) on the A101 ACCT screen must be answered Y.

Find instructions for (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) (b) (2)(b) (2)(b) (2) in the (b) (2)(b) (2)(b) (2) , within the (b) (2) (b) (2)(b) (2)(b) (2) link.

Multiple Periods of Disability

Normally only one period of disability is processed. If the NH is awarded a closed period of disability as well as a new period of disability at the same time, this award is for multiple periods of disability. An initial award with multiple periods of disability cannot be processed by MCS EC. Use special coding on an A101/EF101 so only one award document is necessary. The (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) can help with this process.

EXAMPLE:

Joe is filing for T2 disability with a current onset. When the earnings record is reviewed, you notice a wage gap two years ago. When questioned, Joe states his wife died, and he quit working for 15 months while receiving treatment for severe depression. After treatment, Joe returned to work at the SGA level but had to stop again after 10 months due to depression. In this example, you would develop the closed period of disability along with the current period of disability. If he is approved for both periods of disability, special coding is required on the A101/EF101.

EF 101 Functionality

The Electronic Form 101:

- Processes A101 exclusions;

- Interfaces with Shared processes;

- Is accessed from the Title II PE Menu (T2PE);

- Is made up of screens similar to the A101 screens;

- Has its primary paths determined by claim type and type of action (TOA);

- Connects to the PSCs Paperless system similar to the A101;

- Is stored in ORS.

Most of the screens and fields in the EF101 are comparable to the A101 and the Common Entitlement screens. Instructions for completing the EF101 screens are in **MS 06309.002** or are available using the Help Screens provided.

Amended Awards

When you determine a correction or change is needed in one or more material factors of entitlement, on a previously processed award, you will prepare an EF101. The following are some common situations requiring an EF101 amended award:

- A material change in the NH's DOB resulting in a change in the DOE;

- A material change in the NH's onset date resulting in a change in the DOE;

- To apply the combined maximum provision;

- A material change in the filing date resulting in a change in the DOE.

EXAMPLE:

William Lucas is approved for disability benefits with an onset of 10/05/2016. The claim was processed using a filing date of 11/2018, resulting in a month of entitlement of 11/2017. After the claim is processed you discover Mr. Lucas had a protective filing date of 07/15/18. This means his entitlement date should be 07/2017. An EF101 must be prepared to amend the original award.

Do not prepare an amended award if the following situations:

- To correct errors made by the PC;

- To change the first month of entitlement based on work and earnings;

- To entitle a newly entitled beneficiary that reduces the benefits for a previously entitled beneficiary. Use the A101 instead.

OBJECTIVE 4:

Determine the action(s) necessary to manually adjudicate disallowed and denied DIB claims.

MACADE Disallowance Screens

SM 00380.500ff

The MACADE disallowance screens are accessed by selecting number 10 (MACADE) from the SSA Main Menu. On the MADCAP data entry system menu, select #5 (Disallowance) to access the disallowance screens.

The following screens are available when using MACADE 3428 disallowance. **HELP** (PF1) screens will be available for each. The cursor must be on a specific field on the screen to request a help screen.

Screen Name	Screen ID	POMS Reference
Account Data	ACT	**SM 00380.515**
Name and Address	PNA	**SM 00380.516**
Insured Data	INS	**SM 00380.517**
Benefit Data	BEN	**SM 00380.518**
Child Relationship	CREL	**SM 00380.511**
Beneficiary Marriage	BMAR	**SM 00380.511**
Citizenship	CLCZ	**SM 00380.511**
Lawful Presence	CLLP	**SM 00380.511**
US Citizen	NUSC	**SM 00380.511**
Residency	RES	**SM 00380.521**
Input Screens	IDC	**SM 00380.519**

The MACADE process is entered in batch runs which are done every night. If the FO input does not process, an exception is sent to the servicing payment center. The Field Office is not notified of the exception, but PCACS can be used to determine the exception is pending in the payment center.

Navigating through MACADE

Some important tips when completing MACADE screens:

- Do not use the space bar unless a space is a valid field entry;

- Use the TAB key to move to the next field when the cursor does not automatically move to that field; and

- Unlike the A101, almost nothing is propagated into MACADE; it is a manual process. You must provide it with the required information.

There are several ways to get from screen to screen. The automatic path provides the easiest method for a NH with no MBR. It will take you from a completed screen to the next required screen when you hit enter.

Trans-To Menu

The TRANS screen is a submenu screen which identifies the available screens within Function 5 (Disallowance). The TRANS screen will appear if you enter a question mark (?) or an invalid ID in the TRANS-TO field at the bottom of the ACT screen.

Trans-To Option

You can use TRANS-TO in the option field at the bottom of each screen by putting in the screen name and the BIC to which it applies. To request a specific disallowance screen, type the desired screen identifier (ID) in the TRANS-TO field at the bottom of the screen. If you enter PNA or BEN ID type, you will also need to type the BIC in the PIC/BIC field. Every screen in the MACADE disallowance process includes an OPTION field at the bottom of the screen. Every screen will allow these options:

- **1 IDC** – will transfer you to the IDC screen which will allow you to transmit, hold or cancel a transaction. If you look at the TRANS screen facsimile, you will notice this option is shown in the OPTION field.

- **8 RETURN-TO-MAIN-MENU** – will return you to the MADCAP Data Entry System menu after first querying the IDC screen. This option will only be available in QUERY (Function 7) mode.

MACADE Screens

MBR Not Established

The following screens must be input:

- ACT **SM 00380.515**

- INS **SM 00380.517**

- BEN – For every disallowed beneficiary **SM 00380.518**

- PNA – For every disallowed beneficiary **SM 00380.516**

- EE – Evidence or Shared screens for each beneficiary **SM 00380.511**

- RES – Automatically added to path once BEN is completed **SM 00380.521**

NOTE: For a lump sum only denial action (BIC G) only the ACT, PNA, and the lower portion of the BEN screen need to be input. See **SM 00380.518 C** for the required BEN screen entries.

MBR Established

The following screens must be input:

- ACT – the chart in **SM 00380.515** includes the rules for each data field;

- INS – but only if denial/disallowance is for a NH;

- BEN – for every disallowed beneficiary, but only the fields in the lower portion of the screen (i.e., the BEN DENY data);

- PNA – but only if beneficiary is in LAF T on the MBR.

Access MACADE Denial Screens

Select #10 (MACADE) on the SSA MENU (MAIN).
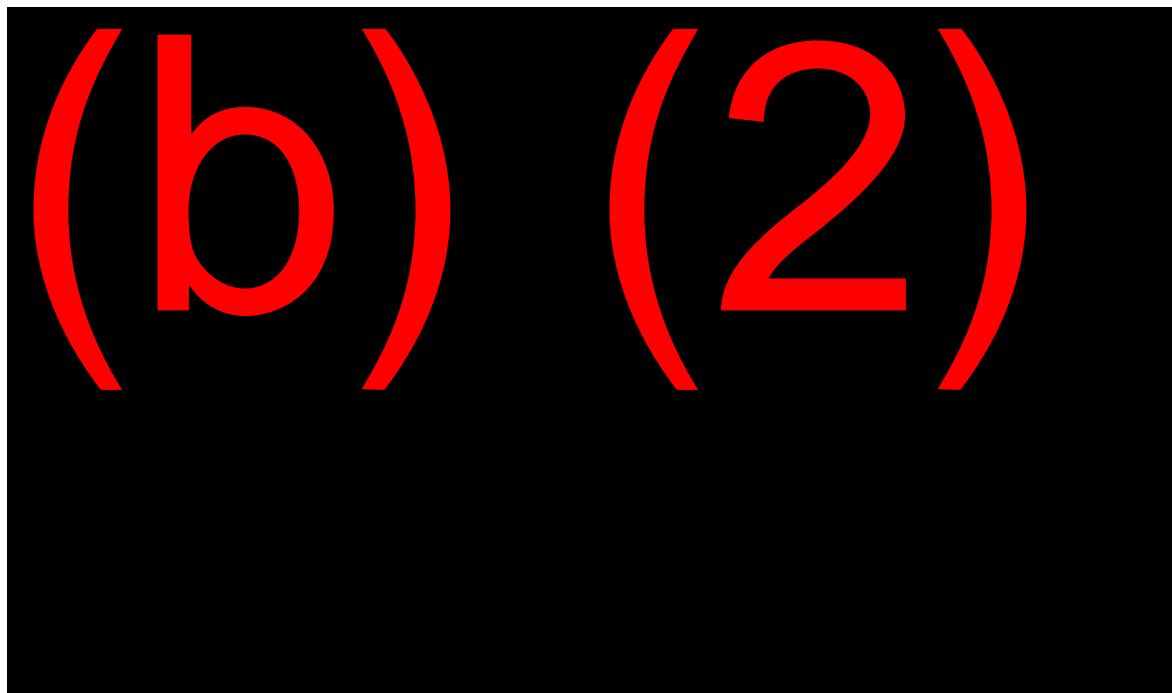
Select #5 on the MAIN (MADCAP Data Entry System) Menu screen. Information correctly updated to the MBR will not have to be entered in MACADE.
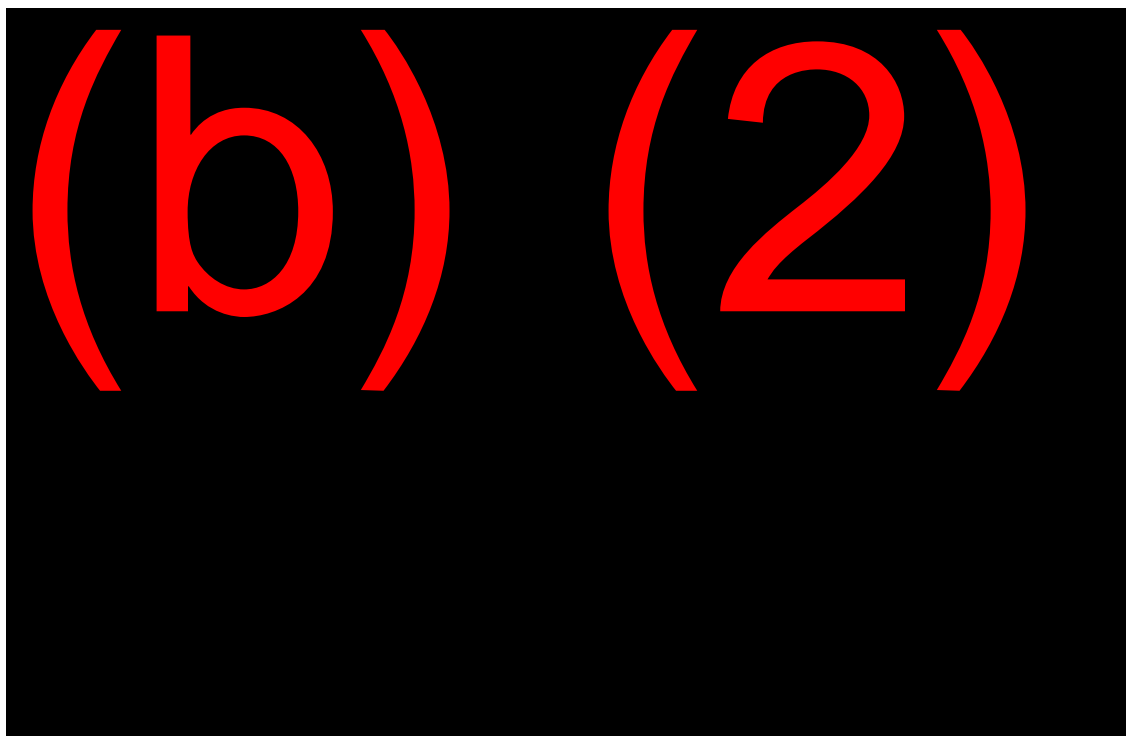
ACT

[SM 00380.515](#)

The ACT screen is the first disallowance screen and completion is mandatory. Completing the ACT screen builds the initial screen path. This screen establishes jurisdictional data and BIC.

Entries will always be required in:

- TYPE OF CLAIM;

- PROCESSING CENTER WITH JURISDICTION; and

- BIC fields. If the beneficiary is already on the MBR under a different BIC (Beneficiary Identification Code), enter the MBR BIC.

  EXAMPLE: A B2 on the MBR in LAF T4 status later files as a BIC W; enter B2 in the BIC field.

If there is an MBR and the beneficiary is already on the MBR, these fields will be all you need to complete. You will receive edits if you complete any other fields.

If <u>no</u> MBR exists, you must input the NH's first, middle and last name, date of birth and if deceased, the date of death. You have to provide the basic information required to establish an MBR.
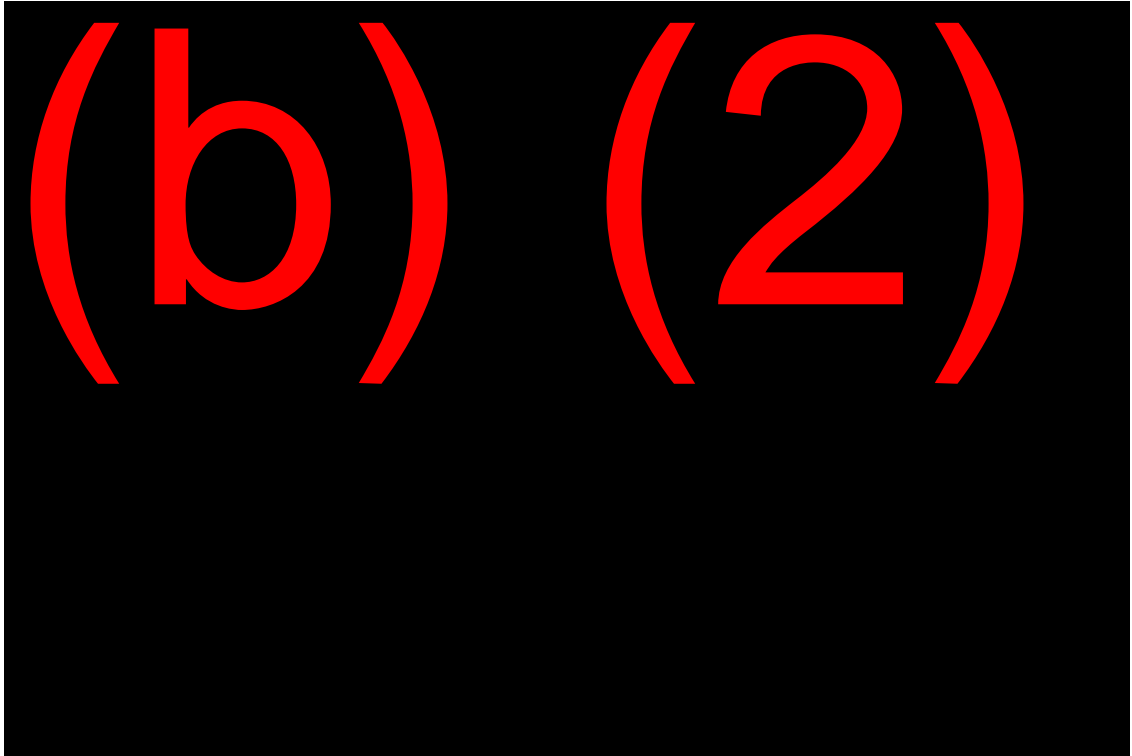
Insured Data (INS) Screen

SM 00380.517

The INS screen will be used to establish insured status for the number holder (NH). Insured status data will not propagate into MACADE so data must be entered on this screen. Insured status data may be available from MCS EC or an ICER.

This screen will be automatically generated if the MBR is NIF (Not in file), all beneficiaries on the MBR are in LAF N/ND or MBR is established and a disallowance/denial for the NH is entered with a level of denial (LOD) 1. The minimum entries are:

- Claim Type and

- Date of Filing.

The INS screen can be manually added to the MACADE action by accessing it from the TRANS-TO menu or by entering INS in the TRANS-TO field at the bottom of any screen.
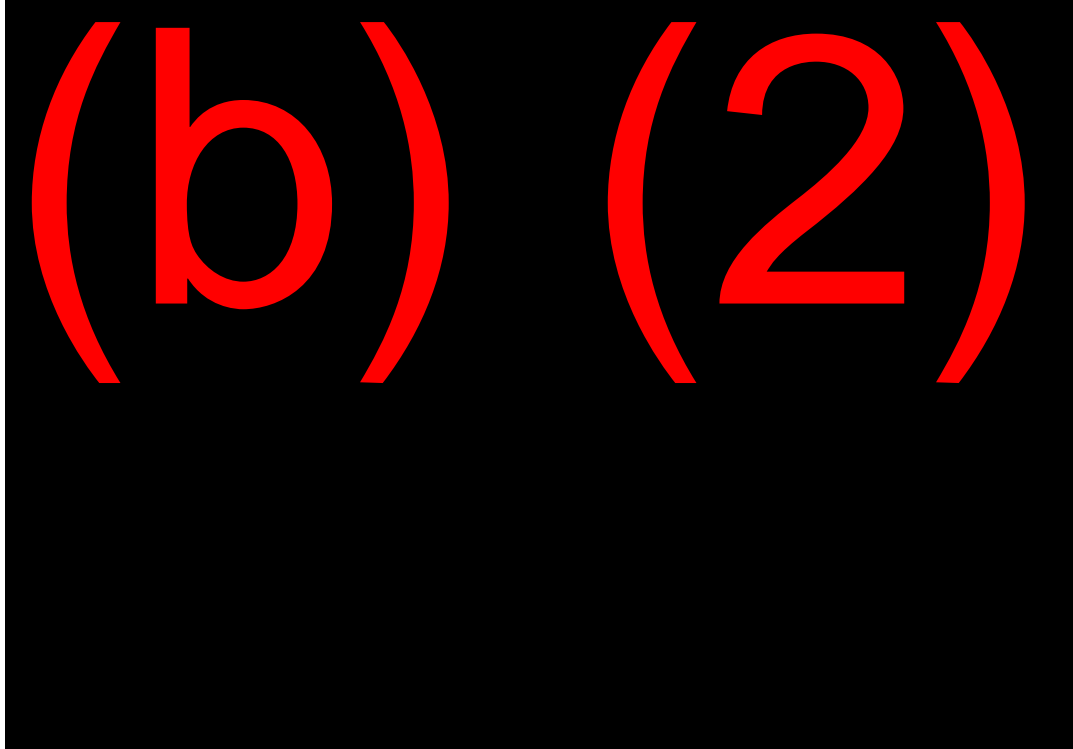
Benefit Data (BEN) Screen

SM 00380.518

The BEN screen is used to establish beneficiary data and denial data on the MBR. If the claimant has already been established on the MBR (other than BIC G), the BIC on the MBR should be used on each screen request. Only limited information and screens will be accepted since there is already a BEN field on the MBR.

Mandatory entries on every disallowance are designated with an asterisk (*) in front of the field name:

- *DATE OF FILING;

- *INPUT BIC FOR CURRENT CLAIM;

- *DISALLOWANCE/DENIAL REASON;

- *LEVEL OF DENIAL.

Disallowance codes are listed in **SM 00380.030**, **SM 00380.090** (in priority order), and **SM 00380.100** (disability denial codes). See **SM 00380.509** for rules involving a higher level of denial.
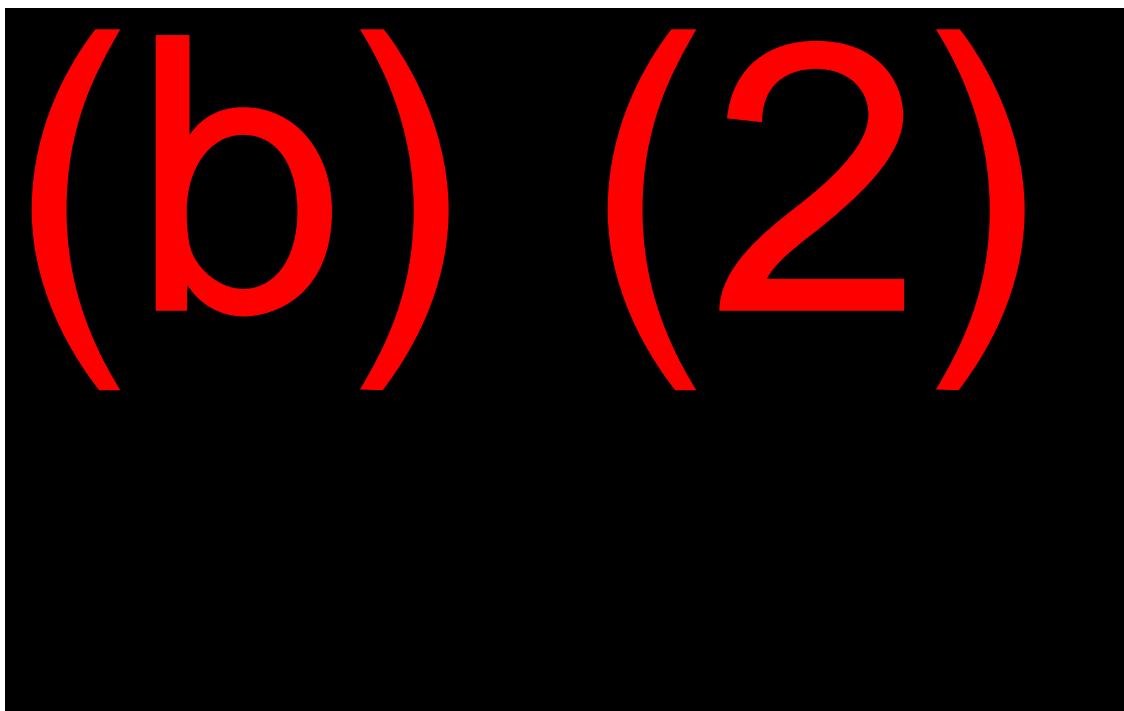
Name and Address (PNA) Screen

SM 00380.516

The PNA screen is required IF the denied beneficiary is NIF on the MBR, or the LAF code on the MBR is N, ND, or T.

NOTE: This screen cannot be viewed or even completed if the beneficiary is currently on the MBR in a LAF other than N, ND, or T.

MACADE will interface with the Representative Payee System (RPS) when you request the PNA screen after entering the beneficiary's own SSN on the BEN (Benefit Data) screen. If data exists on RPS, the payment legend will propagate to the PNA screen. If necessary, you will be able to change (over-key) this information.

Common Entitlement and Eligibility (EE) Screens

The following common EE screens if previously completed will be internally passed to MADCAP from T2 Shared:

- CREL Screen **MS 00705.012**;

- BMAR Screen **MS 00705.007**;

- CLCZ Screen **MS 00705.010**;

- CLLP Screen **MS 00705.011**;

- NUSC Screen **MS 00705.026**.

You will be able to view or update these screens by making your selection from the TRANS menu screen. Only common screens with proven data should be transmitted to the MBR. If you do not have proof, do not request these screens in MACADE.

Residency (RES) Screen

The RES screen is accessed by selecting function 10 on the TRANS menu screen. The data on this screen propagates to MACADE from Client and cannot be over keyed. This screen documents the claimant's U.S. residency START date and STOP date.

Disallowance Input (IDC) Screen

SM 00380.519; **SM 00380.505**

The IDC screen is used to transmit, cancel or hold the transaction. It displays every screen entered for each BIC, and the screens should be reviewed before you transmit your action. Option codes for transmission are at the bottom of the screen:

- **5 TRANS-SSN** – (on IDC screen only) will send action to MADCAP; if interscreen edit exceptions are detected, this option will generate the EDT (Edit) screen with edit exception messages.

- **6 CANCEL-SSN** – (on IDC screen only) will cancel (delete) <u>all</u> screens entered for the SSN. If this option is selected, the VERI

(Verification of Cancel) screen will appear which will allow you to change your mind before data is cancelled.

- **7 HOLD-SSN** – (on IDC screen only) will allow you to hold a transaction for later completion. The data will be saved and the pending file will be updated with a HOLD status for the SSN. Transactions are held for only three workdays. The transaction will be dropped unless the action is completed or held again.
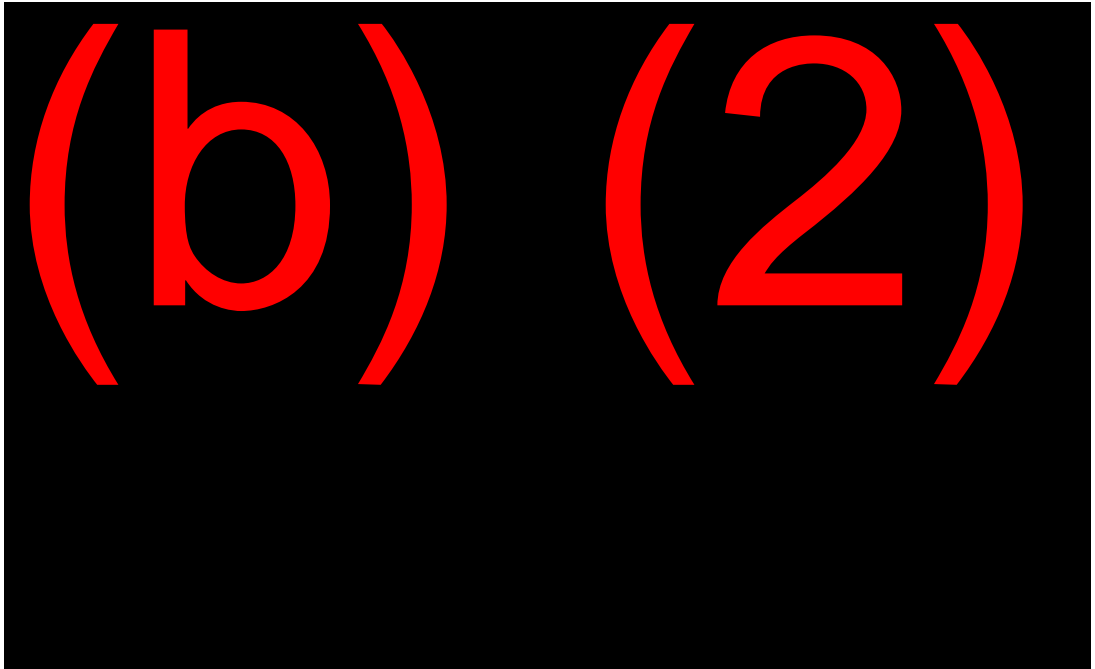

Once an action is on hold you will need to access the input using the SSN and 6=UPDATE on the Main MACADE MENU. This will take you to the IDC screen to begin your update of the denial. When you have completed your update transmit the input by selecting 5=TRANSMIT.

NOTE: If you PF3 out of a MACADE screen your completed screens will be placed on HOLD and not transmitted to the PSC. To transmit an action on HOLD you must go back into MACADE under update, complete any missing data and transmit by selecting 5 in the option field and enter.

Check the Status of Your Final Input

After selecting #10 MACADE from the SSA Main Menu, you will be on the MADCAP DATA ENTRY SYSTEM MENU. On this page, enter the SSN and "7" for Query. This brings up the IDC screen. In the upper-right corner of the screen are the words "**LAST-ACTION**" as well as the status of your input.
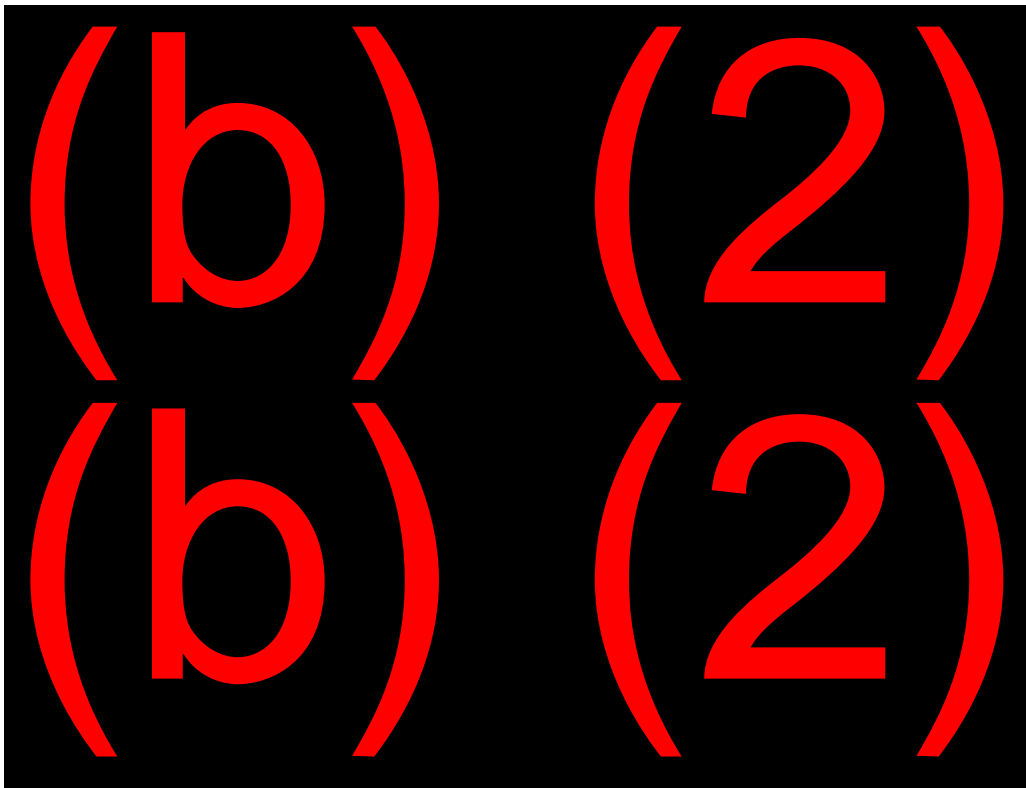
If the MACADE action rejects, a MADCAP input is required by the PC to complete the processing of the disallowance/denial.

MADCAP actions originating from a source other than the payment center are not controlled on PCACS. A MACADE Status Report is used to control this exception. If the exception is not worked within 14 to 15 business days, it will drop from MACADE. FO technicians who input disallowances/denials through MACADE should monitor their inputs closely.

Take the following steps to insure your MACADE input takes:

1. Input the disallowance/denial via MACADE;

2. The following business day, query the MBR:

    a) Is the disallowance/denial information posted correctly? If yes, STOP.

    b) If No, go to Step 3.

3. Query the IDC screen in MACADE ("7" on Menu);

    ▪ If the action is shown as **HOLD**, you must return to the MACADE menu and complete the processing of your action;

    ▪ If the action is shown as **EXC**, go to Step 4.

4. Send an MDW to the PC of jurisdiction informing the BA the MACADE action rejected and PC action is required. On the MDW, include the necessary disallowance/denial information. Tickle the issue for 30 days then follow normal follow-up procedures.

MCS Workflow

MANCLR the claim to your own field office. **Do not access the INTE screen**, and **do not enter "N" PROC Code**.

Use the (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) found in the (b) (2)(b) (2)(b) (2) (b) (2)(b) (2) on the (b) (2)(b) (2)(b) (2)(b) (2)

OBJECTIVE 5:

Determine the proper processing of an SGA denial.

Work Issue Raised

DI 11010.190

The FO has final responsibility in Title II, Title XVI, and concurrent Title II/Title XVI cases involving work issues when SGA is the only issue. When an individual works after an alleged or established disability onset, a work activity report must be completed. If the NH meets the requirements for a "clearly not SGA" determination as defined in **DI 10505.003**, a work activity report may not be needed. If the FO determines the work is SGA, a formal determination and notice of denial must be prepared.

You are responsible for all the necessary development in initial SGA claims. This includes:

- Obtaining all the necessary information in a disability claim and completing all the necessary forms, such as the application, the SSA-820 and/or SSA-821, requesting information from the employer or business records, etc.;

- Determining whether work is SGA and documenting the decision on the SSA-823;

- Ascertaining the proper notice to send and using the Document Processing System (DPS) to prepare it;

- Completing the SSA-831;

- Making appropriate systems inputs through EC to clear claim; and

- Releasing the denial notice to the NH.

Completion of the SSA-831

DI 11010.205

The 831 is the form used to process the SGA denial of a disability claim. The FO is responsible for fully preparing the SSA-831 in SGA denial cases.

NOTE: In concurrent claims, one SSA-831 is prepared for the Title II claim and one is made for the Title XVI claim.

EDCS should be used to process all SGA denials. This saves time and creates an electronic record. If a paper SSA-831 must be completed, follow instructions in **DI 11010.205**.

EDCS and SGA Denials

DI 81010.140

Once your disability claim is loaded into MCS/MSSICS, access EDCS to process the SGA denial. You do not have to complete the entire 3368 in order to process the SGA denial through EDCS. From the "3368 About You" screen (as shown below), select from the upper tool bar, "Claims Action."

(b) (2)

(b) (2)
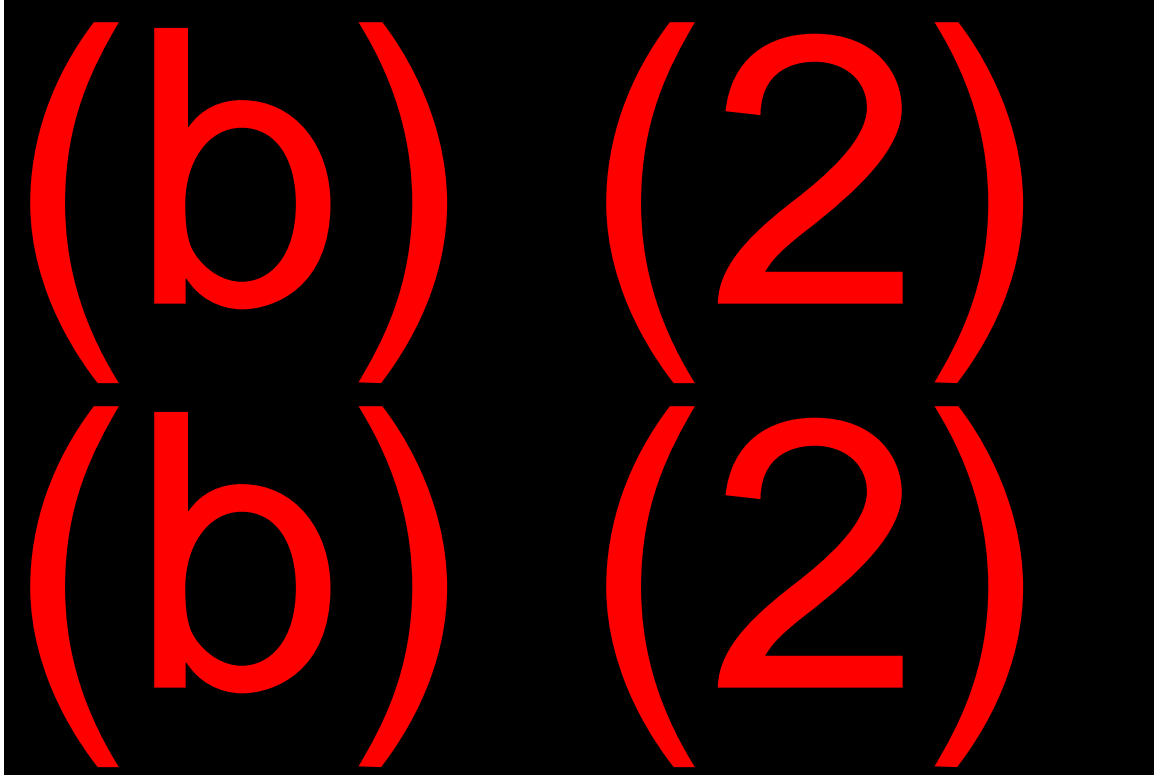
On the "Claims Actions" screen, select the claim for processing and click on the "Add FO Determination" button.

(b) (2)
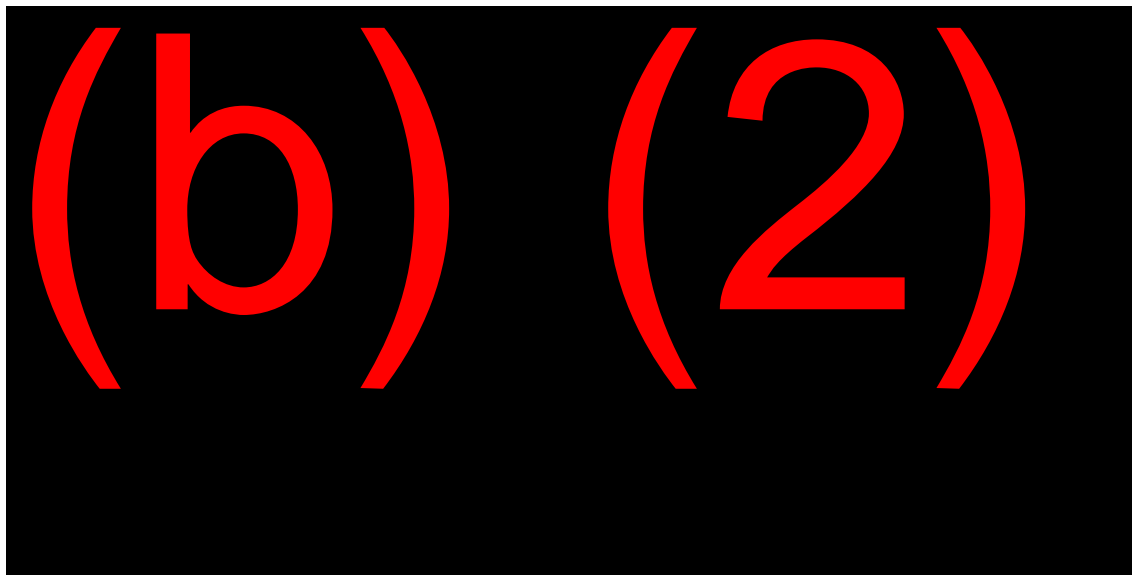
The Select Determination Type screen is present as shown below. Select the SGA Denial radio button. If this were a concurrent SGA decision, another box would appear and you would select the Concurrent Decision box.
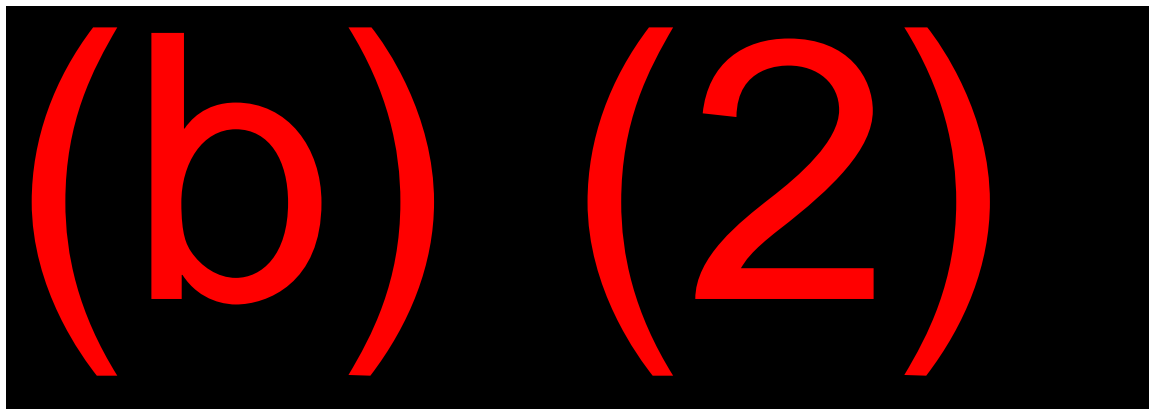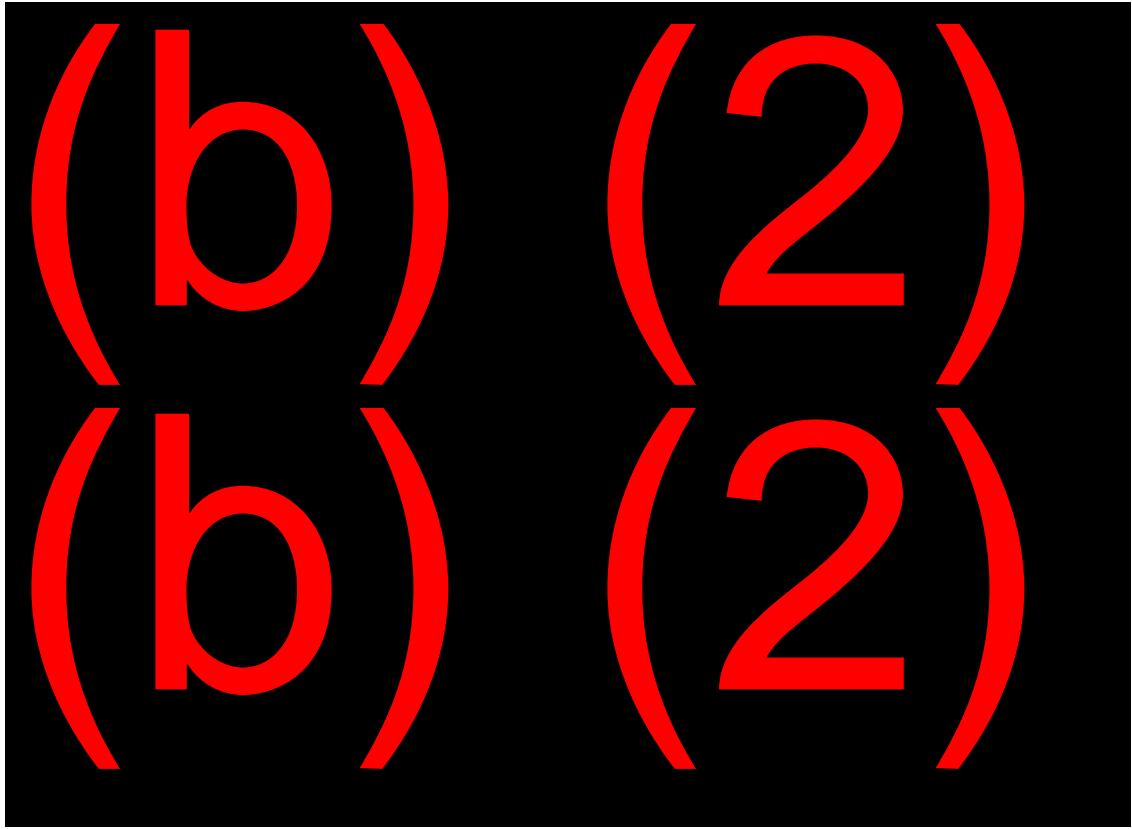
On the "FO SGA Denial" screen, use the radio buttons to select the correct "Reg Basis Code" for the corresponding claim type.

- N1 – DIB/DWB with DLI in future and all CDB claims.

- N2 – DIB/DWB with DLI in the past.

- N33 – For all initial SSI claims denied for SGA.

In the "Prior Action" section of this screen, select:

- Previously denied if the claimant had a prior SGA denial.

- Previously terminated if the claimant was previously entitled to the same type of benefit and such entitlement was terminated.

When you scroll down on the FO SGA Denial screen, the next section covers work and education:
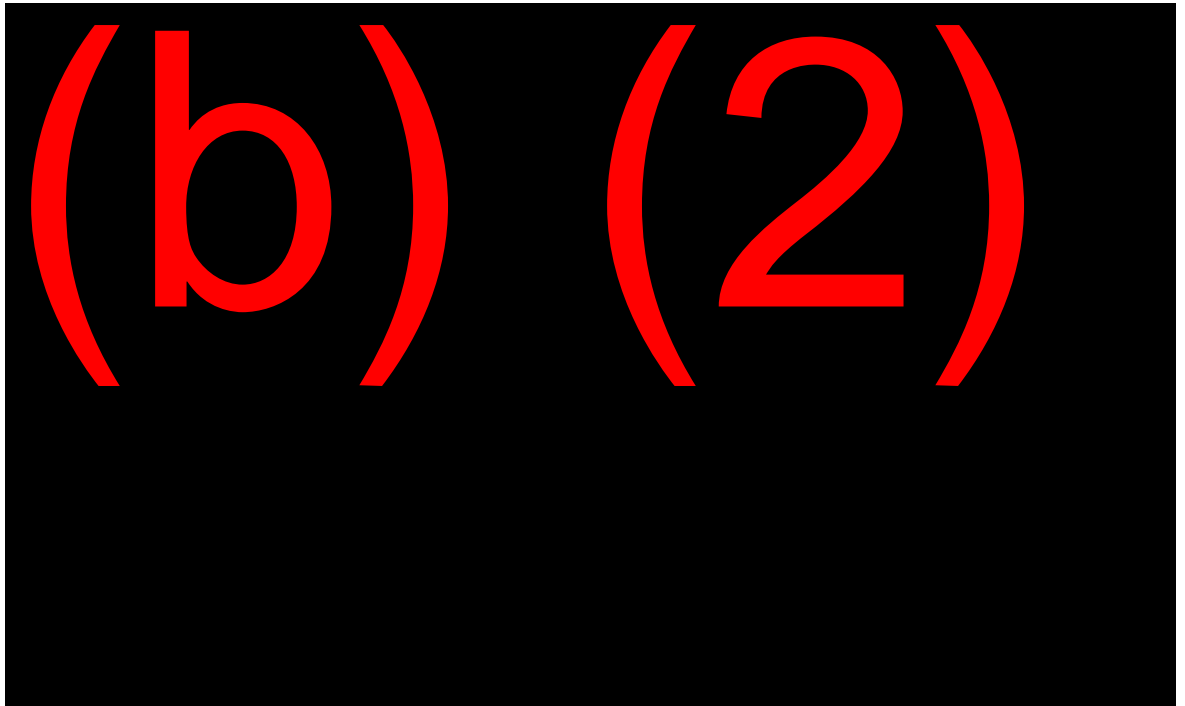
Use the drop down boxes to select the job type most closely relating to the claimant's job in which they are performing SGA. List the number of years the claimant has worked in this job in the Occupational Years field. In the Education Years field, list the highest school grade attained. For example, 12 years if they finished high school, 16 years if they finished 4 years of college.

The bottom part of the FO Denial screen gathers rationale, remarks, and type of filing information as shown below:

(b) (2)
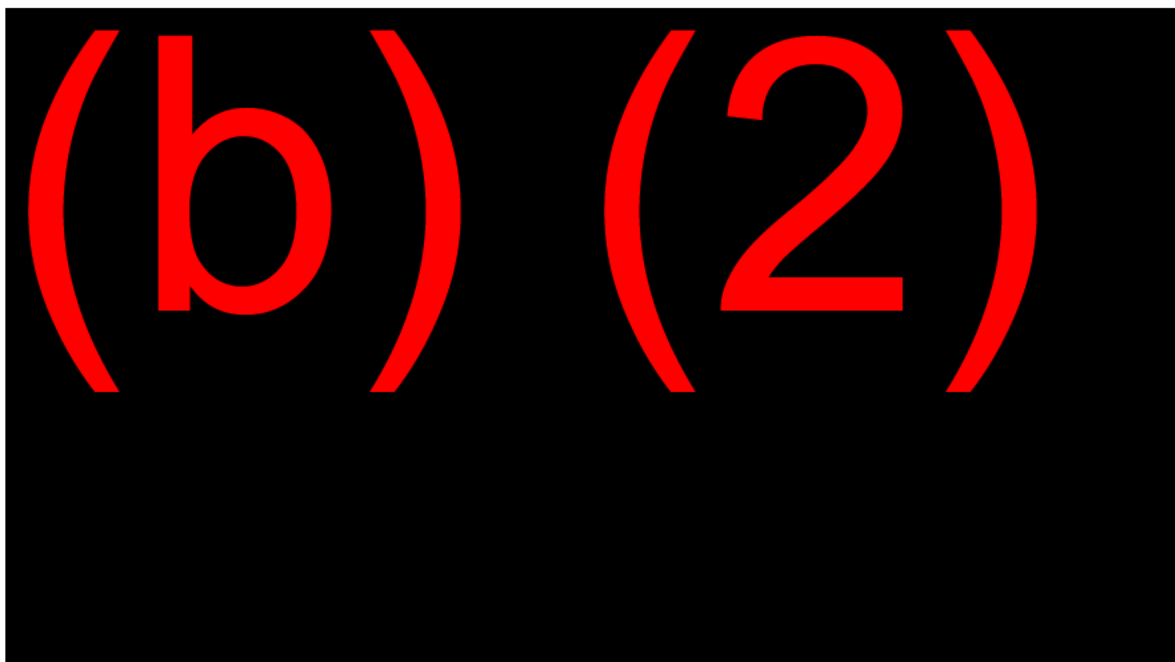
The Rationale field must contain the following elements:

- A list of the reports evaluated;

- A brief description of the findings to support the determination of the SGA denial and the conclusion that the claimant is not disabled because he/she is engaging is SGA;

- An explanation which includes the period of work evaluated, the employer's name, claimant's job title and a brief description of job duties, hourly rate of pay and average monthly earnings as well as the number of hours worked per week, a statement concerning subsidy, impairment work-related expenses or absence of same; and

- A statement regarding the SGA determination including a definition of SGA.

NOTE: If the notice sent to the claimant includes the rationale as outlined above, you can type in the Rationale field of the 831: "See Separate Notices and Determination."

The Remarks section is used to enter the name and address of any attorney or other designated party. **DI 11010.205 F**

Select the appropriate radio button indicating whether the disability folder created will be electronic or paper.

The adjudicator's name, telephone number, and the current date are propagated. Select OK to continue. If the claims specialist selects cancel, data input on the screen is lost.
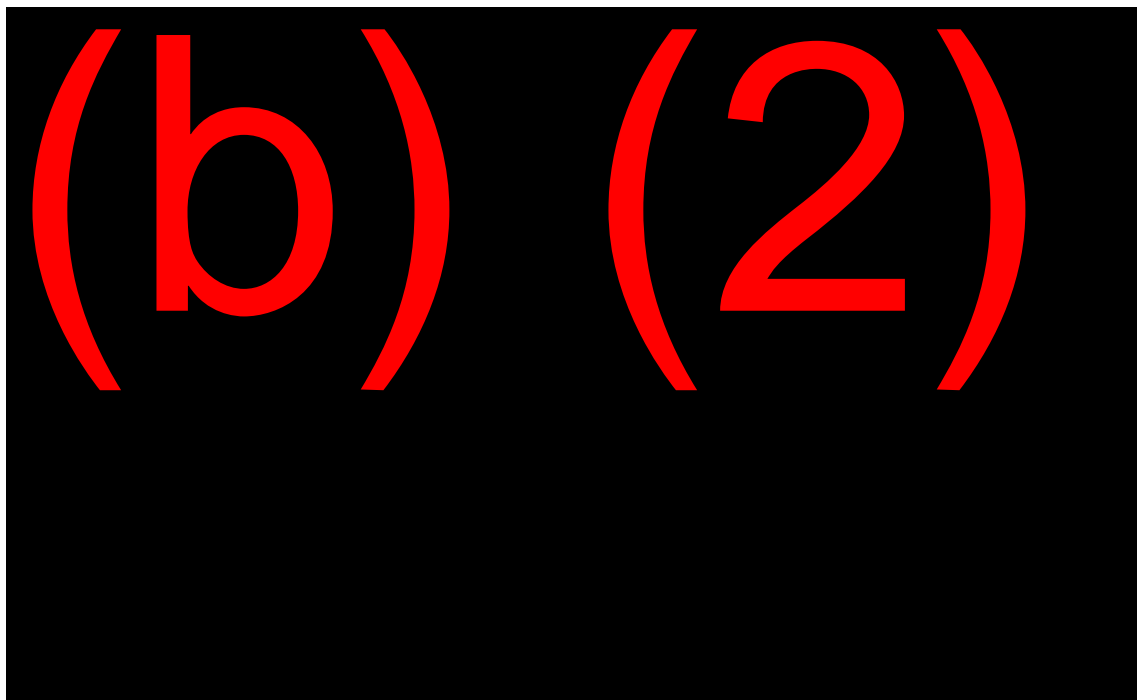
A pop-up box appears (as shown below) when you hit OK that states:

"The determination will be signed and all determination fields will be disabled when you click OK. Are you sure you want to close the claim(s)?"
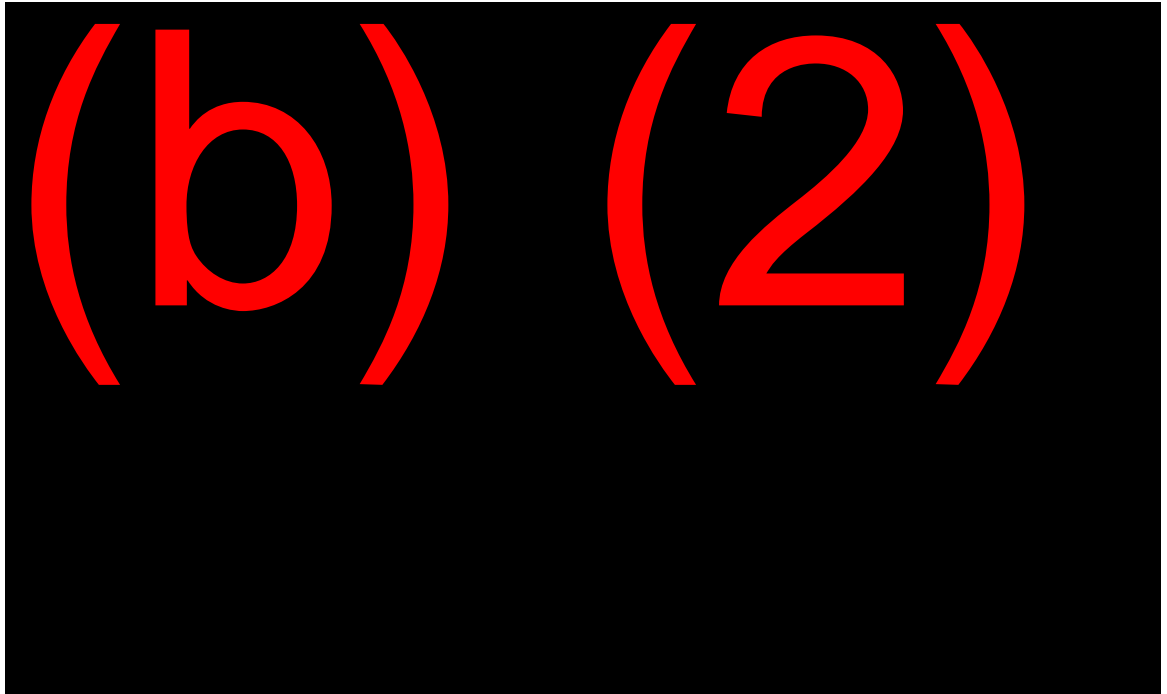
Click "OK" to continue with the processing.

The final screen is the Claims Actions screen which indicates Field Office Denial as shown below in this screen shot:

You can view/print your 831 using eView. On the eView screen, navigate to the Case Documents tab. Click on Section A (Payment Documents/ Decisions). Select the 'Disability Determination Transmittal (831).' Once the document opens, you can view/print the SSA-831.

EDCS/SGA Guides

EDCS and SGA denial desk guides can be found by searching FORCE – Notebook – and typing "N1" in the subject. You will get several items; select "N1 SGA DIB Denials - KC Net". This will bring you to the (b) (2) (b) (2)(b) (2)(b) (2) . The first link shown on this workflow, SGA Denial in EDCS workflow, is a link to the EDCS workflow. **DI 81010.140**

Title II Notices

DI 11010.345
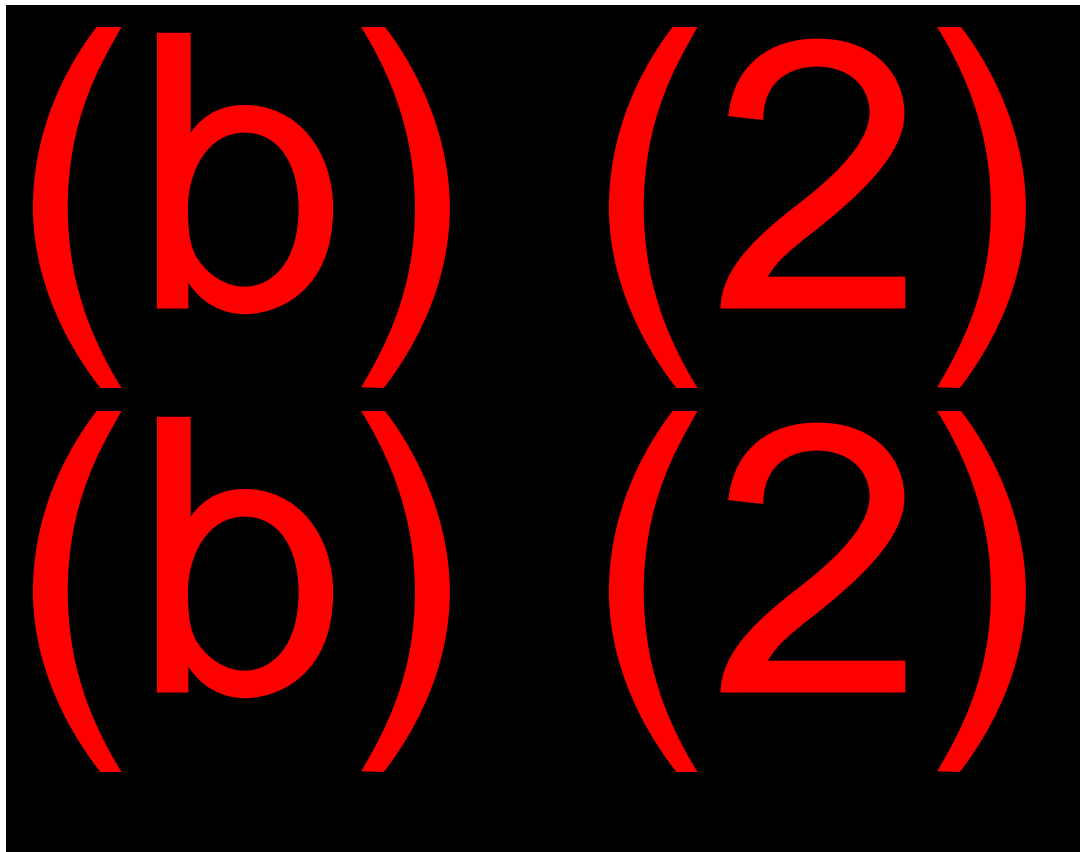
SGA Denial Notice

If the claim is a SGA denial, the FO must notify the claimant by sending:

1. A personalized, pre-printed notice and

2. A personalized attachment Explanation of Determination (i.e. our rationale).

Personalized Notices

A personalized notice is required in all unfavorable or partially unfavorable determinations. The FO prepares a standard notice with an attachment containing required personalized information in every initial and reconsideration Title II SGA denial.

The notice is prepared and released by the FO. It is available in DPS (under Initial Claims – see screen shot below) and requires a fill-in for the date last insured and a page to include the personalized explanation.

(b) (2)
(b) (2)

In concurrent initial and reconsideration Title II/Title XVI SGA denials, DIB/DWB, and DIB/CDB SGA denials, it will be necessary to prepare a separate notice and personalized attachment for each claim.

Personalized Explanation

The personalized explanation contains the same data as the rationale. An explanation of the basis of our decision must also be included. Elements which must be in the explanation of determination include the employer's name, the claimant's job title, a description of job duties, rate of pay (per hour and month), and number of hours worked.

Additionally, it must also include:

- a list of reports evaluated;

- a brief description of findings to support a SGA denial;

- a conclusion that the NH is not disabled because he or she is engaging in SGA;

- an explanation including the period of work evaluated;

- a statement concerning subsidy, IRWE, or the absence of those; and

- a statement regarding the SGA determination including the definition of SGA.

Refer to **DI 11010.345 C.2.b** for an example.

Closeout Paragraph

In Title II cases, initial denials must also include a closeout paragraph.

Title II Systems Input

EC Process

DW01 Screen – On the DDSDEC issue, do not enter a date in the REQ field. Enter the date in the REC field. In Remarks, type HOLD. Create another issue FO DET. In the REC field, enter the date you trigger the claim and in Remarks, put the denial code used (N1/N2).

BECF Screen – Code 0N1 in the Disallowance Reason field (0N2 if the DLI has passed).

NOT3 Screen – Suppress the system-generated notice, since a personalized notice is sent.

DECI Screen – DEC STAT—SGA denials are considered technical denials, not medical denials, and should be coded 03.

Trigger (adjudicate) the claim through the EC screens.

Manual Process

Complete the DW01, DECI, and BECF screens as above. Prepare and release a personalized notice to the claimant.

Transmit the MACADE Denial.

Manually clear (MANCLR) the claim from MCS.

Summary of Process

Processing a SGA denial involves:

- Obtaining the SSA-820 and/or SSA-821 and necessary documentation to make a determination;

- Making the SGA determination;

- Preparation of the SSA-831;

- Preparation and release of personalized notice(s);

- Processing the claim through MCS EC.

OBJECTIVE 6:

Determine the proper action to be taken in the processing of concurrent RIB/DIB claims.

Concurrent RIB/DIB claims

DI 11010.300

Sometimes a NH will file for both RIB and DIB at the same time. Normally you will adjudicate the RIB claim first. The process for adjudicating the RIB claim is basically the same as if no DIB claim had been filed concurrently.

- Complete the Optional Clearance screens, including the NOT3 with notice CLOR06 (see **NL 00725.160** for information on the required fill-ins).

- Complete the DECI with a decision STAT code for the RIB. Do not complete the DIB line.

- Request an adjudicative EC to clear the RIB. On the MREQ, show Y for Adjudicative Request and a Y for Process All Claimants.

- On DAPP, show Y for Permit Claim Payment.

After entry, you will be returned to the main menu with the message FINAL TRIGGER SUCCESSFUL.

When the RIB claim is triggered, MCS segments the claims. This means the DIB claim and the RIB claim will each have their application screens, development screens, clearance screens, EC screens and decision screen.

Go to the DW01 on each claim and enter XXXXXX in the receipt dates of any issues that apply only to the other claim.

EXAMPLE:

A RIB/DIB claim is taken and the DW01 issues include DIB, RIB, AGE, and DDSDEC. The RIB is awarded, the DIB placed in its own segment as a pending claim, and each segment has a DW01. Both DW01s show all issues. AGE has a date in the REC field since it was received and DDSDEC is still outstanding. On the RIB claim, type 6 Xs in the REC field for the DDSDEC issue.

References and Guides

See **Exhibit 1**, Concurrent RIB-DIB Claim Processing.

See the Off-Air Activities for more information on guides available through the (b) (2)(b) (2)(b) (2)(b) (2)

OBJECTIVE 7:

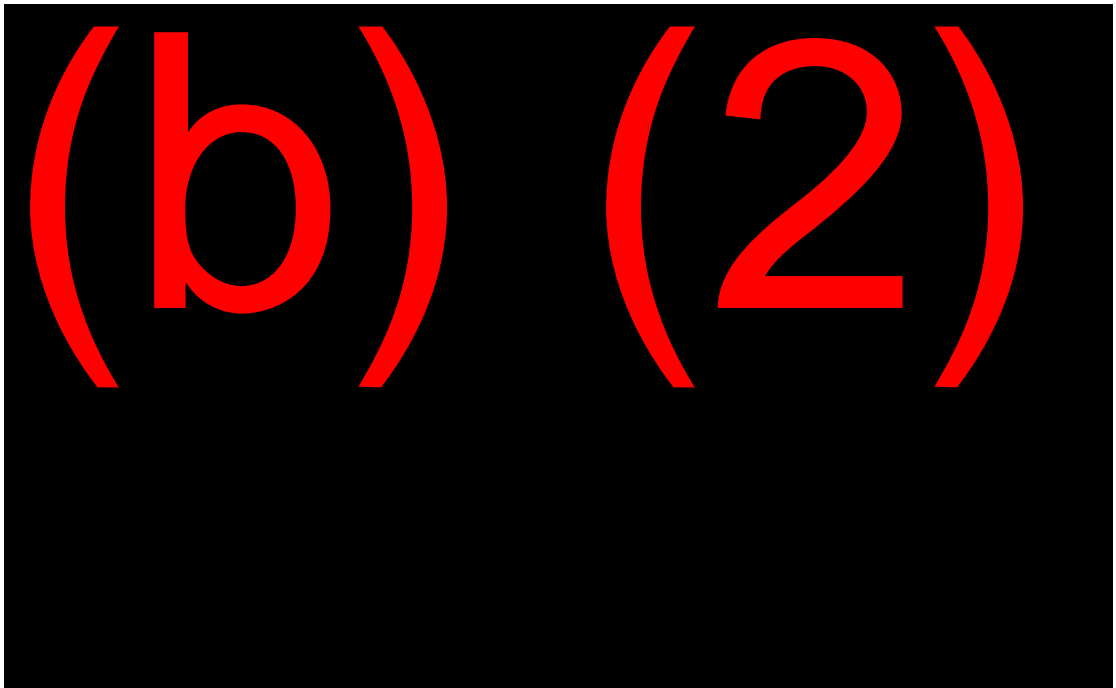## Obtain and interpret DDSQ, eView, and PCACS queries

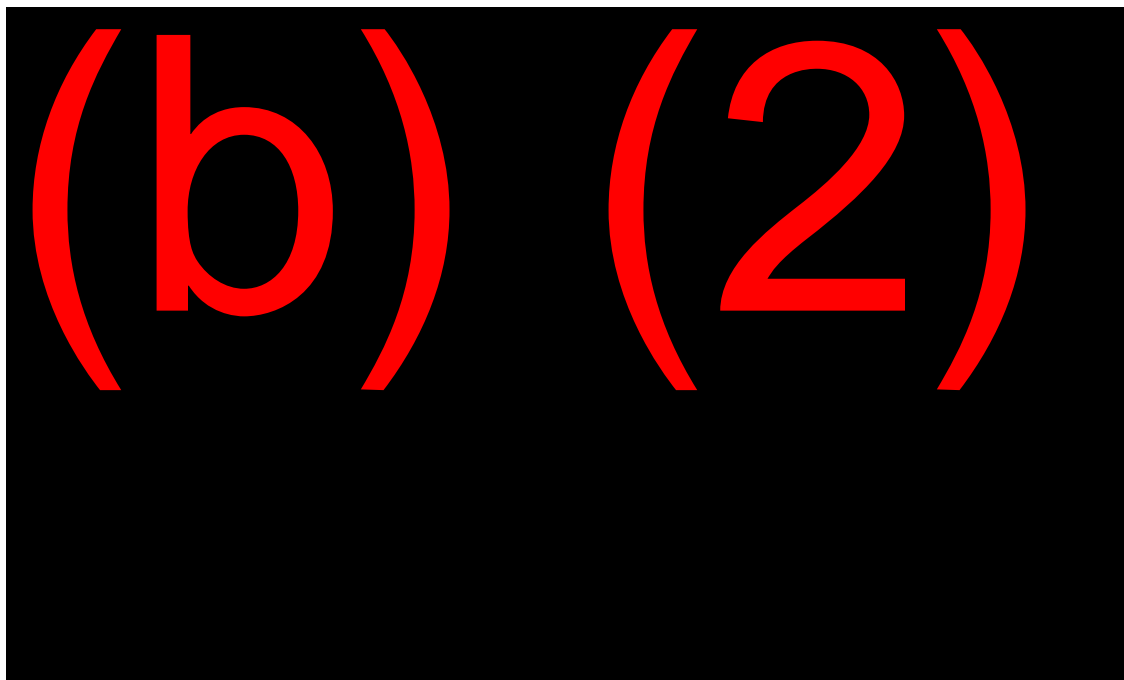| DDS Query (DDSQ) |
|:---:|

SM 06002.000ff

DDSQ

The DDSQ is used by Field Office staff to determine the status of pending claims sent to DDS.

To obtain the query, select #18 – NDDSS Master File Menu (DDSM) from the SSA Main menu.

(b) (2)

On the DDSM, select #1 DDSQ and complete the fields at the bottom of the screen as instructed. Enter "C" in the RS field to return the query to the screen.

(b) (2)

The query response provides information about the status of the claim, the counselor the case was assigned to in the DDS, the decision, if made, and other details about the claim.

This query is helpful when a NH calls the Field Office about the status of a pending DIB claim and no CEF exists.

DDSQ Readers

Query Master on the OQA Toolbar can be used to translate the fields and codes on the DDSQ. Another query reader is located on the (b) (2) (b) (2)(b) (2)

eView

DI 81005.005

eView

As our systems have become more modernized, many technicians are finding eView to be an easier source to obtain Disability Claim status information. eView is a web-based application that allows users, depending on the user's level of authorization, to view, print, copy to CD

and/or take action on disability information within the Certified Electronic Folder (CEF).

To access eView:

- Use the eView desktop icon; or
- Go to the eView website at (b) (2)(b) (2)(b) (2)(b) (2) ; or
- Use interfaces from processing systems linking directly to eView (e.g. CPMS); or
- EDCS has a link to the Alerts and Messages in eView.

After accessing eView, you will enter the SSN of your claimant, then select the Search Button.


Information related to the status of the current claim and any prior claims is then revealed. In the following image we see an original filing was closed and not appealed. The most recent filing was progressed through the initial and reconsideration levels. A hearing request has been filed and is currently pending at that level.
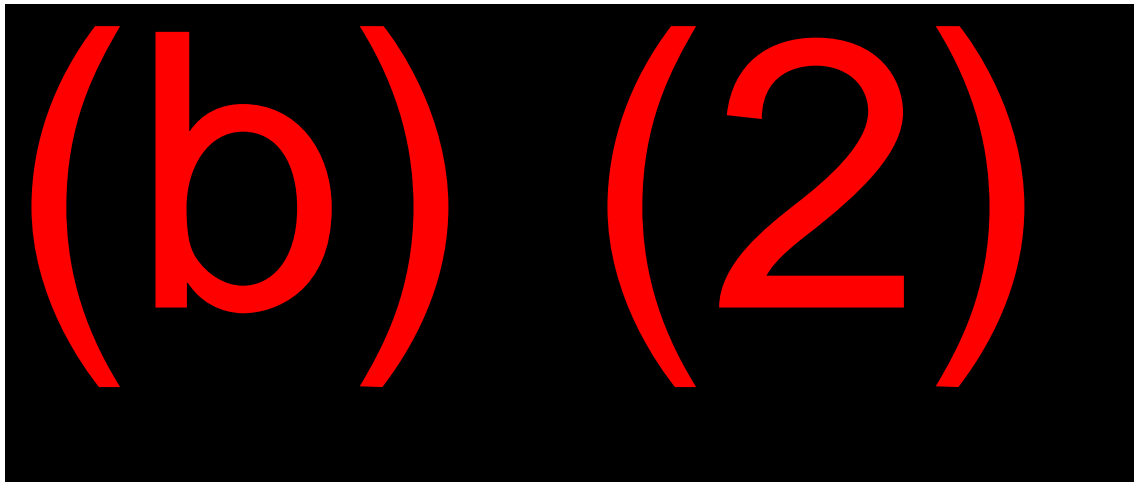
Clicking on the claimant's name will allows quick access to the electronic folder. Clicking on the Status History Tab supplies more detailed information related to the case. In the following image we see the initial

filing and reconsideration were denied, the date of the decision, the basis for those denials, and the deciding office:
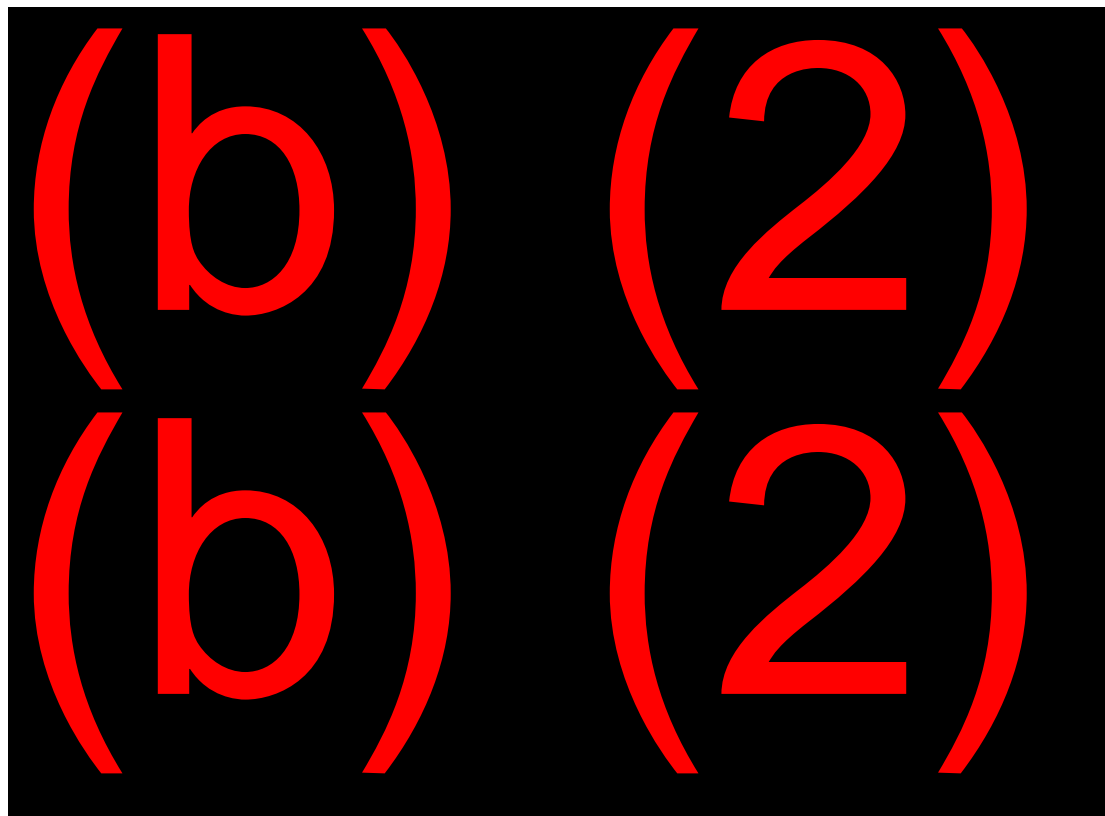
Processing Center Action Control System (PCACS)

MS 04901.001 - **MS 04914.008**

PCACS Query

This query is used for case control of all folders by field offices, payment centers and the Disability Determination Services offices. It indicates folder location, past and present pending items, and allows offices to request folders. PCACS is also used by the payment center to request assistance from field offices.

A PCACS record is established only after the claim package has been received by the payment center. This means you will use this feature primarily for post-entitlement cases. It can be used in initial case processing when an individual had prior entitlement or to check on the

status of a claim sent to the payment center for processing (manual awards).

The PCACS Query is obtained by selecting #26 on the SSA Menu.

(b) (2)
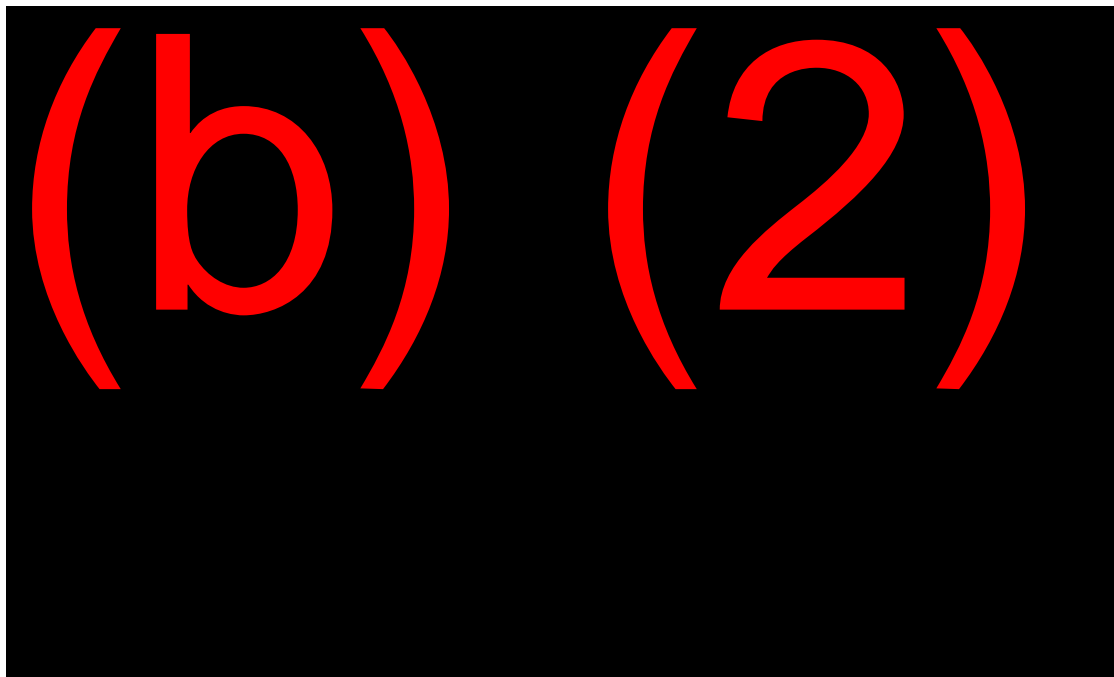
When the PCACS main menu appears, select #1 for Query after entering the SSN and unit. Consult MSOM for interpretation of the query.
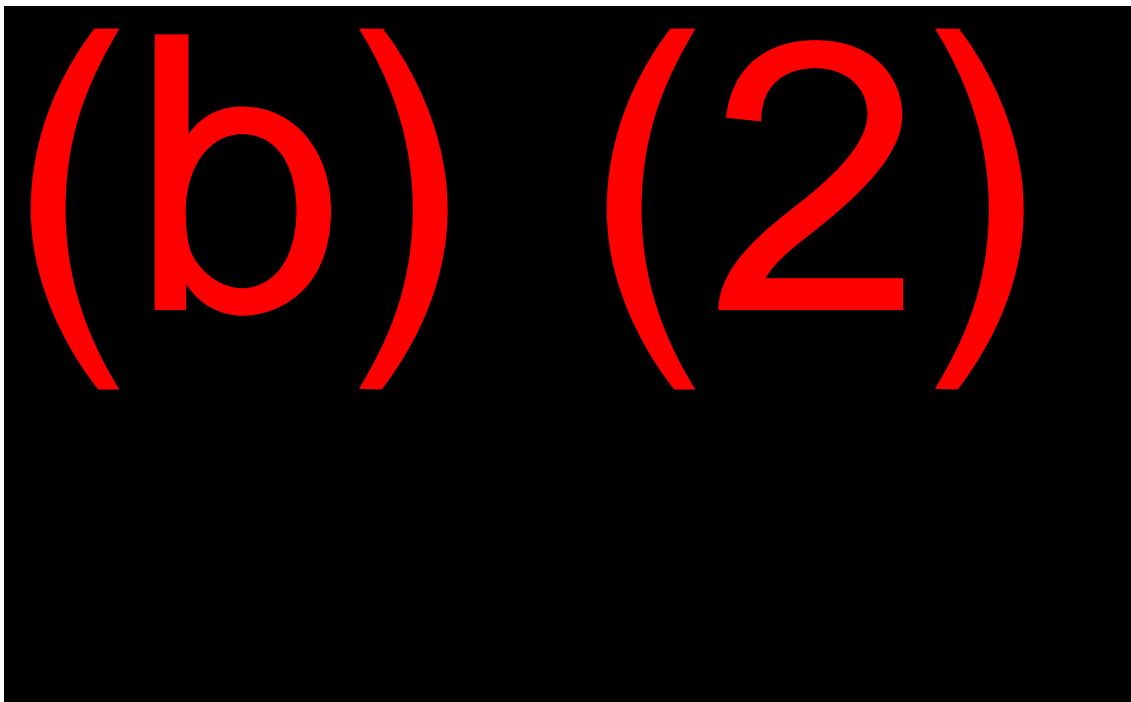
PCACS Readers

Query Master on the OQP Toolbar can be used to translate the fields and codes on the PCACS query.

The (b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2)(b) (2) is another resource which houses a number of helpful links to assist interpreting and using PCACS.

<u>EXHIBIT 1: CONCURRENT RIB-DIB CLAIM PROCESSING</u>

<u>Adjudicate the RIB Claim first as an MCS EC Clearance</u>

1. Complete the application screens as necessary, claim types #1 (RIB) and #2 (DIB).

2. Annotate the DW01 as needed. The DDSDEC will show a request date once the claim is transferred in EDCS. Complete the optional clearance screens (including the special paragraph CLOR06 on the NOT3 screen).

3. Complete the DECI with a decision STAT code for the RIB. <u>Do not complete the DIB line</u>.

4. Select #2 (Update) and #21 (Decision Input) to do an adjudicative computation. On the MREQ, show <u>Y</u> for Adjudicative Request and <u>N</u> for Process All Claimants. On DAPP, show <u>Y</u> for Permit Claim Payment. After entry, you will be returned to the main menu with the message FINAL TRIGGER SUCCESSFUL. At this point, segmentation has occurred. Go back through the DW01 on the RIB claim and enter XXXXXX in the receipt field on any issues which pertain to the DIB claim.

5. The DIB portion of the claim is then processed in the usual manner through EC. If appropriate, a non-medical completion input can be done.

   REMINDER: The most common RIB/DIB situation is when the RIB is ready to clear first while the DIB awaits the DDS decision.

When the RIB is cleared, the DIB is placed in its own segment. It remains pending until final action has been taken on the DIB claim.

OFF-AIR ACTIVITIES

Activity #1

The student should observe a MENTOR/CS/TE during the clearance of a completed DIB claim. Also, take a few minutes to explain the clearance path being used and the necessity of each screen in the path. In addition, the MENTOR/CS/TE should review their EDCS Action list with the student and discuss best practices for how to manage this workload. For instance, navigation to and from WAC, how often to pull this list, the importance of using a non-medical completion, when appropriate, etc.

Activity #2

To gain additional exposure to the screens involved in the clearance of a DIB claim and to gain familiarity with a handy resource tool, the student should explore the following website:

1. The student should go to FORCE.

2. Then, under Systems Information, click on T2-Wrkflows (KCNet). This brings up the (b) (2)(b) (2)(b) (2)(b) (2).

3. Scroll down to review the sections for DIB Workflows and specifically, 090 DIB Denials.

Activity #3

1. Go to FORCE.

2. Then, under Systems Information, click on T2-Wrkflows (KCNet). This brings up the (b) (2)(b) (2)(b) (2)(b) (2).

3. Once there, in the Most Used Workflows section, find the MACADE Denial button.

4. Students should review the information listed in this section.

Activity #4

The student should access an online guide that is available to assist with interpreting the DDSQ.

1. Go to the (b) (2)(b) (2)(b) (2) .

2. Click on the Query Readers link at the top.

3. Click on the DDSQ.

4. Once there, the student will be able to access a system that will interpret individual fields shown on the DDSQ. The EDCS Action list, looked at in Activity #1, may provide a good source for claims to be looked at and interpreted.

EXERCISE #1

OBJECTIVE 1: Determine the action(s) necessary to adjudicate DIB claims through MCS EC.

Indicate whether or not the CS took appropriate action in the following situations by answering true or false.

1. When Ms. Martini's disability claim was returned from the DDS as a disallowance, the CS realized there had been no input done by DDS. Using the information shown on the SSA-831, the CS input the necessary coding on the DICL and the denial code on the DECI. After inputting the DAPP, the CS tracked the case until it showed up on the WMI completed list.

2. In order to review Mr. Adam's earnings for gaps, the CS requested EC screens and went over the EARQ alerts with him.

3. Sam Stone is 38 years old, and his disability has been approved. The claim has been processed through EC and appears on the WMI completed list. His claim had an exclusion to electronic processing, so the paper folder was sent to PC5 for storage.

EXERCISE #2

OBJECTIVE 2: Determine if a non-medical completion input can be done, and determine proper folder processing.

PART I

In the following, identify whether the FO can use the non-medical completion procedure.

1. John has an attorney representing him on his DIB claim.

2. Jack's mother filed the disability application on his behalf. She did not apply to be his representative payee and a capability determination has not been completed yet.

3. Joe has submitted everything for his claim except for proof of military service. The military service increases his PIA by at least $1.

PART II

In the following, what action, if any, is necessary?

4. The disability application was taken and no additional proofs are needed. It appears the NH is insured.

5. The CS has input a non-medical completion and now DDS has input the DIB denial.

EXERCISE #3

OBJECTIVE 5: Determine the proper processing of an SGA denial.

Describe what further action is needed on this claim.

Mr. Swenson came into the office to file for disability benefits and had never filed for any benefits before. He has worked for the same company for the last 22 years. He lost his leg about a year ago in an automobile accident, and it has never healed properly. He has been unable to do his regular work since then. His company is having him do a different job, which only pays $1,220 per month instead of his old salary of $1,500 per month. He doesn't allege any subsidy and has no IRWEs. The CS takes the disability claim and makes a determination Mr. Swenson is working at SGA level.

EXERCISE #4

OBJECTIVE 7: Interpret the DDSQ.

Use the sample DDSQ below to answer the following questions.

MSG-1234567 **DATE**-08/02/18
DDSQ   **SSN:** XXX-XX-XXXX **BIC:**   **ST**: MO   **SA**:   **UNIT:**

AN   XXX-XX-XXXX BIC-HA DB: XX/XX/XX   RI: STATE: MO   SA: S82   STATUS: ACTIVE
AH: JOE, SHOELESS   MCS REF: MDT: PGM: 02
AD: 123 MAPLE STREET   JEFFERSON CITY MO
APD: 07/10/18   TYP: IN-DIB   DO: 123   ZIP: 12345   SCI: CCI:Y
RCD: DEC: BAS: LUN: A1   TEL: 1234567899 NP: QA: N
SRD: 07/15/18   OND: LEX: 6000   SLC: VOC: FS: N
PSD: ABO: LMC: CDF: RLB: EOR: N
MDF1:   DSI: DST: 123   SCF: APL: CER: N
              DIA: FMD: SC1:   SC4:
ESD: CSD: RTN: CDT: RTG: SC2:   SC5:
MSD: SCD   SO: BOD: SC3:
OCC: SDI: SPC: J1:   RFC: LB:
OYR: 01   MLN: MUL: J1A: WRM: LC:
EDU: MOB: ESC: J1B: DAA: LD:

1. What type of case is pending?

2. What is the code of the state agency processing this case?

3. Has a decision been made yet, and if so, what was it?

EXERCISE ANSWERS

Exercise #1

1. True. This is the appropriate processing.

2. True. This is the appropriate action.

3. False. The case should be sent to PC7, not PC5.

Exercise #2

1. No, attorney representation prevents non-medical completion

2. No, payee issue

3. Yes, you can input a non-medical completion on this claim. When Joe submits his DD-214 remove the non-medical completion, add the military information to the NHMS screen, and reestablish the non-medical completion.

4. Review the DADE screens, complete the optional clearance screens, and complete the DECI with an entry of 06 in the DEC STAT field. Request an adjudicative EC, review the EC screens, and complete the DAPP by putting a Y in the NON-MEDICAL COMPLETION field. Await the medical decision.

5. If no DDS exception occurs, the claim processes automatically through EC. Track the case to ensure WMI reflects clearance and MBR is established.

Exercise #3

After completing the claim, including an SSA-821 and SSA-823, the CS should prepare a SSA-831 and input an FO determination in EDCS. **Reminder** - the EDCS actions should be completed before the decision is adjudicated through EC. Otherwise there would not be an active claim to attach the EDCS actions to.

After the EDCS action is completed, an N1 denial should be coded on the BECF. The NOT3 should be completed, showing the automated notice is being suppressed. A

code of "03" (technical disallowance) should be entered on the DECI screen, and then the claim can be adjudicated through EC. A personalized denial notice should be released to Mr. Swenson.

Exercise #4

1. An initial DIB claim – TYP field; **SM 06002.200**

2. State Agency (SA) S82

3. No decision yet – Status field and an empty Decision Code (DEC) field