

Benefits

What Kinds of Disability Benefits are Available from the Social Security Administration (SSA) to Persons with HCV?

The Social Security Administration (SSA) administers two programs that provide cash benefits for disabled persons too sick to work. Social Security Disability Insurance (DI) pays a monthly cash benefit to disabled people who have recently worked without regard to income or resources. DI is an insurance based program. Supplemental Security Income (SSI) pays a low monthly cash benefit to people in severe financial need who have little or no income and very limited resources. SSI is a needs based program. Medicare and Medicaid benefits are available to pay for medical expenses. Medicare is an insurance based program. Medicaid is a needs based program.

What Other Kinds of Benefits are Available to Persons with HCV?

Medical workers who contract HCV from “needle sticks” or exposure to blood on the job may be entitled to state Workers’ Compensation benefits. In addition to payment of cash benefits, Workers’ Compensation pays 100% of reasonable and necessary medical expenses arising from job related illnesses or injuries.

HCV positive veterans may be entitled to VA disability benefits. The VA definition of disability is less stringent than the SSA definition, and under a new VA regulation, HCV infection is presumed to be service connected. VA medical facilities provide free HCV testing, treatment and medication to HCV infected vets.

What is the Difference Between a Needs Based Program and an Insurance Based Program?

A needs based program requires you to be poor or “need” the benefit to be entitled to receive it. An insurance based program requires you to pay a tax or premium to be eligible. Middle income and working people do not have to sell assets or impoverish themselves to be eligible to receive benefits from insurance based programs.

How Poor Must I be to be Eligible For SSI?

Practically destitute. Financial eligibility is determined by review of the claimant’s income and resources. Claimants must have countable resources of less than \$2,000 (\$3,000 if the claimant is married) and income of less than \$700 a month. Assets not counted as resources include a home of any value, personal property or household goods with a value of \$2,000 or less, a car with equity value of \$4,500 or less, income producing property used in a trade or business, and retroactive DI or SSI benefits for up to 6 months after benefits are received. Real estate, money and most personal property in excess of these exclusions are counted. Earned and unearned incomes are counted, including income from other public benefits programs. Food stamps are not counted. Resources of an applicant’s ineligible spouse are counted but not on a dollar for dollar basis.

Benefits

How Do I Qualify for Social Security Disability Insurance (DI)?

Claimants need to qualify as “fully insured” and meet a “recency of work test.” Claimants over 30 must have worked in covered employment five out of the past ten years. Eligibility for DI can lapse due to passage of time without working. Middle income and working people do not have to impoverish themselves or sell assets to be eligible. Unless you have an Americans with Disabilities Act (ADA) claim pending, DI benefits should be applied for as soon after loss of employment and onset of disability as possible. There is a five month waiting period from onset of disability to eligibility for DI benefits. There is no waiting period for SSI.

Disabled persons of all ages are eligible for Medicare after collecting DI for 24 months. Medicare is an insurance based program. It pays some of the cost of liver transplantation. If you have decompensating cirrhosis, DI benefits should be applied for as soon after onset of disability as possible to start the time running on the 24 month waiting period for Medicare. Patients with End Stage Liver Disease (ESLD) have been known to die waiting not for a liver but for Medicare benefits to kick in to help pay for a transplant.

Should I Apply for Medicaid?

Medicaid is a needs based medical benefits program for the poorest of the poor. Medicaid regulations requires applicants to spend down most of their income and assets before becoming eligible. You can own a home and will not be forced to sell it, but in some states, Medicaid is allowed to file a lien on your home in the amount of benefits expended. Federal regulations require states to enact and enforce strict Medicaid expenditures recovery programs. Because of these provisions, Medicaid is the medical benefits program of last resort.

Careful planning for future disability is a better plan than resorting to Medicaid. Disabled former employees are allowed to continue group medical insurance coverage after leaving employment under a federal law called COBRA. The employee is responsible for payment of medical insurance premiums during the period COBRA coverage is in effect, and COBRA premiums are expensive, but not as expensive as spending down and losing everything to make oneself eligible for Medicaid. A better plan than Medicaid is applying for DI benefits immediately upon loss of employment and onset of disability, keeping group medical insurance benefits in effect through COBRA during the 24 month waiting period for Medicare, and switching medical insurance plans from COBRA to a less expensive Medigap policy 24 months later when Medicare coverage kicks in.

What is the Social Security Administration’s Definition of Disability?

The SSA’s definition of disability is “the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”. This is a different definition of disability than the definition of disability in the Americans with Disabilities Act (ADA).

Benefits

What is a Medically Determinable Impairment?

A medically determinable physical impairment is an impairment that results from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques.

Are Alcoholism and Drug Addiction Disabilities?

Yes, but persons whose disabilities are drug addiction or alcoholism are prohibited from receiving Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) benefits based on these disabilities. Do not list these conditions as disabilities on an application for benefits.

How Do I Apply for Social Security Disability Benefits?

Social Security is administered through a network of local field offices. Go to the nearest field office of the SSA and ask for assistance filing an application, obtain an application and file by mail, or call the toll free number of the nearest office and a representative will take your application over the telephone.

The application and related forms ask for a description of the impairment(s), names, addresses and telephone numbers of all medical treatment providers, and other information relative to the alleged disability. If you are applying for SSI, proof of lack of income and resources will be requested and must also be provided. You do not have to provide medical reports or copies of medical records to the SSA as part of the application process. When the application process is complete, the file is transferred from the local field office of the SSA to a state Disability Determination Services (DDS) office.

What is a Disability Determination Service (DDS)?

DDS's are state agencies responsible for developing medical evidence and rendering initial determinations on whether or not you are disabled. DDS will obtain medical reports and copies of medical records. Disability determinations are made by two-person teams consisting of a medical or psychological consultant and a disability examiner. After DDS makes a determination, it returns the file to the SSA field office where the application originated. If the claimant is disabled, the SSA computes the benefit amount and starts sending benefits. If the claimant is not disabled, a written decision denying benefits and advising the claimant of his or her right to request reconsideration is sent to the claimant from the SSA office. If the claimant requests reconsideration, the file goes back to DDS and is reconsidered by a different team than the one that decided the original case.

Should I Request a Hearing Before an Administrative Law Judge (ALJ) if Benefits are Denied at the Reconsideration Level?

Definitely. DDS initial determination and reconsideration decisions tend to be the same. Many meritorious claims for benefits are denied by state DDS evaluation teams. More

Benefits

than half of these claims are granted by federal ALJ's at the administrative hearing level. If benefits are not granted at the reconsideration level, request a hearing before an ALJ within sixty days of the date of denial and consider retaining the best and most experienced disability attorney you can find.

How Do I Retain a Decent Attorney With No Money?

Social Security regulations forbid attorneys from accepting money up front from clients in Social Security disability cases or accepting any fee not approved by the SSA. SSA approved fees are a percentage of back benefits payable to the attorney at the end of the case. If the attorney loses the case, he or she gets nothing. Attorneys work hard to win Social Security cases because we lose along with the claimant when the case is not won! To retain an attorney in a Social Security case, all you should have to do is sign a contract authorizing payment of a SSA approved fee at the end of the case. SSA regulations protect claimants from exploitation by attorneys. If you have questions or concerns about a fee, raise them at the hearing with the ALJ.

How are Social Security Disability Determinations Made?

Social Security disability determinations are made according to a step by step procedure known as "the sequential evaluation process." Here are the steps in the sequential evaluation process:

1. Is the claimant doing substantial work? Substantial gainful activity is work of a productive nature for money or that could be for money. Benefits for full or part time workers earning more than the SSA monthly exempt amount (\$700 a month) will be denied.
2. Is the impairment severe? Severe impairments must result in death or be expected to last at least 12 months. Impairments that meet or equal one or more of the listings in the "Listing of Impairments" are presumed without further inquiry to be severe. If the claimant has a severe impairment that meets or equals a listing, benefits will be granted without proceeding to Steps 3 or 4 of the sequential evaluation process.
3. If the impairment does not meet or equal a listing, is the claimant able to do the same kind of work he or she has been doing for the past 15 years? If so, benefits will be denied.
4. If the claimant is unable to do the same kind of work, can he or she do any other kind of work? To decide this issue, the evaluator or ALJ consults a chart known as "the grids" for determining residual work capacity based on age, education and work experience. If there is no other kind of work the claimant can do, benefits will be granted.

What Medical Evidence Do I Have to Present to "Meet or Equal the Listing" For Chronic Liver Disease?

Benefits

There is no specific listing for hepatitis C. The HCV virus was discovered in 1989 and the listing for Chronic Liver Disease has not been updated since before discovery of the virus. To meet or equal the listing, the claimant must show:

5.05 Chronic Liver Disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease) with:

- A. Esophageal varices (demonstrated by x-ray or endoscopy) with a documented history of massive hemorrhage attributable to these varices; or
- B. Performance of a shunt operation for esophageal varices; or
- C. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater persisting on repeated examinations for at least 5 months; or
- D. Ascites, not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm per deciliter (100 ml) or less; or
- E. Hepatic encephalopathy. Evaluate under the criteria in Listing 12.02.
- F. Confirmation of chronic liver disease by liver biopsy...and one of the following:
 1. Ascites, not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm per deciliter (100 ml) or less; or
 2. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater persisting on repeated examinations for at least 5 months; or
 3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

In other words, to meet or equal the listing for Chronic Liver Disease, you must have End State Liver Disease (ESLD) or decompensating cirrhosis confirmed by biopsy and specific laboratory findings. Stage IV compensated cirrhosis does not meet or equal the listing. Stage IV compensated cirrhosis with elevated enzymes does not meet or equal the listing. The point in progression of the disease where the listings line is crossed is when abnormalities in clotting (prothrombin) time that signal the start of decompensating cirrhosis begin to appear in laboratory results.

I Do Not Meet or Equal the Listing for Chronic Liver Disease. I am Disabled by Depression, Brain Fog and Fatigue. Is There any Chance of Someone Like Me Being Granted Benefits?

Yes. Benefits may be granted for a different disability or combination of disabilities. It is not unusual for HCV positive persons to meet a listing for one or more psychological or psychiatric disorders. Major Depression is a common side effect of treatment with interferon and chronic presence of the virus. Look at the listings for psychological and psychiatric disorders and claim and document one or more of them.

Not meeting one or more of the listings means you will not be granted benefits at Step 2 of the sequential evaluation process. It means that DDS probably will deny the claim and requesting a hearing before an ALJ probably will be necessary. It does **not** mean you have no chance ever of winning the claim. It means you are going to have to be creative

Benefits

and present a better case for benefits to be granted. It means the case proceeds to hearing and to Steps 3 and 4 of the sequential evaluation process.

It is important for non-listings claimants to keep a daily log of activities affected by symptoms and to complain about symptoms to medical sources. Daily logs and frequent documentation of symptoms and effects of symptoms in complete medical records are essential evidence in non-listings cases.

Another useful tactic in non-listings or marginal cases is reliance on one or more other ailments or disabilities to bolster the case. Social Security law recognizes that the combined disabling effect of a collection of mild to moderate ailments can equal in severity the disabling effect of a major one. Extra-hepatic manifestations and ailments associated with chronic infection or side effects of treatment such as diabetes, hypothyroidism, cryoglobulemia, glomerulonephritis, autoimmune disorders, vasculitis, migraines, arthritis, depression, and exacerbation of manic depression should be documented in medical records and listed as separate ailments. Unrelated ailments should be documented and claimed. Non-listings cases should list all ailments and disabilities for which benefits might be granted to make the case a combination case.

You do not have to be permanently disabled to receive benefits. Side effects of treatment may be the basis for a finding of temporary disability. Remember, temporary disabilities must be expected to last for twelve months or more. A written report from a doctor stating that side effects of a 48-week course of treatment with interferon linger and are expected to be disabling for four or more weeks after treatment stretches the expected period of disability over the twelve month line. Date of onset of disability in these cases is the first day of treatment. Application for benefits should be made for on or near the exact date of onset.

What Do I Have to Lose?

Unless you have an Americans with Disabilities Act claim pending, you have nothing to lose. There is no application fee and it is easy to apply. DDS orders medical records and builds the file. You do not have to pay a fee up front to retain an attorney, and you owe the attorney nothing if benefits are denied. You understand the process and pitfalls now. What have you got to lose?

Barbara Chassie, JD., 2001