1310 When Disability Should Be Developed

Development of a disability claim can be quite costly, time consuming and can cause apprehension for the applicant. Therefore, it is important to develop the disability claim only when it will result in a benefit otherwise unattainable for the applicant (annuity, Medicare, overall minimum, vested dual benefit), or for the program (quality assurance). There are three basic situations in which a claimed disability should be developed:

- Application for annuity;
- Application for additional benefits;
- Application for a disability freeze after an employee's death.

These situations are discussed in detail in the remainder of this chapter.

An individual may make inquiries concerning disability annuities by phone, by letter, by email, or in person. Never advise a potential applicant to wait until medical evidence is gathered to file an application. When you receive an inquiry about disability benefits, take the following actions:

- In all cases, ask whether the individual intends to file an application or is simply seeking information. If the inquiry is received other than by phone call or personal visit, call the person in order to ask this question. Document the response.
- For inquiries by phone, letter, or email with an intention to file, set up an appointment date to take the application and send an application packet with cover form G-249. The packet should contain applicable supplemental application forms (AA-1d for employees, AA-17b for widows, AA-19a for children), G-251 Vocational Report for employees and widows, G-197 consent forms, and those forms required by each specific case to develop the medical and non-medical information needed to process the application. Assure inquirer of field office assistance in filling out the forms and gathering the information.
- If someone comes to a field office personally wishing to file, take the application on the spot if scheduling permits. (Otherwise, set up an appointment to take the application and provide an application packet.) Do not tell the applicant to come back at a later date for the purpose of providing medical information.
- For inquirers who do not wish to file, provide the requested information. This may include booklets or an estimate. Inform the inquirer that when he does wish to file, he will need to contact the RRB at that time. Document the contact.

1310.5 Application For Annuity

Articles 3 and 4 of FOM Part I give the eligibility requirements for annuities under the Railroad Retirement Act. The establishment of a disability within the meaning of the Act can replace the age requirement for certain annuities. A disability claim should be developed if all of the following conditions exist:

- Applicant claims to be disabled, or a spouse or widow(er) applicant claims to have a disabled child in his/her care and custody;
- A determination of disability within the meaning of the act would cause an annuity to be payable that otherwise would not, or would cause an annuity to be payable at a higher rate.
- All other eligibility requirements are met.

1310.5.1 Employee Applicant

A. Employee under 62 and not eligible for 60/30 annuity - The only way this employee can qualify for an annuity is to be determined disabled to the extent required for a total and permanent disability, or if other requirements are met, for an occupational disability.

B. Employee age 62 to FRA and not eligible for 60/30 annuity - If other eligibility requirements are met, this employee could qualify for a reduced age annuity. However, if a disability is established, a full annuity could be paid, thus avoiding the reduction for age. This is important not only for the initial annuity rate, but also means that future cost-of-living increases will not be reduced, Medicare coverage could begin before age 65 and that survivor benefits will be based on the full rather than reduced rate. It also may mean further retroactivity.

C. Employee first eligible for 60/30 annuity 1-1-2002 or later - It is to the applicant's advantage to file for an age and service annuity. The calculation of the tier 1 PIA would be the same, however the employee would not be subject to the RR Act disability work deductions if he became employed prior to FRA. The employee should file for a DF application only.

D. Employee over FRA - There are only two situations in which an employee applicant over FRA would be advantaged by filing for disability.

- Disability annuity would permit retroactivity of ABD to earlier date than age and service annuity

  NOTE: This only applies if the twelve month retroactivity on the disability application will take the applicant to before the attainment of FRA.

- Applicant has less than 30 years of service and ABD could retroact before FRA without an age reduction.

1310.5.2 Widow(er), Remarried Widow(er), Surviving Divorced Spouse Applicant

A. Under Age 50 - Surviving widow(er)s and former spouses cannot qualify for a disability annuity before age 50. Upon the attainment of age 50, they may file an application if the other eligibility requirements are met.

B. Age 50-59 - Unless these potential beneficiaries have a minor or disabled child in care or custody, these applicants must file an application for a disability annuity in order to qualify for a monthly benefit.

If there is a minor or disabled child in care and custody, the applicant should file for an annuity on the basis of having a qualifying child in care and custody. This is true even if the age reduced disability annuity would be higher at the ABD than the child-based annuity, because the age reduction at the ABD for the disability annuity will apply as long as the annuitant receives an annuity, whereas the age reduction as of the time of conversion from a child-based annuity to an age or disability annuity would apply from that point as long as the annuitant receives an annuity. Conversion cannot occur until the widow(er), remarried widow(er) or surviving divorced spouse could no longer qualify on the basis of a child in care and custody or until age FRA is attained.

However, the disabled applicant might qualify for early Medicare by filing a separate claim (application Form AA-17b with supporting evidence) for a disability determination only.

C. Age 60-FRA - As far as annuity rate goes, there is no advantage to filing for a disability annuity. However, consideration must be given to whether the establishment of a disability will qualify the applicant for early Medicare (see FOM-1 1310.10.2). If so, a disability application for Medicare only should be filed separately from the application for annuity.

D. Over FRA - There is no advantage to filing for a disability annuity except possibly with respect to retroactivity.

1310.5.3 Disabled Child

The establishment of the disability of a child may qualify a survivor child for an annuity or may cause a female spouse or widow(er) to be qualified for an annuity when she would not otherwise have been eligible. In any of these cases, develop the disability claim from the child, parent or representative payee.

Before age 18, a child is generally regarded only as a minor child. Therefore, the earliest that child usually can be considered a "disabled child" is at age 18. The only exception is that for spouses, remarried widow(ers) or surviving divorced widow(ers), whose entitlement to the tier I portion of his/her annuity terminates upon the youngest

child's attainment of age 16, tier I benefits will be continued if the child is found to be totally and permanently disabled.

Additionally, for a child to qualify for benefits or cause a parent to qualify for benefits, the onset of the disability had to occur before the attainment of age 22.

A. Survivor child - The child of a deceased employee can qualify for a disabled child's annuity if he is at least age 18, disabled within the meaning of the Railroad Retirement Act, AND the disability began before age 22.

   Prior to age 18, the child receives benefits as a minor child even though he or she may be disabled. Therefore, a disability claim for a child's insurance annuity should not be developed until just prior to the attainment of age 18, unless the spouse/widow would lose SSEB Tier 1 status when the child attains age 16.

B. To qualify a widow(er) under age 60 - A widow(er) under age 60 must have a minor or disabled child in care and custody to qualify for a monthly annuity. If the child's mother/father would not otherwise be eligible for an annuity because of age, the development of the child's disability will serve to qualify both the child and the parent.

   Beginning August 1, 1992, the Board approved a change in policy that ceased the termination of tier 1 benefits to the young mother/father whose last child attained age 16. However, the tier 1 benefit would not be considered SSEB for tax purposes for a minor child age 16-17. Therefore the disability determination for a child will be developed at the time the child attains age 16.

C. To qualify an under-age spouse - A spouse can receive an unreduced annuity by having a disabled (or minor) child in care and custody, when otherwise she could only have received a reduced annuity. Also, beginning 5-1-83, a husband can qualify for a tier I spouse annuity on the basis of having a disabled child in his care and custody. Prior to this time, only a wife was eligible for an annuity.

   Beginning August 1, 1992, the Board approved a change in policy that ceased the termination of tier 1 benefits to the young mother/father whose last child attained age 16. However, the tier 1 benefit would not be considered SSEB for tax purposes for a minor child age 16-17. Therefore the disability determination for a child will be developed at the time the child attains age 16.

1310.10 Application For Additional Benefits

In addition to causing an annuity to be payable when it otherwise would not be, the establishment of a disability could cause an employee or a family member to receive additional monetary or non-monetary benefits. FOM-I 325 describes the criteria required for the payment of the overall minimum guaranty (O/M) and of an early vested dual benefit based on disability; FOM-I Article 8 explains how an employee, widow(er) and child can qualify for early Medicare coverage based on disability. Following are

specific situations in which a claimed disability should be developed so that additional benefits will result.

1310.10.1 Overall Minimum Guaranty (O/M)

The overall minimum guaranty (O/M) applies only to employee cases and only if the employee could have been eligible for benefits under the Social Security (SS) Act had his railroad work been covered under that act. One of the conditions of eligibility under the SS Act is the establishment of disability within the meaning of that act. In other words, developing a disability could possibly result in an increased annuity rate for the employee. It could be the disability of the employee himself, or that of a child of the employee who could be included in the computation of the O/M rate.

A. Employee disabled - Benefits to a disabled employee may be increased if all of the following conditions are met:

- Employee disabled within the meaning of SS Act (Disability Freeze);
- Employee has spouse and/or children who would be eligible for benefits under the SS Act;
- The combined benefits that would be payable to all family members under the SS Act exceed the combined benefits payable to the family group under the RR Act.

Generally, it will not be known if all these conditions will be met until after an annuity is awarded. Therefore, do not develop the disability of an employee under age 62 at initial filing if it is solely for O/M purposes. If the employee is age 62 or over, he can qualify for O/M consideration on the basis of age; therefore, disability should not be developed for O/M only.

B. Disabled child of employee - If all other conditions for an O/M are met by the employee, the establishment of the disability of a child of the employee may cause the annuity rate of the employee to be increased. This could be done in two ways:

- The inclusion of the disabled child in the computation. Note that a child cannot be included in the O/M based on disability prior to age 18. (See FOM-1 1310.5.3 for information about disabled IPI children.)
- The inclusion of a wife in the computation on the basis of having a disabled child in her care and custody.

1310.10.2 Medicare

The establishment of a disability within the meaning of the SS Act could qualify an employee, widow, or child to early Medicare coverage. A spouse cannot qualify for early Medicare on the basis of disability.

Keep in mind the waiting period requirement and the "time on the rolls" requirement for early Medicare (see FOM-1 1305.40.2). For example, if the ABD is after age 63, the annuitant would qualify for Medicare based on the attainment of age 65 before qualifying on the basis of disability.

Also, keep in mind that since a child is not eligible for inclusion in the O/M based on disability prior to age 18, an application for early Medicare for a child should not be developed prior to attainment of age 18. To be entitled to Medicare, the child must have been eligible for O/M inclusion for at least 24 months and be at least 20 years of age. (see FOM-1 810.15.4 and 810.30.8)

Employees who do not meet the service requirements to qualify for a disability freeze (20/40 or minimum QC test) based on wages and compensation, may use certain quarters of coverage based on Federal service to establish a disability freeze for Medicare purposes only. (see FOM-I 810.5.6).

1310.10.3 Vested Dual Benefit

Assuming all other conditions of eligibility are met, an employee can receive the vested dual benefit (VDB) when he meets the requirements for a social security benefit, (i.e., attains age 62, or meets the disability and insured status requirements of the SS Act). Therefore, a 60/30 annuitant may qualify for the VDB before age 62 by establishing disability. However, do not develop unless it appears that both the disability requirement and the insured status requirement are met (see FOM-1 1305.20.1).

1310.15 Application for Disability Freeze After Employee's Death

A survivor can file an application to establish a disability freeze (DF) for a deceased employee. A survivor application must be filed within 3 months after the employee's death. Although a disability annuity cannot be paid to the survivor, the establishment of a DF may increase the amount of survivor annuities (see FOM-I 1005.25.6).

1310.15.1 When to Develop

Field offices should initiate development of an application for a DF after death when all of the following conditions exist:

- Employee does not have a disability freeze;
- Employee was under age 62 on the disability onset date, or under age 63 if he was disabled for more than 24 months before his death;
- Employee became disabled before the year of death;
- Employee had been unable to work due to disability for at least 5 full months;
- A survivor application was filed, or is being filed, within 3 months after the month of the employee's death.

1310.15.2 How to Develop

A. Application - Secure a modified Application AA-1 as prescribed in FOM-1 1710.

B. Medical evidence - Secure a copy of available hospital records and any other available medical evidence (i.e. treating physician's records/RFC assessment), and a copy of the death certificate which shows the cause of death. In some states this information is available only on a "long form" death certificate. If additional medical evidence is required it will be requested by the Disability Benefits Division (DBD).

Hospital records should be submitted to document the medical condition. Ask the survivor applicant for sufficient information to obtain hospital records that will document the medical condition. If there are no hospital records, record that information in the remarks section of Form G-659a.

C. Submission of claim - Submit the modified Application AA-1 and medical evidence under cover of Form G-659a. It can be submitted along with the survivor application. However, the modified Application AA-1 must be listed in item 15 of the Form G-659a in all cases, not in item 14.

1310.20 Request For Tentative (Disability) Rating

Effective November 19, 1991, field offices should not accept applications or requests for tentative disability ratings.

1310.25 Reconsideration And Appeal

When a disability determination is made, the applicant or annuitant may request reconsideration and/or appeal the decision if he or she believes that it is incorrect. Depending upon the circumstances, additional development of the disability may be appropriate. Follow the guidelines in this section for development when an applicant or annuitant has been notified of a disability determination which he or she believes is incorrect.

If an individual calls a field office and inquires about a disability case, ask appropriate questions to determine if he/she believes that a disability rating is at least partially incorrect in order to prevent an unnecessary letter of protest or appeal. (For example, a claim is rated disabled but the determined date of disability onset may not be what the claimant expected. This type of situation could occur in cases involving an illness which would gradually worsen over time rather than beginning on an exact date.) The inquirer may actually be asking about the status of a disability annuity payment rather than questioning a rating. An explanation may satisfy the inquirer. If the explanation does not satisfy the inquirer and the individual had not previously questioned the decision or there is no record of a recent reconsideration request, secure a signed statement requesting reconsideration of the disability determination.

NOTE 1: DBD sends claim folders to the Reconsideration Section (Recon) at the time that an individual is rated not disabled (for disability annuity, freeze, or Medicare purposes) in anticipation of a possible request for reconsideration. Claim folders held in Recon in anticipation of a possible request for reconsideration of a "not disabled" rating are logged into AFCS location J206 ("Dis Holding File Possible Recon Request"). If a folder is charged to this location, Recon has not received a reconsideration request on the disability decision. If no reconsideration request is received, Recon will forward the claim folder to Claims Files or to another unit if other action is required.

NOTE 2: To determine if there is an active or completed reconsideration of a disability decision, check Universal STAR (USTAR) (FOM-1 15120). Reconsideration requests of disability decisions have the following USTAR category ("Cat") codes:

- RDI00N,
- RDI00O,
- RDI00P,
- RDI00Q,
- RDI00S,
- RDI00T,
- RDI00U,
- RDI00V, or
- RME00R.

Reconsideration requests undergoing active review do not have a date in the "Complete Dt" column in USTAR. In addition, the claim folders with active disability reconsideration requests will be logged into J202 ("Recon - Active" [a reconsideration request has been received timely but has not yet been assigned to an examiner for review]), J203 ("Dormant" [a Recon examiner is developing for additional information]), or a specific AFCS Recon examiner folder location.

1310.25.1 Reconsideration/Appeal Filed Within 60 Days of Date of Denial Notice

A. Application - A new application is not required if:

- The request for reconsideration is filed within 60 days of the date of the denial notice;
- The appeal is filed within 60 days of the date of the notice of reconsideration decision;

- The second appeal is filed within 60 days of the date of the Bureau of Hearings and Appeals (BHA) referee's decision.

A new application is not required in these situations even if the disability onset date is more than 3 months after the application filing date.

B. Medical evidence - Encourage the applicant to obtain copies of existing medical evidence which has not been previously submitted. Do not schedule specialized exams unless requested to do so by Operations - Reconsideration Section or by BHA.

1310.25.2 Reconsideration/Appeal NOT Filed Within 60 Days of Date of Denial Notice

A. Application - A new application is required if the 60 day appeal period has expired and a good cause for filing a late appeal is not established. Administrative finality is applied to the adjudicative decision after the appeal period expires without an appeal or reconsideration request having been filed.

However, if the applicant submits new evidence within 60 days of the date of the denial notice, even though he did not request reconsideration, the decision may be reopened. A new application is required only if the disability onset date is after the date of the denial notice. A new application is not required in this situation if the disability onset date is before the date of the denial notice.

Under certain conditions a final decision can be reopened. Reopening is required if the decision was erroneous or fraud is involved; reopening is permitted under certain other circumstances. However, an application should still be developed along with other pertinent evidence and information in order to protect the ABD and save later development if reopening is not permitted. If you believe a previously denied application should be reopened, so indicate in a memorandum accompanying the new application package. DBD will determine if reopening is permitted and will advise the field office. Do not give the applicant false hopes; assure him that the new application ensures that his case will receive full consideration.

B. Medical evidence - Develop applicant source medical evidence and secure hospital records that have not been previously submitted. Do not schedule specialized exams unless there is a clear indication that the applicant's condition has worsened and that such exam is needed to make a rating (see FOM-1 1325).

1310.30 Program Integrity

The Railroad Retirement Board (RRB) monitors the disability program to identify cases which may require additional review because of conflict, inconsistency, ambiguity, insufficiency in the evidence or change in the claimant’s condition. When determining if

additional case review is needed, consider the factors outlined in DCM 8.8.2. Once disability benefits are awarded, any disability case may be reviewed to assure that the annuitant continues to be entitled to a disability annuity.

There may be situations in which an individual is either discredited by the RRB or other Federal agency such as the Social Security Administration. As such, the evidence submitted and/or assistance provided to a claimant filing for a disability annuity may put that application or disability decision (grant or denial) into question.

When individuals are discredited and made known to the RRB, Policy & Systems will issue an Instructional Memorandum listing the names of those discredited individuals. These discredited individuals could be physicians, attorneys, attorney representatives, facilitators, or medical providers.

In addition, the RRB will also monitor applications in which the claimant used third-party facilitators when completing their applications. These third-party facilitators **may or may not have been discredited.** In most situations, these facilitators charged the claimant a fee for their services. The Disability Tracking of Physicians and Patterns (DTOPP) database will be used to enter the names of physicians and facilitators.

NOTE: The term "Facilitator" is defined as a third-party individual, company (application service), or attorney/law firm who has no relation to nor serves as a representative payee for the claimant, and whose purpose is to file an application on behalf of the claimant for a fee. The term "Facilitator" specifically excludes all RRB field employees; individuals who are filing on a disability applicant's behalf as their representative payee; as well as any family members of the applicant (i.e. spouse, son/daughter, etc.).

Below are instructions for Field Service (FS) and Disability Benefits Division (DBD) staff to follow when an individual has been identified as a third-party facilitator.

Field Service Instructions

If a third-party facilitator (i.e., examples mentioned above) is identified as an evidence source when reviewing the disability application package or was used by the claimant during the application taking process, field offices should enter the following identifying information in the Application Express (APPLE) System Remarks section (See FOM-1 110.100.3 and FOM-1 1325.20.6):

- Enter "Facilitator" followed by:
    - Facilitator name(s);
    - Professional title;
    - Organization name; and
    - Address information

Entering the word “Facilitator” first will help to identify facilitators when conducting a query in APPLE.

> **NOTE:** FS staff should only enter the information above so that all the pertinent information is shown on the first screen page of APPLE.

FS should verify that the third-party facilitator information is printed on the Form G-626, *Application & Form Transmittal*, before forwarding to DBD. If facilitator information is added to the APPLE System Remarks section after Form G-626 has been released to DBD, FS should send an email with identifying facilitator information to Program Evaluation and Management Services group mailbox - FacilitatorReplies@rrb.gov.

FS should complete development of the disability application package following standard procedure and forward to the Disability Benefits Division (DBD) for adjudication.

Disability Benefits Division Instructions

Identification of a third-party facilitator can occur during any type of case adjudication (this includes Continuing Disability Review [CDR]). DBD staff will evaluate and process the disability application package in accordance with DCM 3.6.1 and DCM 13.2. If a facilitator is identified during the adjudication process, send an email with identifying facilitator information to Program Evaluation and Management Services group mailbox - FacilitatorReplies@rrb.gov.

> **NOTE:** Continuing disability reviews (CDR) are initiated by the Disability Benefits Division - Disability Post Section (DBD-DPS) based on anticipated possible recovery or on reported work activity.
>
> Field offices should not develop in support of CDR cases unless requested by DBD-DPS. If a disability annuitant reports recovery or work activity, Field offices can develop a statement from the annuitant and submit the facts to DBD-DPS.

1310.35 Terminally Ill (TERI) and Compassionate Allowance (CAL) Claims

This procedure has been formulated to allow the RRB to more expeditiously process claims for applicants who have a medical impairment which:

- Is generally expected to result in death;
- Involves a high probability that the applicant can be rated disabled

  AND

- The evidence of the applicant’s allegations is expected to be easily and quickly verified.

The procedure standardizes the identification, development and processing of terminally ill (TERI) and compassionate allowance (CAL) claims. The coordinated efforts of field office and Headquarters employees to timely handle TERI / CAL claims in accordance with this procedure will greatly improve our responsiveness to the needs of these individuals.

TERI and CAL claims both involve a high probability of allowance. While TERI claims generally involve an illness which cannot be reversed and is expected to result in death, not all CAL claims involve terminal illness.

There is no relevance if the claim meets the TERI criteria, the CAL criteria, or both. Once identified as a TERI / CAL claim, that designation remains on the case until all administrative appeals of that claim are exhausted or it is obvious that the TERI / CAL criteria are no longer met. Headquarters will determine when a claim no longer meets the TERI / CAL criteria and then notify the responsible field office.

A. Identifying TERI Claims

Disability claims with an indication of a terminal illness will receive priority handling because of their sensitivity. Field office personnel should make every effort to attempt to identify all disability claims meeting the criteria for a TERI claim by reviewing the AA-1d and/or other evidence that was submitted. A claim may be identified as a TERI claim by using the following criteria:

1. There is an allegation from the claimant, friend, family member, doctor, representative payee, attorney, court or other medical source that the illness is terminal;

2. There is an allegation or confirmed diagnosis of Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome (AIDS);

   NOTE: All claims involving an allegation or a confirmed diagnosis of Human Immunodeficiency Virus (HIV) infection must also be handled expeditiously but should generally not be labeled as a TERI claim. An individual alleging or having a confirmed diagnosis of HIV infection may or may not be prevented from performing work under applicable sections of the Railroad Retirement Act (RR Act) or Social Security Act (SS Act) depending on the severity of the residual effects. Conversely, an individual who has AIDS has reached a progressively advanced stage of HIV infection with accompanying medical signs and symptoms which result in a poor prognosis and a reasonable expectation in eventual death.

3. The claimant is receiving inpatient hospice care or is receiving home hospice care, such as in-home counseling or nursing care;

4. There is an allegation or diagnosis of Amyotrophic Lateral Sclerosis (ALS), known as Lou Gehrig's Disease;

5. The claimant has a condition which medical records indicate is untreatable, cannot be reversed and is expected to end in death. These conditions would include but are not limited to the following:

    a. Chronic dependence on a cardiopulmonary life-sustaining device;

    b. Awaiting a heart, heart/lung, or bone marrow transplant (excludes kidney and corneal transplants);

    c. Chronic pulmonary or heart failure requiring continuous home oxygen and the claimant is unable to care for personal needs;

    d. A malignant neoplasm (e.g. cancer) which is:

        - Metastatic (has spread);
        - Stage IV (final stage);
        - Persistent or recurrent following initial therapy; or
        - Inoperable or unresectable.

    e. An allegation or diagnosis of:

        - Cancer of the esophagus;
        - Cancer of the liver;
        - Cancer of the pancreas;
        - Cancer of the gallbladder;
        - Mesothelioma;
        - Small cell or oat cell lung cancer;
        - Cancer of the brain; or
        - Acute Myelogenous Leukemia (AML) or Acute Lymphocytic Leukemia (ALL).

    f. Comatose for 30 days or more.

The above list **is not** intended to be all-inclusive. Rather, it should be used as general guidance in the identification of TERI cases. Other cases may be

considered TERI cases as long as the medical condition is untreatable and is expected to result in death.

In most instances, TERI claims are easily identified by the nature of the illness or by an indication from the applicant or his/her representative. Claims representatives should look for disability claims which may meet the criteria for TERI claims given above. Claims representatives and field office managers seeking guidance as to whether a claim should be considered a TERI claim should immediately telephone the supervisor of the Initial Section of the Disability Benefits Division (DBD-DIS) (x4740).

B. Identifying CAL Claims

Compassionate Allowance is a Social Security Administration (SSA) initiative to quickly identify diseases and other medical conditions that invariably qualify as a disability allowance based on minimal but sufficient objective medical information that is readily available and can be obtained quickly. The RRB has adopted this initiative as a way of providing for the needs of individuals whose medical condition is so serious that it obviously meets the disability standards. Accordingly, conditions in the CAL list may be considered when adjudicating all disability claims under the SS Act (i.e. disability freeze; early Medicare coverage; O/M) as well as the RR Act.

The list of conditions that SSA has developed under the initiative is a result of information received from internal and external medical, legal, and scientific professionals, the public, and disability claims specialists throughout the country. SSA is solely responsible for and continues to evaluate conditions to be included in or removed from the list. Accordingly, since conditions are added and removed from the CAL list, refer to the list on a regular basis to verify that you have the most updated information.

Field office personnel should make every effort to attempt to identify all disability claims meeting the criteria for a CAL claim by reviewing the disability application (forms AA-1d, AA-17b, or AA-19a) and/or other evidence that was submitted. Claims representatives and field office managers seeking guidance as to whether a claim should be considered a CAL claim should immediately telephone the supervisor of DBD-DIS (x4740).

The listing of impairments that SSA considers CAL conditions can be found in SSA's POMS DI 23022.080. That web page contains links to summaries about all of the conditions. The summaries include information about:

- Alternate impairment names, if any;
- A detailed description of affected body systems and how each impairment incapacitates an individual;
- Diagnostic tests that are usually performed, if any;

- Onset and progression;
- Treatments, if any; and
- Suggested evidence to support the claimed impairment.

The list of CAL impairments **is** all-inclusive and contains adult, child, and infant-related medical conditions. An individual can be rated disabled as a result of having any impairment in the CAL list regardless of age presuming that individual continues to be affected by that impairment and sufficient medical evidence to support the claim has been obtained.

C. Field Office Handling

Once a field office has identified or been notified that a claim is a TERI or CAL claim, flag your file "TERI / CAL" and take appropriate action to expedite handling to completion.

In order to provide good customer service and provide for the special needs of individuals meeting the criteria for a TERI or CAL claim, the field office which received the initial notification shall be responsible for all aspects of the claim until that office has been notified that the claim has been effectuated, even if it is not the same field office as the claimant's home field office.

Take special care not to use words such as "terminal," "terminal illness," or "allowance" when speaking to or showing the applicant any material on his or her claim. Do not advise the claimant that his or her case has been selected for expedited handling unless he or she specifically asks the question.

The following guidelines are to be taken to ensure expedited handling:

- If a field office has received information, evidence, or notification that an individual has stopped working and may be terminally ill or have a condition in the CAL list, schedule an appointment to contact the applicant within 3 days of the date in which a TERI or CAL is first identified to verify the allegations, identify family members who could help in any additional development of evidence, obtain possible rep payee information, and, if necessary, complete the application.
- Try to obtain relevant medical evidence as soon as possible by enlisting the help of family members or, by phone contact, with doctors and hospitals or other primary treating sources that can provide the evidence necessary for a quick determination. Ask medical providers to send medical documentation via fax or express mail to the field office. Request medical evidence by mail **only** if no other means of obtaining it are available.

All follow-up attempts for medical evidence shall be made with a phone call or fax no later than 7 days from the date of the most recent request. Consider contacting the claimant or official representative for assistance if there has not been any reply from his/her medical source. When appropriate, mail or fax a G-197 to the claimant or official representative to take to the treating source for completion. Update Contact Log regarding all actions taken.

- Simultaneously develop non-medical factors (e.g. G-251, releasing G-251a or G-251b, ADL's, etc) with medical development.

  Because of the special circumstances, all follow-up attempts for non-medical documentation shall be made with sensitivity of the claimant and his or her family in mind. Unless directed otherwise by the field office manager, all follow-up attempts shall be made with a phone call no later than 7 days from the date of the most recent request. When appropriate, mail or fax the RL-57b tracer letter. Update Contact Log regarding all actions taken.

- Enter applications on the APPLE system in the usual manner.

- Contact the Supervisor of DBD-DIS through e-mail (Outlook) or telephone (x4750) to advise that a TERI / CAL claim will be submitted.

- Transmit all claim material in an envelope marked "TERI / CAL Claim - Attention – Supervisor of DBD-DIS." Also, show "TERI / CAL CLAIM" on the cover sheet transmitting the claim.

  Do not unnecessarily delay the transmission of any TERI or CAL claim material. Indicate on APPLE and/or the cover sheet what evidence is being submitted and what evidence, if any, is outstanding and continues to be developed for. In addition, show that same information in an E-mail to the DBD group inbox.

- Whenever possible, utilize fax machines to transmit material which could not be submitted with the initial transmission; use the Disability fax number (312-751-7167) for the telecommunications.

- Establish a special control file designated for TERI and CAL claims only.

  Due to the sensitivity involved, it is recommended that the field office keep a photocopy of all applications and evidence of TERI and CAL claims until it is notified by headquarters that the claim has been effectuated. Properly dispose of personally identifiable and medical information as shown in FOM-1 125.5.1.

  Follow the same procedure if a determination is made that a claim meets the criteria for TERI or CAL claim handling after completing the initial

development. Be sure to contact the supervisor of DBD-DIS to ensure that the case is properly flagged in Headquarters.

Remove the TERI / CAL designation if headquarters notifies the responsible field office the claim no longer meets the criteria as a TERI / CAL claim.

D. Handling Request for Reconsideration or Appeal

Reconsideration requests for TERI or CAL claims will receive expedited handling.

- Forward reconsideration requests for disability-related decisions to Operations, Reconsideration. The Reconsideration Section will handle these cases.

  Contact the Chief of the Reconsideration Section by e-mail (Outlook) or telephone (x4621) to advise that a reconsideration involving a TERI or CAL claim is being submitted.

- If an individual is not satisfied with a reconsideration decision and files a formal appeal, contact the Bureau of Hearings and Appeals by e-mail (Outlook) or telephone (x4946) to advise that an appeal involving TERI or CAL claim is being submitted.

- Do not unnecessarily delay the transmission of any TERI or CAL claim material. Indicate on transmittal cover sheet what evidence is being submitted and what evidence, if any, is outstanding and continues to be developed for. In addition, show that same information in an E-mail to either the Reconsideration section group inbox or the hearings officer handling the claim.