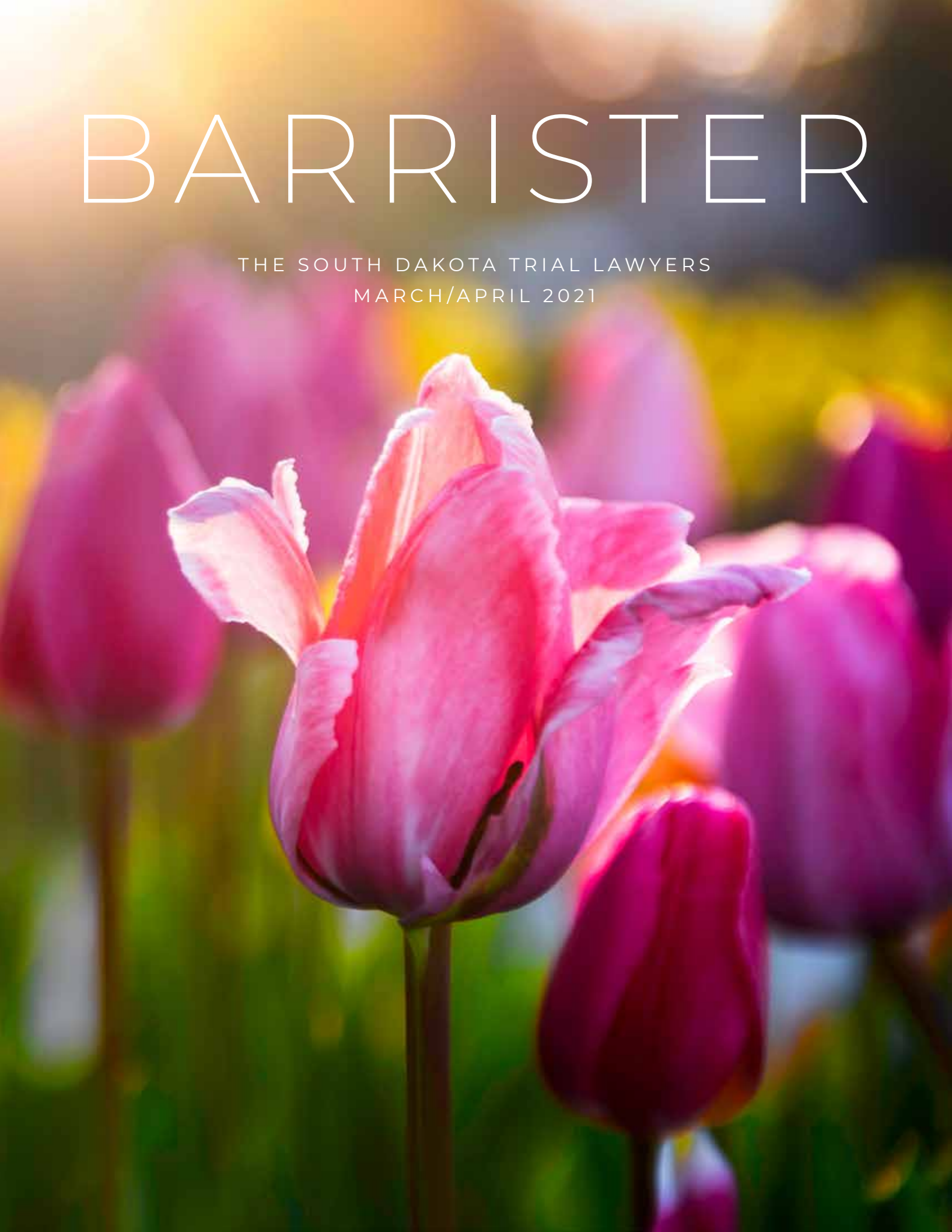
BARRISTER

THE SOUTH DAKOTA TRIAL LAWYERS

MARCH/APRIL 2021



WHAT'S INSIDE

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PRESIDENT'S MESSAGE

WRITTEN BY KASEY OLIVIER

2020-21 is another year in the books, and one that won't fade from memory any time soon. I first started serving on the SDTLA board eight years ago, and it has been an honor and a privilege to now have served as your 57th SDTLA President.

When I was passed the gavel, the future of our organization hung in the balance. As you are aware, our Board was forced to make tough financials decisions, which as a result, allowed our organization to emerge stronger and more united than I have witnessed in the past several years. A large thank you must go out to all of the members that helped fundraise and made donations this year. Your efforts allowed us to host an in-person CLE in Deadwood, create a new Barrister format, develop a new website, engage in the legislative session, expand workshop opportunities, and promote good-will within our organization and our national partner, AAJ. The kindness and generosity of our membership has been the driving force behind our organization this year.

Another large thank you must go out to Executive Director, Linda Stevens, and the rest of the Board for their hard work this year. Their commitment and support turned 2020-2021 into a successful year for SDTLA.

But we still have several things to accomplish. The annual meeting will be held in-person this year during the Annual Bar Convention in Sioux Falls. There, we will honor our Fred J. Nichol outstanding jurist, our well accomplished Trial Lawyer of the Year, a life-time achievement award winner and more. We will also be voting for the 2021-2022 SDTLA board members, of which we have some outstanding candidates. Our annual CLE seminar will be held in Deadwood this fall, there will be additional workshop opportunities, courtesy of George Johnson, and Joe Erickson is working to plan more hunting trips. 2021-2022 is shaping up to be a great year.

Next month, the final goodbye for me will be to hand off the gavel to my colleague and friend, Tim Rensch. There are very few people I have met that are as passionate about being a trial lawyer and about their clients as Tim. As our 2016-2017 Trial Lawyer of the Year, he has demonstrated some of the best qualities of a trial lawyer and has always stepped up when our organization is in need. I am excited to watch his presidency and the amazing job he will do. Tim, you have a membership that is pulling for you, and you will be inspired by the character, kindness and compassion of the members you will lead.

Kasey L. Olivier, *President 2020-2021*

EDITOR'S NOTE

WRITTEN BY ANDY FICK

Hello all,

In this issue, we're introducing a new series titled "Past President Proverbs." In this first article, our Executive Director Linda Stevens had a chance to speak with former SDTLA President Tex Hoy to discuss his legal career.

This edition also features an article written by Jim Leach that serves as an introductory primer for those interested in taking on workers' compensation cases. Supplemental articles cited by Mr. Leach are included in the attached appendix.

Finally, we also have an article by Meteorologist Matthew Bunkers explaining the role and function a Certified Consulting Meteorologist can play in your current and future cases.

As always, if you have an article you would like to publish or ideas for articles you would like to see published, please do not hesitate to contact me. I would love to hear from you.

Sincerely,
Andy

TEX HOY

PAST PRESIDENT PROVERBS

Where did you grow up?

Vermillion, South Dakota

Where did you go to law school?

University of South Dakota, graduating in 1956.

Why did you choose the law?

My family early on was helpful in this decision. When I was in Korea, my mother wrote to me and suggested that I think about returning home to Vermillion to attend law school. I was single at the time. When I was in undergraduate school, my favorite course in the business school was business law, taught by my favorite teacher, Dr. Kenneth Raschke. I thought so much of him. Then when Jo Hoy came into the picture, knowing that her father was a leading lawyer in the Cherokee, Iowa, vicinity, I was all the more enthused about going to law school.

Where have you practiced law?

All in Sioux Falls. I was under the roof at Davenport, Evans, Hurwitz & Smith from 1957 to 1987. That time was preceded by my year as a law clerk to the Hon. George T. Mickelson, United States District Court in South Dakota. I was his first law clerk, as that program had just been initiated.

In 1987, James Hoy and I started our own law firm, Hoy & Hoy, where we stayed until 2004, at which time we both joined Scott Hoy in his practice of Hoy Trial Lawyers, where we remain today.

What is your most memorable case?

Henry Carlson was the defendant in a case brought by the Northwestern Bell Telephone Company, claiming suction air in the building which is on South Minnesota Avenue in the City of Sioux Falls. The case was tried in the United States District Court. James Hoy was our principal counsel for the defense. It was a heavy-duty case, with a lot of questions, including coverage questions in a case that had tremendous exposure.

The jury found in favor of our client, Henry Carlson. What makes this the most memorable case is that my office in Sioux Falls today is approximately 10 blocks west of that building. My window to the east points directly to that telephone company building, and each day I am reminded of the case and the result.

What is the best advice you have been given during your career?

Louis R. Hurwitz, one of the senior partners of Davenport, Evans, Hurwitz & Smith, taught me early on, "It is better to get a matter resolved than to resolve it absolutely perfectly."

What are the most important skills a trial lawyer needs to develop?

Self-confidence, eye contact with the jury, courtesy to opposing counsel and all court personnel, confidence in your client's version of the case, and timely preparation.

Why is SDTLA important?

In the beginning, there were just a handful of us, and it was like a brotherhood, which has remained throughout my entire career.

What are your personal interests?

All sports, especially tennis, from which I had to retire a few years ago.

What else do you want readers to know about you?

The practice has provided a fascinating and satisfying experience and life work.

A special thank you to Tex Hoy for being part of our inaugural Past President Proverbs series. For more from Tex, please see his book *According to Tex—A Jury Verdict* available for purchase from the SDTLA. Please contact Linda Stevens at mrs.lindasuestevens@gmail.com for your copy today.

STORIES WITH TEX HOY

Tex will remember a civil trial we had in federal court involving the rape of a young woman in a mall parking lot. He was defending the Mall ownership. I had the mother of the victim on the stand, and she gave tearful and effective testimony about the after effects on her daughter. When the Court asked Tex if he wanted to cross-examine her, in Tex's unique style, he stood up, walked to the witness, held out his hand, and just escorted her back to her seat in the audience. No questions. He will also remember the verdict; I won't reveal it.

Steven M. Johnson

A number of years ago, Tex and I were representing co-defendants in a med mal case in which Judge Charles Kornmann represented the plaintiff (this was obviously before he became a judge). We had a deposition of an expert witness in Flagstaff, Arizona, after which we had to drive to Phoenix to catch a flight the next day. Being the young guy, I was made the designated driver so Tex and Judge Kornmann could have a couple beers. When we got to Phoenix, we all went to visit a college roommate of mine. Tex proceeded to charm my friend and his wife. For several years thereafter my friend and his wife always asked me how Tex was doing. Tex has always been extremely gracious and favorably impresses people he meets.

Reed Rasmussen

I was about two years out of law school and was asked to be second chair defending a large personal injury case. I was second chair to Don Shultz. The plaintiff's attorney was from Alabama. He hired Tex Hoy to be his local counsel. Tex was a superb lawyer with a great reputation in the legal community. The case was tried in federal court in the old territorial courthouse in Deadwood. It may have been the last civil case tried there. The courtroom had a regal 20' high ceiling. The bench and the woodwork were nearly 100 year-old craftsmanship. You had the feeling you were in the courtroom of To Kill a Mockingbird or the Scopes Trial.

Tex was a handsome figure in his dark suit and perfect tie. He had warm greetings for the court reporter, clerk of courts, bailiff, and the federal judge. He came to our counsel table and greeted us with a warm, engaging smile. He was the center of attention for the prospective jurors seated in the back. Tex owned the courtroom.

Alabama counsel had Tex conduct the voir dire. Tex engaged the jury with meaningful open-ended questions. His voir dire involved the jurors. They felt comfortable talking to Tex. He listened to each juror and was respectful of their time and opinions. The jurors felt comfortable speaking truthfully to Tex. He never asked them for a commitment to anything but listened carefully to each witness.

Alabama counsel was lead counsel. The plaintiffs were from Alabama. Alabama counsel was flamboyant, bellicose, and downright snarly. He took over the presentation of the evidence and almost all of the cross-examination. He allowed Tex to do cross-examination of only one witness. Tex, with his calm demeanor, put together one of the shortest and most effective cross-examinations I have seen in my career. At the end of the cross-examination, as opposing counsel, I found myself wanting to say, “Wow”.

Tex gave a fine closing argument using testimony and analogies that the jury understood. Alabama counsel reserved half of the time for rebuttal. He was theatrical, waving his arms, and pounding on the jury rail within two feet of a number of the jurors. He was so close to the jury and so loud that the jurors were actually leaning back in their chairs to avoid his tirade.

When the verdict came in, Alabama counsel pounded his fist on the table and immediately demanded that the jury be polled. They were, and the verdict was accepted by the court. As Alabama counsel was angrily stuffing papers into his briefcase, Tex stood, faced the jury, and thanked them for their time and their consideration. A true class act.

After watching Tex in that trial, I knew what kind of lawyer I wanted to be.

Gregory A. Eiesland

The next edition of the Barrister will feature the SDTLA Past President, Horace R. Jackson.

If anyone has lessons learned or stories about him, please share them with Linda Stevens, SDTLA Executive Director. She can be contacted at mrs.lindasuestevens@gmail.com

WINNING WORKERS' COMPENSATION CASES FOR INJURED EMPLOYEES

JIM LEACH[1]

South Dakota has a severe shortage of lawyers who will represent injured employees in workers' compensation cases, especially where a six-figure recovery isn't at stake. This article explains workers' compensation law from A to Z. My goal is to encourage lawyers to represent injured people in workers' compensation cases, including cases that don't involve big money.

Without an attorney, an injured worker is helpless. The worker faces a system that is much the same as the civil litigation system, with many technical and evidentiary requirements, except it has no jury trials. A layperson has no more hope of beating a lawyer in a workers' compensation case than in a civil lawsuit.

If your main interest in practicing law is making money, I recommend that you do not represent injured people in workers' compensation cases. You are unlikely to be good at it, and you won't be happy doing it. But if your heart is with the working people of this world, representing them in workers' compensation cases can be incredibly gratifying. And sometimes you will even make money.

[1]*In alphabetical order, Russ Janklow, Margo Julius, Brad Lee, and Mike Simpson, all skilled and experienced workers' compensation attorneys, reviewed this article and provided valuable advice. The opinions I express are my own, and all errors are mine.*

I won't sugarcoat it: litigating a workers' compensation case, even one that should be simple, can take years. The client has no recourse during the delay. A bad faith case, which can be brought only when the workers' compensation case is completed, is rarely a viable possibility, and comes with its own set of challenges. Almost every insurer invests in a reputation for tough defense. And workers who finally win must pay their own attorney fees and costs, so their best possible outcome is 65 to 70% of what the law entitles them to.

If you're just starting out in workers' compensation, I recommend that you associate with an experienced lawyer for your first few cases, and develop a mentor. This will help you avoid the experience of one very good attorney I know who had such a bad time in his first workers' compensation case that he swore off them forever.

I. The theory of workers' compensation—and reality in South Dakota

Workers' compensation law is based on what is called a "grand bargain": workers lost the right to sue an employer in tort, the right to a jury trial, and the right to damages to compensate them for their losses, including pain and suffering, in exchange for a no-fault defined benefit system. "Work[ers'] compensation legislation is based upon the idea that the common law rule of liability for personal injuries incident to the operation of industrial enterprises, based as it is upon the negligence of the employer, with its defenses of contributory negligence, fellow servants' negligence, and assumption of the risk, is inapplicable to modern conditions of employment." *Scissons v. Rapid City,* 251 N.W.2d 681, 686 (S.D. 1977).

To accomplish these goals, workers' compensation law was intended to give employers "liability which is limited and determinate," and in exchange to give employees "relief based on the fact of employment, practically automatic and certain, expeditious and independent of proof of fault." Id. (emphasis added).

As I look back at five decades of representing injured workers in South Dakota, it's obvious that only employers received what they were promised: limited, determinate liability. The promise of relief for injured workers that is "practically automatic and certain" and "expeditious" is tragically unfulfilled.

Instead, insurers deny workers' compensation claims on any colorable basis, knowing that the vast majority of claims are not sufficiently valuable for the worker to be able to find a lawyer. Once a claim is denied, an injured worker will receive nothing until litigation is concluded. Insurers, with their premiums invested, are well positioned to withstand long delays until the case is resolved. Injured workers, most of whom lived paycheck to paycheck before their injury, have no such ability. They may be forced to settle their cases for a fraction of their value, then will see part of that fraction disappear into their attorney's pocket, a necessary evil of a system that requires people whose claims are denied to pay for their own attorneys, thereby making it impossible for any injured worker ever to be made whole.

Making the problem far worse, workers' compensation law has become sufficiently complicated that most attorneys won't venture into it. And the system, far from being "expeditious," moves far slower than the civil litigation system. *Sowards v. Hills Materials Co.,* 521 N.W.2d 649, 652 (S.D. 1994), reminded everyone that workers' compensation procedures should be "generally as summary and informal as is compatible with an orderly investigation of the merits," that they should "reach a right decision by the shortest and quickest possible route," with "informality" that "prevents the defeat of claims by technicalities" and "simplifies and expedites the achievement of substantially just results." (internal quotations omitted). But this reminder had little effect.

As I write this, the Department has only one Administrative Law Judge to process cases, decide motions, and hear trials. It used to have three. One judge cannot do the work of three.

The Department is also to blame. It allows cases to move at a snail's pace. For example, in a civil case a motion must be filed ten business days before the hearing, a response is due five business days before the hearing, and a reply is due two business days before the hearing. SDCL 15-6-6(a) and (d). So you might have a decision from the bench within two weeks after filing a motion. But workers' compensation cases have no such time requirements. The Department of Labor still operates entirely on paper, so if you have a motion, you mail it to the Department for filing. After your letter reaches the Department, it will, in a few days, send a letter to the defense typically giving it 30 more days to respond, and giving you 15 days to reply. Usually there is no hearing on the motion, and the Department decides it on no fixed schedule.

If a case gets to trial, after it is concluded typically the parties will wait weeks for a transcript, then briefs will be filed over a period of two to three months, then the Department will make a decision a couple of months later, then competing findings of fact and conclusions of law are filed, then the Department enters findings and conclusions and an order. The whole process from trial to order takes at least half a year, and sometimes more.

As to the merits, workers' compensation law and regulations are supposed to be construed liberally in favor of claimants. *LaPlante v. GGNSC, Madison S.D., LLC,* 2020 S.D. 13, ¶ 22. But this principle is often honored more in its breach than in its observance. The circuit courts and the Supreme Court are more likely than the Department to think it makes a difference in any particular case.

II. Does your client have a workers' compensation case, a tort case, or both?

1. Workers' compensation is an exclusive remedy

Workers' compensation is the exclusive remedy for all personal injury or death arising out of and in the course of employment that is caused by the employer or a fellow employee. SDCL 62-3-2. The vast majority of injuries that

occur at work fall into this category. In some cases, the injured employee might prefer a tort remedy; in other cases, the employer might prefer it. Whether either or both sides prefer the tort system is irrelevant. The employer and the employee cannot by agreement change how workers' compensation law applies to them. SDCL 62-3-18.

An injury "arises out of" employment when "there is a causal connection between the injury and the employment. The employment need not be the direct or the proximate cause of the injury, rather it is sufficient if the accident had its origin in the hazard to which the employment exposed the employee[.]" *Mudlin v. Hills Material Co.,* 2005 S.D. 64, ¶ 11(internal quotations and citation omitted).

An injury occurs "in the course of" employment when an employee "is doing something that is either naturally or incidentally related to his employment or which he is either expressly or impliedly authorized to do by the contract or nature of the employment." *Fair v. Nash Finch Co.,* 2007 S.D. 16, ¶ 11 (internal quotations omitted). If this were a law review article, I would write many pages explaining the nuances of the "arises out of" and "in the course of" requirements. But such a discussion here would take me away from the practical focus of this article. If one of these issues comes up in your case, I suggest you go to SDCL 62-3-2, start with the headnotes, and find the relevant cases.

2. Exceptions to the exclusive remedy rule

The exclusive remedy rule has six main exceptions. The first is provided by SDCL 62-3-11: if an employer does not have workers' compensation insurance, and is not self-insured under SDCL 62-5-5, an injured employee may sue the employer for damages, or may bring a workers' compensation action in circuit court and recover twice the compensation otherwise due. These are usually useless remedies, because uninsured employers tend to be fly-by-night businesses that have few assets, and that threaten bankruptcy at the drop of a summons. Efforts to require that all South Dakota employers carry workers' compensation insurance have failed.

The second exception is farm and agricultural laborers, and some "domestic servants," unless the employer chooses to buy workers' compensation insurance covering them. SDCL 62-3-15 and 62-3-17. A "domestic servant" is "an employee who performs services in or around a home, which pertain to a house, home, household, lawn, garden, or family." SDCL 62-1-1(5).

The third exception is independent contractors. As in other areas of the law, whether a person is an "independent contractor" or an "employee" is a mixed question of law and fact, and the parties cannot control it by agreement. A person is presumed to be an employee until shown to be an independent contractor. *Egemo v. Flores,* 470 N.W.2d 817, 821 (S.D. 1991). The

factors that distinguish employees from independent contractors are found in *Jackson v. Lee's Travelers Lodge,* 563 N.W.2d 858, 861 (S.D. 1997).

The fourth exception is intentional torts. An "intentional tort" occurs only when "an ordinary, reasonable, prudent person would believe an injury was substantially certain to result from the employer's conduct," or the employer has "a conscious and deliberate intent directed to the purpose of inflicting injury." Conduct that is "grossly negligent, reckless or wanton" is not "intentional." Even an employer who "knowingly permits a hazardous work condition to exist, knowingly orders a claimant to perform an extremely dangerous job, or willfully fails to furnish a safe workplace," causing an injury, has not committed an intentional tort. *McMillin v. Mueller,* 2005 S.D. 41, ¶ ¶12 and 14.

The fifth exception is torts committed by third parties who are unconnected with the employer. For example, an employee is struck by a negligent driver who has no connection with the employer. The negligent driver is not protected by workers' compensation.

An injured employee who has a tort action is entitled to pursue it as well as workers' compensation benefits. Remedies in a tort action differ from but overlap with workers' compensation remedies. An injured worker is entitled to receive benefits in both actions, so long as they are not benefits for the same elements of damage (so-called "double recovery"). But it's usually hard to determine what benefits are for the same elements of damage, especially because most cases are settled, so there is no jury or court determination of how much money was received for each element of damages.

SDCL 62-4-38 to 40 address coordination of potential remedies in such cases to preclude "double recovery." These issues are addressed in a number of cases, including *Zoss v. Dakota Truck Underwriters I and II,* 1998 S.D. 23 and 1999 S.D. 37, *Dakota Plains AG Ctr., LLC v. Smithey,* 2009 S.D. 78, and *Luze v. New FB Co.,* 2020 S.D. 70.

As a practical matter, if a client has a workers' compensation claim and a tort claim, the client's attorney must give careful consideration, beginning at the start of the case, about how to maximize the recovery to the client, and minimize the windfall to the workers' compensation insurer that a tort recovery can provide. These can be difficult and complex issues, and they are prone to result in litigation after the merits of both claims are decided. If different attorneys are handling the workers' compensation and tort claim, communication between them throughout is essential.

The sixth exception is for "a mental injury arising from emotional, mental, or nonphysical stress or stimuli." SDCL 62-1-1(7). Because this is not covered by workers' compensation, tort remedies remain alive and well.

3. Occupational diseases

Very occasionally you may run into an employee whose claim is considered an "occupational disease." Such claims are covered by workers' compensation under SDCL Chapter 62-8, which differs significantly from the law that applies to other work injuries.

Because occupational disease claims are unusual, I won't address how the law that applies to them is different. What's important is that you be able to recognize a potential occupational disease claim.

SDCL 62-8-1(6) defines "occupational disease" as "a disease peculiar to the occupation in which the employee was engaged and due to causes in excess of the ordinary hazards of employment and includes any disease due or attributable to exposure to or contact with any radioactive material by an employee in the course of employment."

A social worker who developed fungal sinusitis because of mold in her workplace did not sustain an occupational disease, because the disease arose from an environmental condition of her workplace, not a condition intrinsic to the occupation of social workers. *Sander v. Parkview Care Ctr.,* 2007 S.D. 103, ¶ 32. For the same reason, a commercial laundry worker who developed skin problems and asthma as a result of exposure to bleach did not sustain an occupational disease. *Sauer v. Tiffany Laundry & Dry Cleaners,* 2001 S.D. 24, ¶¶ 11-14. And a bookkeeper and salesperson who had allergic reactions to lawn and garden chemicals did not sustain an occupational disease. *Zoss v. United Bldg. Ctrs.,* 1997 S.D. 93, ¶ 14.

III. Starting a workers' compensation case

1. Your client's right to medical treatment

Often an injured worker sees you for the first time after having been denied medical treatment. That's an urgent situation for anyone, and usually even more so for your potential client, because it is often tied to the potential client's ability to work and to control pain. These people need your immediate advice about their right to medical treatment, and often your immediate intervention to try to get it. None of them will be able to pay you hourly. These situations allow you to really help people with often a minimum investment of your time.

The insurer is required to provide medical care that is "necessary" or "suitable and proper." SDCL 62-4-1. This determination is up to the patient's doctor: "It is in the doctor's province to determine what is necessary or suitable and proper. When a disagreement arises as to the treatment rendered, or recommended by the physician, it is for the employer to show that the treatment was not necessary or suitable and proper." *Engel v. Prostrollo Motors,* 2003 S.D. 32, ¶ 2, 656 N.W.2d 299, 304, quoting *Krier v. John Morrell & Co.,* 473 N.W.2d 496, 498 (S.D. 1991). This is a heavy burden that an insurer can rarely meet.

The injured worker, not the employer or insurer, has the right to select the initial medical provider. SDCL 62-4-1 ("The employee shall have the initial selection to secure the employee's own physician, surgeon, or hospital services at the employer's expense.") The client's medical provider has the right to refer the patient to the physicians the medical provider deems appropriate. "The medical practitioner or surgeon selected may arrange for any consultation, referral, or extraordinary or other specialized medical services as the nature of the injury shall require." SDCL 62-4-43.

The employer or insurer have no right to interfere in the referral, or to choose their preferred medical provider. The client does not have a right to choose which physician to be referred to, but if the client wants to see a particular physician, the client should ask the medical provider for a referral to that person, and if the medical provider makes it, the insurer must pay for it. *Dittman v. Rapid City School Dist. et al.,* 32 Civ. 19-114 (Hughes Co. 2020) at 5-6, https://dlr.sd.gov/workers_ compensation/appeals_decisions/32_dittman.pdf.

All these rules are subject to the managed care regulations of the Department, promulgated pursuant to SDCL 58-20-24, which limit referrals to medical providers who participate in the insurer's approved case management plan, subject to the exceptions set out in ARSD 47:03:04:05. Id.

Medical treatment provided under workers' compensation is paid for according to the workers' compensation fee schedule. SDCL 62-7-8. The client cannot be required to pay a co-payment or a deductible. The medical provider may not "balance bill" the client for the difference between what the medical provider claims the services are worth and the amount specified in the fee schedule. Id. An insurer who denies workers' compensation coverage loses the right to use the fee schedule. *Wise v. Brooks Const. Services,* 2006 S.D. 80, ¶ 38.

Medical services needed to diagnose whether an employee's symptoms resulted from a work injury are covered, even if the tests show that the symptoms are unrelated to the injury. *Mettler v. Sibco., Inc.,* 2001 S.D. 64, ¶ 9.

Once an injured employee is found entitled to medical care for an injury, the employee's entitlement continues until and unless the insurer brings an action under SDCL 62-7-33 and obtains an order terminating it. A medical examination obtained by the insurer that states a valid ground to terminate medical benefits does not authorize the insurer to terminate them. This has been the law for decades. *Johnson v. UPS,* 2020 S.D. 39, ¶¶ 36-45.

2. If the workers' compensation insurer refuses to provide medical treatment, and your client has health insurance, use SDCL 62-1-1.3 to get the medical treatment your client needs

If your client has health insurance, and needs medical treatment that the workers' compensation insurer will not authorize, the client is in luck. Every health insurance policy excludes coverage for injuries covered by workers' compensation. But if the workers' compensation insurer refuses to pay for

medical treatment, the health insurer must pay for it. If the injury is later determined to be compensable, the workers' compensation carrier must reimburse the health insurer. SDCL 62-1-1.3.

If the health insurer pays, your client will be subject to the policy's co-payments and deductibles. But if the injury is later determined to be compensable, the worker's compensation insurer must reimburse your client for these expenses, plus interest. Id.

An attorney is entitled to a fee from the health insurer for recovering its money by establishing that the workers' compensation insurer is liable. *Bowen v. American Family Ins. Group,* 504 N.W.2d 604 (S.D. 1993). But if the health insurer that paid benefits provided them pursuant to an employer-sponsored plan that is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and the ERISA plan provides that it is not responsible for any attorney fees incurred in recovering subrogated benefits, this agreement, because of the supremacy clause, controls over state law. *Admin. Comm. of the Wal-Mart Stores, Inc. v. Shank,* 500 F.3d 834 (8th Cir. 2007). Be sure the ERISA plan is entitled to all the money it claims. If it's not, negotiating with or suing the plan may save your client tens of thousands of dollars. See *Noble v. Operating Engineers Local #49 Health and Welfare Fund,* Civ. 20-5022 (D. S. D., W. Div.)

3. Understand how your client is going to survive until and after the workers' compensation case is resolved

The particular circumstances and needs of the human being who sits in front of you are critical. This person is often in crisis. Sometimes you need to push a slow insurer to start paying disability benefits. By demonstrating that you understand your client's needs and will fight for your client, you develop a bond with your client that will help you both throughout the case.

4. Understand depression, how to perceive it, and how to listen, and talk, to your client about it

Your client often will be depressed. People who are unable to work because of an injury are usually in pain; are trying to come to terms with losing part of their physical ability; are facing potential job loss; have lost the sense of meaning and purpose that most people get from work; often are suffering a loss or impairment of their sexual life because of pain and disability; and face financial distress, especially if the insurer is not paying workers' compensation benefits. That's more than enough to depress anyone, including even those among us who have never struggled with the ups and downs of life.

I don't mean that you should attempt to become your client's psychotherapist. But you need to learn how to sit with people, checklists aside, and just listen, and gently probe, and listen more. At some point I often ask "Have you been depressed?," then listen some more. I have asked hundreds of clients "Have you thought about taking your own life?"

If they have, I'll ask "Do you have a plan?" If they do, I talk to them in a non-judgmental manner about options and resources.

Why do this? Because it is the reality in which many injured people live; because you as a lawyer are probably the first person outside their family who has really listened to them; because by asking these questions, then really listening, you communicate to your client that you are genuinely interested, and that you care; and because this genuine interest and caring is therapeutic. And when the client cries in your office, as hundreds have cried in mine, I show them by my words and actions that I accept their tears and their pain. This helps them and it helps my relationship with them throughout the case.

If you'd like to understand this better, I recommend On Becoming a Person by Carl Rogers. It never mentions lawyers, but it's all about how to create a helping human relationship.

5. With very limited exceptions, an injured employee has no right to continued employment

One of your client's first questions may be whether the employer can terminate employment because the client no longer can do the job because of the work injury. Usually the answer is "yes." If the employer is subject to the Family and Medical Leave Act or the Americans with Disabilities Act, your client may have some limited rights. As a practical matter, the insurer will often pressure the employer to keep the employee at work, even in modified, lighter work, to avoid paying workers' compensation benefits.

6. Investigating a potential case

Sometimes I take a case when the client first sits down with me. But it's often not possible to judge whether a case has merit without seeing documents. I recommend you start by gathering the following:

- The South Dakota Department of Labor's file on your client, which includes every workers' compensation injury your client has ever had in this state. You'll need a release, and the Department will charge you $20 per reported injury, but the documents you receive can be invaluable in understanding and evaluating the potential case.
- Any workers' compensation files for injuries your client received in another state.
- All your client's medical records for the past 15 years, and all medical records for the injured body part as far back as you can get them. Once you receive the records, you or your legal assistant should organize them chronologically by provider, bates-stamp them, then dictate a synopsis.
- Your client's federal income tax returns for as long back as you can get them. All you need from them is the W-2's, which will allow you to construct an accurate job and earnings history. Sometimes the client,

or the client's tax preparer, has them. Sometimes you have to order them from the IRS.

7. Time limitations

If the insurer notifies the injured worker and the Department that it intends to deny coverage—either in total or for future benefits— the worker has two years to file a written petition for hearing. SDCL 62-7-35; *Owens v. F.E.M. Elec. Ass'n,* 2005 S.D. 35, ¶ 9. If no such notice is given, an employee must file a petition for hearing within three years after benefits are last paid, or future compensation is barred, unless a change in the employee's condition justifies it. SDCL 62-7-33 and 62-7-35.1.

8. Costs and attorney fees

In a significant workers' compensation case, I typically advance between $5,000 and $10,000 before the case is over. I never create a budget; if I take a case, I consider it my obligation to spend what's necessary. If you aren't in a position to advance such costs, find someone to associate with you who is, or refer the case.

Attorney fees are limited to 25% of the disputed amount if the case is settled before trial; 30% if the case is tried to the Department of Labor or decided on appeal to circuit court; and 35% if the case is decided by the Supreme Court. SDCL 62-7-36. These are maximums, not automatic awards. If the case is settled without trial and without any real dispute, attorney fees should be based on an hourly rate, in accordance with Rule of Professional Conduct 1.5, comment [3], which says that contingent fees, like all fees, must be reasonable. A lawyer was suspended for six months for attempting to charge a workers' compensation client a fee of 25%, amounting to $62,446, for minimal work. *Iowa Supreme Court Board of Prof. Ethics and Conduct v. Hoffman,* 572 N.W.2d 904 (Iowa 1997).

SDCL 62-7-36 provides that attorney fees in workers' compensation cases are "subject to approval of the department." The Department has always read this to mean that the employee's attorney's fees must be approved by it, but that despite the plain language of the statute, insurer's attorney's fees are not subject to its approval.

SDCL 58-12-3 provides that if the insurer's refusal to pay was "vexatious or without reasonable cause," the claimant can recover attorney's fees from the insurer. But the Department rarely finds that an insurer's refusal to pay was "vexatious or without reasonable cause." And just to seek such fees, an attorney has to bring a new case, for which no fees are recoverable. *Lagler v. Menard, Inc.,* 2018 S.D. 53, ¶¶ 45-49, is a rare case in which the Supreme Court reversed the Department's refusal to award fees under SDCL 58-12-3.

Unlike civil litigation, a prevailing party in a workers' compensation case does not recover taxable disbursements as a matter of right. *Johnson v.*

Powder River Transp., 2002 S.D. 23, ¶¶ 35-41. The Department has discretion to award disbursements, but rarely does so.

IV. Moving the case forward

1. Finding the law

South Dakota workers' compensation law is purely statutory. *Aadland v. St. Luke's Midland Regional Medical Ctr.,* 537 N.W.2d 666, 668 (S.D. 1995). The law as it existed on the date of the worker's injury applies throughout the case, without regard to later changes. *Sandner v. Minnehaha County,* 2002 S.D. 123, ¶ 8. There is no common law of workers' compensation. The law is found in SDCL Chapter 62. Unfortunately, many provisions on the same or related subjects are spread around Chapter 62 in no rational order, like it was written by a jigsaw puzzle master with a nasty sense of humor. Reading workers' compensation cases is a good way to see how the statutes fit together, and to learn common strategies and arguments.

Besides Chapter 62, the law is contained in the decisions of the South Dakota Supreme Court. A few circuit court decisions are found at https://dlr.sd.gov/workers_compensation/decisions_appeals.aspx. Hundreds of decisions of the Department are on Westlaw and Lexis. But the Department does not consider its own decisions to establish precedent. *Kafka v. Shopko Stores, Inc.,* et al., 1995 SD Wrk. Comp. Lexis 52 * 5. So in any particular case, the Department chooses whether or not to follow its previous decisions. On a number of issues, the Department has issued decisions that contradict each other.

Larson's Workers' Compensation Law, which is on Westlaw and Lexis, is the authority in the field. The Supreme Court regularly relies on it in deciding any question not resolved by Chapter 62 or its own previous decisions. According to my Lexis search, the Supreme Court has cited it 134 times.

The Department's regulations are at ARSD 47:03. Most relevant to you is 47:03:01, "Workers' compensation hearings," which despite its title actually covers a number of important procedural matters relevant to a workers' compensation case, not just hearings (which means trials). The regulations aren't long and I suggest you review them before starting your first case.

2. Acting promptly

The insurer, unlike your client, never has problems supporting its family, eating, paying rent, or becoming depressed while the case lags and it loses hope. Delay is always the insurer's friend, and your client's enemy.

So you need to push the case forward as rapidly as possible. After the Answer is filed, I immediately ask the Department to enter a Scheduling Order. The Department responds by sending a form asking each side to submit a proposed schedule. You want the quickest schedule possible consistent with your ability to develop the case.

The Department may dismiss a case for lack of prosecution if "no activity"

has occurred for at least one year, unless "good cause" to the contrary is shown. Any such dismissal is with prejudice. ARSD 47:03:01:09. *LaPlante v. GGNSC, Madison S.D., LLC,* 2020 S.D. 13, ¶¶ 20-25, reversed the Department's dismissal because the injured worker's participation in a vocational rehabilitation program constituted "activity," even though her attorney did not notify the Department or the defense of it. LaPlante suggests, but does not decide, that the regulation's requirement that the dismissal be with prejudice is improper. Id. n.6. But there is never any reason for an attorney to let a case go for a year without making progress in it and notifying the Department of the progress, and even a dismissal without prejudice may preclude the case from being refiled because of the statute of limitations.

3. The petition for hearing

A workers' compensation case begins with a petition for hearing. SDCL 62-7-12. By regulation, it need contain only a few simple facts: "the name of the claimant, the name of the employer, the name of the insurer [if you call the Department, it will look it up for you], the time and place of [the] accident, the manner in which the accident occurred, the fact that the employer had actual knowledge of the injury within 3 business days or that written notice of injury was served upon the employer, and the nature and extent of the disability of the employee." ARSD 47:03:01:02. I've rarely known "the nature and extent of the disability" when I've filed the petition, and no one has ever complained. You need not know the relief you want: "A general equitable request for an award shall constitute a sufficient prayer for awarding compensation, interest on overdue compensation, and costs to the claimant." Id. In practice, a simple, standard form that you can modify to fit the facts of each case is sufficient.

A case presently pending before the Supreme Court, *May v. Spearfish Pellet Co., LLC,* No. 29386, will decide whether an injured worker's pro se letter to the Department sufficiently complied with the regulation to qualify as a petition for hearing, and thereby satisfy the statute of limitations.

4. Choosing whether to disqualify the Administrative Law Judge, or move the case to the Office of Hearing Examiners

Just as in circuit court, each side has the right to disqualify the Administrative Law Judge assigned. This request must be made within twenty days after the Department gives notice that the Administrative Law Judge has been assigned to the case. SDCL 62-7-12.2. Each side also has the right to move the case from the Department to the Office of Hearing Examiners for hearing (trial) by giving notice of the request within ten days after the Department serves notice of the hearing. SDCL 1-26-18.3.

5. Computing your client's average weekly wage and compensation rate

Your client's average weekly wage determines how much the client receives if eligible for benefits, and whether the client is entitled to certain benefits. To determine average weekly wage, start by determining the date of

injury. In a traumatic injury case, this is obvious, but in a gradually-developing injury case, it is not, as I discuss below.

Once you have a date of injury, two statutes usually control how average weekly wage is computed: SDCL 62-4-24, which applies to most employees, and SDCL 62-4-25, which applies to employees in jobs in which it is customary to operate throughout the working days of the year, but who are not covered by SDCL 62-4-24. Statutes that only rarely apply are SDCL 62-4-26, 62-4-27, and 62-4-28.

To make the computations required by SDCL 62-4-24, you'll need the employee's wages for each of the fifty-two weeks before the injury. To make the computations required by SDCL 62-4-25, you'll need the employee's wages for each week of employment. For both statutes, knowing the employee's total wages will not allow you to compute average weekly wage.

The easiest way to get the records you need is if your client has kept pay stubs for the year before the injury. The second easiest way is if your client can get them, or a printout of them, from the employer. Otherwise, they may be in the Department's file, or you can get them in discovery.

SDCL 62-1-1(6) defines "earnings," a term used in 62-4-24 through 62-4-28, to include "payment for all hours worked, including overtime hours at straight time pay[.]" So the 50% extra an employee earns for overtime is not counted in determining average weekly wage. Wages from other employment at the time of the injury are also not included. SDCL 62-1-23.

The Department of Labor excludes most bonuses from earnings. The Supreme Court has never ruled on this subject, but may do so in *Dittman v. Rapid City School District,* No. 29548, a recently-filed appeal.

Never rely on the average weekly wage calculation of an insurance company or the Department of Labor. I can't remember the last time an insurance company accurately computed an average weekly wage. The Department of Labor, which will compute it on request, is better but still makes mistakes. The only way you can know the correct average weekly wage is to compute it yourself.

The employee's benefit rate is two-thirds of the average weekly wage, subject to two exceptions. The first is that the rate may not be lower than the state minimum or higher than the state maximum. SDCL 62-4-3. These numbers rise a little every year to reflect wage increases. For injuries occurring in the year beginning July 1, 2020, the minimum is $429 and the maximum is $857. So an employee whose average weekly wage for a July 2, 2020, injury was $450 will have a compensation rate of $429. The maximum and minimum amounts for other years are available at https://dlr.sd.gov/workers_compensation/documents/weekly_rates_historical.pdf.

The second exception is that if the employee earned less than the state minimum, the compensation rate is the earnings less the deduction for

federal taxes and F.I.C.A. payments. So an employee who was injured on July 2, 2020, whose average weekly wage was $400 (which is below the state minimum of $429) has a compensation rate of $400 less the amounts deducted for federal taxes and F.I.C.A. payments. In all other computations of average weekly wage, deductions for federal taxes and F.I.C.A. payments are part of earnings.

6. Educate your client on the need to attend all medical appointments and to be on time

A client can inflict completely avoidable wounds on the case by missing medical or being late to physical therapy appointments. The client may not be very organized, or may have car trouble, or may not think that the appointments are helping, or may have a habit of being late. But many doctors, most physical therapists, the defense, and usually the judge, will interpret these behaviors as meaning that the client doesn't really want to get well, and will implicitly or explicitly hold this against the client. Explain to your client why it's important to attend all appointments, on time, and that if the client has to miss an appointment or be late, to call the medical provider well ahead of time and explain the problem, and reschedule if necessary.

7. Don't allow the insurer's "case manager" to meet with your client, or to attend your client's medical appointments

In any case involving disability, the insurer will assign a "case manager" to meet with your client and attend all medical appointments. Don't be fooled by the neutral term "case manager." These people will pretend to be on your client's side. But the insurer has hired them and is paying them to watch, manipulate, and undermine your client at every turn. Some companies that provide "case managers" are owned by insurance companies or administrators. Insurer Risk Administration Services owns Ohara Managed Care. Insurance administrator Claims Associates owns Rehabilitation Associates. Regardless of whether the insurer or administrator owns the case management company, they expect "case managers" to be on their side and to save them money.

I never let these people meet with my client, and I don't let them attend my client's medical appointments. They have no right to do either unless the client allows them to. I have never met a client who wants an adversary attending a medical appointment. The "case manager" is allowed to visit with the client's medical provider, but not while the client is there. HF No. 1D, 2009/10, Declaratory Ruling (2009) at 5 (neither "case manager" nor any other representative of insurer has the right to be present during a medical examination).

V. The three essential elements of every workers' compensation claim: notice, injury, and causation

1. Proving notice that an injury occurred and notice that it may be work-related

An essential element that, unless admitted, you must prove for your client to receive any benefits in a workers' compensation case is that the employer received notice within three business days that an injury occurred, and notice that it may be work-related. Notice may be actual or written. SDCL 62-7-10.

The three-business-day period begins to run upon "the occurrence of the injury." It's easy to determine when a broken leg occurred, but what about a gradually-developing injury like back pain that keeps getting worse, or wrist pain that begins as a nuisance but becomes disabling?

In general, "The time period for notice or claim does not begin to run until the claimant, as a reasonable person, should recognize the nature, seriousness, and probable compensable character of [the] injury or disease." *Miller v. Lake Area Hosp.,* 1996 S.D. 89, ¶ 14, quoting Larson's Workmen's Compensation Law § 78.41(a) (1995). Whether a claimant's conduct is reasonable is judged "in the light of his own education and intelligence, not in the light of the standard of some hypothetical reasonable person of the kind familiar to tort law." *Loewen v. Hyman Freightways,* 1997 S.D. 2, ¶ 15, quoting Larson's Workmen's Compensation Law § 78.41(d) (1996).

In some cases, the time period does not begin to run until the employee misses work because of the injury. *Tieszen v. John Morrell & Co.,* 523 N.W.2d 401, 405 (S.D. 1995). In other cases, it occurs before then. *Miller v. Lake Area Hosp.,* 1996 S.D. 89, ¶ 17. And in still other cases, it does not occur until the worker learns that the symptoms are work-related. *Vu v. John Morrell & Co.,* 2005 S.D. 105, ¶ 27 (33-month delay between injury and when employee recognized she had sustained a compensable injury at work; notice was adequate because it was given within the statutory time period after she became aware of the "nature, seriousness, and probable compensable character" of the injury).

Merely proving that the employer knew of the injury is insufficient. In addition, the employer must have had notice of at least the possibility that the injury is work-related. *Shykes v. Rapid City Hilton Inn,* 2000 S.D. 123, ¶ 37. Work-relatedness may seem obvious to you, but if you have a chance to give notice within the statutory period, tell the employer in writing that the injury is related to the employee's work, otherwise you may end up litigating the issue, as in *Streyle v. Steiner Corporation,* 345 N.W.2d 865 (S.D. 1984).

SDCL 62-7-10(2) provides an exception to the three-business-day rule if the employer receives written notice and the employee had "good cause" for failing to give written notice within three business days. The statute provides that this determination "shall be liberally construed in favor of the employee."

2. Proving with medical evidence that your client sustained an injury

Unless the insurer admits that your client was injured on the job, you must prove it through medical evidence. "An injury is compensable only if it is established by medical evidence[.]" SDCL 62-1-1(7). A simple hypothetical question to your client's doctor is all you need: "Assuming that what your

patient told you about what happened is correct, did your patient sustain a work injury on [the date alleged]?" The defense will object that your question "lacks foundation," and will ask on cross-examination whether the doctor can verify that the injury happened when and where the patient said it did. But this objection and these questions are legally meaningless. Of course, if your client has given multiple versions of when, where, and how the injury occurred, you have a problem.

Any claimed injury is "given greater weight if supported by objective medical findings." SDCL 62-1-15. But objective findings are not required to sustain a workers' compensation claim. *Vollmer v. Wal-Mart Store, Inc.,* 2007 S.D. 25, ¶ 25. "Simply because an ailment does not manifest objective evidence does not mean it does not exist." Id. at 23.

3. Proving causation

SDCL 62-1-1(7) establishes three alternative methods of proving causation:

- First, by medical testimony that "the employment or employment related activities are a major contributing cause of the condition complained of[.]"
- Second, by medical testimony that "the injury combines with a preexisting disease or condition to cause or prolong disability, impairment, or need for treatment," and "the employment or employment related injury is and remains a major contributing cause of the disability, impairment, or need for treatment[.]"
- Third, by medical testimony that "the injury combines with a preexisting work related compensable injury, disability, or impairment," and "the subsequent employment or subsequent employment related activities contributed independently to the disability, impairment, or need for treatment."

The first two tests use the term "a major contributing cause." This is a legal term, not a medical one. Every doctor I've ever questioned agrees that the term has no medical definition, that it's not addressed in any medical textbook, and that they never heard the term in medical school. Nonetheless, the Department and the courts rely on medical conclusions about "a major contributing cause," supplemented by the few cases on the subject, and their own sense of what the term should mean.

Insurers and physicians often believe the test is "the major contributing cause" not "a major contributing cause." The significance of the difference was confirmed in *Brown v. Douglas Sch. Dist.,* 2002 S.D. 92, ¶¶ 23-26, which held that medical opinion testimony based on "the major contributing cause" held the injured worker to too high a standard.

A medical opinion that a work injury was fifty percent responsible for an injured worker's condition, as a matter of law, is sufficient to show that a work injury is "a major contributing cause" of the condition. *Orth v. Stoebner &*

Permann Constr., Inc., 2006 S.D. 99, ¶ 42. But the Supreme Court has never said that a work injury must be at least fifty percent responsible in order to be "a major contributing cause" of the condition. The statute uses the indefinite article "a." There can be only one "the" major contributing cause, but several "a" major contributing causes. *Cavender v. Bodily, Inc.,* 1996 S.D. 74 ¶19 ("an injury may have had several contributing or concurring causes[.]")

An injury may be "a major contributing cause" of a condition when it combines with a preexisting asymptomatic condition. *Sorensen v. Harbor Bar, LLC,* 2015 S.D. 88, ¶ 27. But the fact that a work injury creates the need for treatment of a previously asymptomatic condition, standing alone, is not necessarily sufficient to prove that it is "a major contributing cause" of the treatment. *Armstrong v. Longview Farms, LLP,* 2020 S.D. 1, ¶ 26. Likewise, the fact that an injury is a "but-for" cause of treatment, standing alone, is insufficient to prove causation. Id. ¶ 28. Additional law on "a major contributing cause" may be made by a case now pending before the Supreme Court, *Hughes v. Dakota Mill and Grain, Inc.,* No. 29091.

The third test, which applies where "the injury combines with a preexisting work related compensable injury, disability, or impairment," uses a lower standard of causation: that "the subsequent employment or subsequent employment related activities contributed independently to the disability, impairment, or need for treatment." Despite the plain language of the statute, the Supreme Court has said that the third test "assist[s] with assigning responsibility between a former or subsequent employer or insurer—not determining a question of causation between an employer and employee." Id. ¶ 30.

Nonetheless, after saying this, the Supreme Court went on to analyze whether the claimant had proven his case under the third test. Id. ¶¶ 31-33. So the Supreme Court actually applies the third test to mean what it says, which is that an injured worker can use it to prove causation against an employer. And this is exactly how the Supreme Court has previously read this standard, stating that under it, the injured worker can prove causation by "prov[ing] her occupational duties independently contributed to her resulting pain[.]" *Byrun v. Dakota Wellness Found.,* 2002 S.D. 141, ¶ 15.

As with the "a major contributing cause" test, the "independently contributed" test is a legal term, not a medical one. And as with the "a major contributing cause" test, the Department and the courts nonetheless rely on medical conclusions as to what does or does not "independently contribute," and the cases on the subject, plus their sense of what it should mean.

Whatever causation test applies, it's essential that your expert—ordinarily a treating physician—understands the facts of the injury, knows the client's entire relevant medical history, and understands the legal standard and the defense's probable lines of attack. An unprepared expert can be easy fodder for cross-examination. Always remember that your treating-physician experts,

unlike the defense hand-selected experts, are not professional witnesses. An injured employee can establish causation under the "a major contributing cause" standard even if the expert's testimony does not use that term, but it is far better for the expert to use it. *Wise v. Brooks Constr. Servs.,* 2006 S.D. 80, ¶ 22.

In judging physician testimony, the clarity of the doctor's reasoning, and whether it is consistent with the evidence, are critical. *Pearson v. Evangelical Lutheran Good Samaritan Society,* 2012 S.D. 52, ¶ 23. "[A]n expert's opinion is entitled to no more weight than the facts it stands upon." *Jewett v. Real Tuff, Inc.,* 2011 S.D. 33, ¶ 29. Your expert needs to give a solid explanation, not just a conclusion. *Martz v. Hills Materials,* 2014 S.D. 83, ¶¶ 32-33.

If your physician's testimony is merely that your client's injury preceded the client's condition, you will lose, because "temporal sequencing of symptoms" alone is insufficient to establish causation. *Jewett v. Real Tuff, Inc.,* 2011 S.D. 33, ¶ 24. But "the causation of symptoms is an important factor in finding a causal relationship." Id. So the sequence of symptoms is part, but not all, of a sufficient and convincing opinion on causation.

The Supreme Court has used different language in describing the injured employee's burden of proof. Insurers are fond of citing cases saying that "The evidence necessary to support an award must not be speculative, but rather must be precise and well supported." *Horn v. Dakota Pork,* 2006 S.D. 5, ¶ 14 (internal quotation omitted). But the Supreme Court has recognized that the employee's burden is only to prove causation by a preponderance of the evidence. Id. ¶ 14. Your expert must testify based on reasonable medical probability, not possibility. "It is only when a claimant's expert testimony is equivocal or based on mere possibility that we have found the evidence to be inconclusive and insufficient to satisfy the claimant's burden." *Tebben v. Gil Haugan Constr.,* 2007 S.D. 18, ¶ 25.

Your job is to prepare the physician to give the strongest opinion possible, grounded in the facts of the case, consistent with the other factual and medical evidence, legally sufficient, and with adequate explanation of facts that seem to favor the defense. To do so, you may need to break through the doctor's reluctance to spend the time with you to prepare the doctor's testimony.

Finally, the causation standards of SDCL 62-1-1(7) apply to the injured employee's condition—not to the injury. A "[c]ondition is the loss produced by some injury; i.e., it is the result rather than the cause." *Haynes v. McKie Ford,* 2004 S.D. 99, ¶ 17 (internal quotation, ellipsis, and emphasis omitted).

4. The "clear and convincing evidence" rule for a "mental injury" arising from a compensable physical injury

As discussed above, "a mental injury arising from emotional, mental, or nonphysical stress or stimuli" is not covered under workers' compensation. SDCL 62-1-1(7). But if the mental injury arises from a compensable physical

injury, the mental injury is compensable if causation is shown by "clear and convincing evidence." SDCL 62-1-1(7). This means "that measure or degree of proof" that produces "a firm belief or conviction as to the allegation sought to be established. It is evidence that is so clear, direct, weighty, and convincing that it allows [a person] to reach a clear conviction of the precise facts at issue, without hesitancy as to their truth. Evidence need not be voluminous or undisputed to accomplish this." South Dakota Pattern Jury Instruction (Civil) 1-60-30.

5. "Willful misconduct," but not negligence or assumption of the risk, is a defense

SDCL 62-4-37 prohibits workers' compensation benefits for an "injury or death due to the employee's willful misconduct." This includes "intoxication" and "willful failure or refusal to use a safety appliance furnished by the employer, or to perform a duty required by statute." The burden of proof is on the employer.

To prevail on a safety rule or safety appliance defense, the employer must prove that the employee had actual knowledge of the safety rule or appliance, and its purpose, as well as actual understanding of the danger; that the employer kept the rule alive by bona fide enforcement; and that the employee had no valid excuse for violating the rule. *Bonebright v. City of Miller,* 2020 S.D. 16, ¶ 17. "Horseplay" alone does not prove "willful misconduct." *Petrik v. JJ Concrete, Inc.,* 2015 S.D. 39. In addition, to satisfy the "due to" language of the statute, the employer must prove proximate cause. *Vansteenwyk v. Baumgartner Trees & Landscaping,* 2007 S.D. 36, ¶ 12.

VI. Proving your client's limitations

1. Proving physical limitations

In a personal injury case, your client's testimony about the physical limitations that resulted from an injury, standing alone, may be sufficient to prove them. Not so in a workers' compensation case. Your client's testimony about physical limitations, without medical support, will rarely be believed. You have to support it with corroborating medical evidence.

After your client reaches maximum medical improvement, there are three options for proving your client's limitations. One is through the testimony of a treating physician. Physicians differ in their willingness to provide such testimony. Usually only rehabilitation specialists will do so. The second is through the testimony of a physician, typically a rehabilitation specialist, to whom you refer your client. The third is through a functional capacity evaluation, typically performed by a physical therapist with special training.

2. Proving mental limitations

If an injured employee cannot return to former employment, I usually have a licensed psychologist give an I.Q. test. It's important to document I.Q. because this allows a vocational expert to determine whether some jobs are

beyond your client's mental ability. With the I.Q. test results come subtests that show verbal comprehension, perceptual reasoning, working memory, and processing speed, all of which may show types of jobs that your client cannot do.

If I have a relatively low-functioning client, often a person who has not graduated from high school, I will ask the psychologist to administer achievement tests, which will show the grade level at which the client functions. A person who reads at a sixth grade level, or does math at an eighth grade level, will be extremely limited in the ability to be rehabilitated, or to adapt to a new type of work.

VII. Potential workers' compensation benefits

1. Medical treatment

Because medical treatment is often one of the first and most important issues you discuss with your client, I addressed it in Section III above.

2. Temporary total disability and permanent partial disability benefits

"Temporary disability, total or partial" begins on the date of injury, and continues until the employee "attains complete recovery or until a specific loss becomes ascertainable, whichever comes first." SDCL 62-1-1(8). But no such benefits are payable unless the injury makes the employee unable to work for seven consecutive days. SDCL 62-4-2. In the Department's opinion, an employee who is partially unable to work for seven consecutive days meets this requirement. Declaratory Ruling Re: SDCL ¶¶ 62-4-2, 62-4-5 (2005). The amount of temporary total disability benefits is based on the claimant's average weekly wage, discussed in Section IV above. These and all other workers' compensation benefits are paid in installments at the same intervals at which the employee received wages, and are not taxable. SDCL 62-4-10; 26 U.S.C. 104(a)(2).

In applying SDCL 62-1-1(8), a "specific loss becomes ascertainable when it becomes apparent that permanent disability and the extent thereof has resulted from an injury and that the injured area will get no better or no worse because of the injury." SDCL 62-1-1(2). This determination is made by a physician who assesses whether the injured worker is at "maximum medical improvement." The insurer will push for your client's doctor to find that your client is at maximum medical improvement as soon as possible, so that it can stop paying temporary disability benefits. If your client's doctor isn't sufficiently compliant with the insurer's wishes, it will often have your client seen by a physician of its own choosing, as allowed by SDCL 62-7-1.

Your client's percentage of permanent partial disability is a medical determination that must be based on the American Medical Association Guides to the Evaluation of Permanent Impairment, Sixth Edition. SDCL 62-1-1.2. This determination is called an impairment rating. It takes into consideration only physical impairment, not loss of the ability to work. An

impairment rating may cost in the range of $600. The insurer must pay for it. *Morstad v. Minnehaha County,* HF No. 182, 2010/11 (Letter Decision and Order, September 26, 2012); *Reil v. Midcom, Inc.,* 2000 SD Wrk. Comp. Lexis 39 * 13.

The amount of money your client receives based on the impairment rating is the percentage impairment rating, times the average weekly wage, times the number of weeks specified in SDCL 62-4-6. Typically the amounts are shockingly low. For example, complete loss of the thumb on a client's dominant hand—a grievous lifetime injury—entitles the client to fifty weeks of compensation. SDCL 62-4-6(1). If the client's compensation rate is $400 per week, that's $20,000.

In older workers' compensation cases, you may see references to benefits for permanent partial disability based on the injured worker's "loss of use" that include vocational factors. This benefit was first recognized in *Cozine v. Midwest Coast Transp.,* 454 N.W.2d 548 (S.D. 1990), but the Legislature abolished it in 1994. SDCL 62-1-1.2.

3. Temporary partial disability benefits

SDCL 62-4-5 establishes compensation for temporary partial disability benefits if an injury causes the client to become partially unable to engage in the client's "usual and customary line of employment," as defined in SDCL 62-4-54, or if the physician has released the client from temporary total disability but an impairment rating has not been assigned. The benefit amount is half the difference between the average amount the client earned before the accident, and the average amount the client is now earning or able to earn, subject to the maximum and minimum amounts in SDCL 62-4-3.

4. Rehabilitation benefits

"The fundamental purpose of rehabilitation benefits is to insure that an injured worker has an opportunity to develop marketable and transferable skills that enable him to secure suitable, substantial, and gainful employment." *Beckman v. John Morrell & Co.,* 462 N.W.2d 505, 509 (S.D. 1990). Appropriate rehabilitation can include vocational training or even college education.

Cozine v. Midwest Coast Transp., 454 N.W.2d 548, 553 (S.D. 1990), breaks down the rehabilitation statute, SDCL 62-4-5.1, into its elements:

> "1. The employee must be unable to return to his usual and customary line of employment [as later defined by the Legislature in SDCL 62-4-54];
>
> "2. Rehabilitation must be necessary to restore the employee to suitable, substantial, and gainful employment [as later defined by the Legislature in SDCL 62-4-55];
>
> "3. The program of rehabilitation must be a reasonable means of restoring the employee to employment;

"4. The employee must file a claim with his employer requesting the benefits; and

"5. The employee must actually pursue the reasonable program of rehabilitation."

Chiolis v. Lage Dev. Co., 512 N.W.2d 158, 161 (S.D. 1994), found a sixth, non-statutory requirement for rehabilitation benefits: that the employee file a petition for hearing with the Department before starting the rehabilitation program.

The rehabilitation benefit consists of payment of the client's compensation rate during the rehabilitation program. Because a rehabilitation program requires tuition and costs, plus living expenses, a rehabilitation benefit alone, especially after reduced by the attorney fees and costs needed to obtain it, is insufficient to allow a client to pursue a rehabilitation program. So anyone who wants rehabilitation must explore other resources to help pay for it.

A critical resource is SD Works, a state agency that is part of the Department of Labor, but separate from the workers' compensation system. Your vocational expert is also an important source of information about options to make a rehabilitation program a reality.

Rehabilitation claims require a motivated client, vocational expert testimony that will cost several thousand dollars, careful attention to detail, the delay involved in getting a case to trial and then getting a decision, all while the client tries to keep a life together financially, in pursuit of benefits that will not be enough by themselves to allow the client to pursue the rehabilitation program. Rehabilitation claims are not brought frequently, but in the right case, with the right client, they can make a big difference in a client's ability to work.

5. Permanent total disability ("odd lot") benefits

In permanent total disability cases, a lawyer can earn real money. I hope you don't become an attorney who takes only such claims. But that will be your choice.

"Total" disability is a term of art. It means that because of a work injury, the injured employee cannot earn as much as the employee's compensation rate, and that vocational rehabilitation will not allow the employee to do so. SDCL 62-4-53. The term "odd lot" comes from extending to injured employees the analogy that a product may be of so limited use that no reasonably stable market for it exists.

SDCL 62-4-53 defines permanent total disability, and imposes critical procedural rules. The statute has five parts.

First, it provides: "An employee is permanently totally disabled if the employee's physical condition, in combination with the employee's age, training, and experience and the type of work available in the employee's

community, cause the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income."

The employee's "community" is defined in SDCL 62-4-52(1). In a nutshell, it ordinarily means the area within sixty road miles of the employee's residence, if the employee is able to travel that distance. If an employee when injured lives in an area with more jobs, then moves to an area with fewer jobs, the new residence is the relevant "community," unless the employee moved to try to avoid available work. *Lagler v. Menard, Inc.,* 2018 S.D. 53, ¶¶ 27-28 (employee injured in Sioux Falls moved to Winner, where her daughter lived, to avoid becoming homeless, so Winner became her "community").

"Sporadic employment resulting in an insubstantial income" is defined in SDCL 62-4-52(2). It means work that does not allow an employee to earn at least as much as the employee's workers' compensation benefit rate. If the employee has to commute to work, the cost of commuting is deducted from the employee's wage to determine whether the net wage is at least as much as the workers' compensation benefit. SDCL 62-4-52(b); *Johnson v. Powder River Transp.,* 2002 S.D. 23, ¶ 25.

Second, SDCL 62-4-53 provides: "An employee has the burden of proof to make a prima facie showing of permanent total disability." A prima facie showing is made when "there 'are facts in evidence which if unanswered would justify persons of ordinary reason and fairness in affirming the question which the plaintiff is bound to maintain.'" *Sandner v. Minnehaha Co.,* 2002 S.D. 123 ¶ 13, quoting *Rosen's Inc. v. Juhnke,* 513 N.W.2d 575, 577 (S.D. 1994).

Third, SDCL 62-4-53 provides that if the employee makes a prima facie case, "[t]he burden then shifts to the employer to show that some form of suitable work is regularly and continuously available to the employee in the community. The employer may meet this burden by showing that a position is available which is not sporadic employment resulting in an insubstantial income as defined in subdivision 62-4-52(2)." The ultimate burden of persuasion is on the employee. *Lagler v. Menard, Inc.,* 2018 S.D. 53, ¶ 25.

To meet its burden, the employer must "show more than a general availability of jobs to persons with some of claimant's disabilities." The employer must show "the existence of specific positions regularly and continuously available and actually open in the community where the claimant is already residing for persons with all of claimant's limitations." *Shepherd v. Moorman Mfg.,* 467 N.W.2d 916, 920 (S.D. 1991) (emphasis by Supreme Court, internal quotations omitted). "While it is not required that an employer actually place a claimant in an open job position, more than mere possibility of employment must be shown; the employer must establish that there are positions actually open and available." *Spitzack v. Berg Corp.,* 532 N.W.2d 72, 76 (S.D. 1995).

In making this determination, the Americans with Disabilities Act, which requires some employers to accommodate some workers who have

impairments, is irrelevant. *Bsharah v. Beverly Enterprises,* HF No. 179, 1995/96, Letter Decision on Remand (January 24, 2000).

In addition, the employer's vocational expert's testimony that such jobs are available is insufficient as a matter of law unless the vocational expert has actually told possible employers all of the injured worker's limitations. *Eite v. Rapid City Area Sch. Dist. 51-4,* 2007 S.D. 95, ¶ 27. This requirement has a critical impact on discovery, as discussed below.

Under some circumstances, an employer can temporarily defeat a permanent total disability claim by offering the employee "favored work," but if it does so, the Department retains jurisdiction over the case, so if the employer ends the favored work, the litigation resumes. *McClaflin v. John Morrell & Co.,* 2001 S.D. 86. Such work is relevant only if it is "bona fide." SDCL 62-4-52(2). A job offered by a company that pays wages based not on the type of work, but on the injured employee's workers' compensation rate, does not defeat a permanent total disability claim. *Clyde v. Hardees,* 2013 SD Wrk. Comp. Lexis 28. Such companies are creations of the insurance industry, and operate solely for the purpose of attempting to defeat workers' compensation claims. Other states have found that the "jobs" they offer are not "bona fide." *Avramovic v. R.C. Moore Transportation, Inc.,* 954 A.2d 449 (Me. 2008); State ex rel. *Con-Way Freight, Inc. v. Indus. Comm'n,* 2011 Ohio App. Lexis 3752.

An injured worker's eligibility for and receipt of unemployment insurance benefits likewise does not defeat a permanent total disability claim. Id. Unemployment insurance benefits have different requirements than odd-lot benefits; a person can be eligible for both, for one but not the other, or for neither.

Fourth, SDCL 62-4-53 provides: "An employee shall introduce evidence of a reasonable, good faith work search effort unless the medical or vocational findings show such efforts would be futile. The effort to seek employment is not reasonable if the employee places undue limitations on the kind of work the employee will accept or purposefully leaves the labor market."

This gives an injured worker two ways to make a prima facie showing of permanent total disability. One is by showing that permanent total disability is "obvious," so that a work search would be futile. The other is by showing reasonable and unsuccessful efforts to find work. *Shepherd v. Moorman Mfg.,* 467 N.W.2d 916, 918 (S.D. 1991).

A recent case, *Billman v. Clarke Machine, Inc.,* 2021 S.D. 18, ¶¶ 36-41, ___ N.W.2d ___, held that the injured employee was obviously unemployable, and reviewed other cases in which it found likewise. Billman is well worth reading from beginning to end.

Nonetheless, I rarely rely on the "obvious" theory alone, because if this is reasonably disputable, I'm subjecting my client to an unnecessary risk. I supervise the vast majority of my clients in making reasonable efforts to find work. Injured workers need a lot of attorney help and support to do so, and

to document their efforts in a way that can't be picked apart by a defense attorney. I discuss below how to provide clients with the help they need.

Fifth, SDCL 62-4-53 provides: "An employee shall [i.e. must, in order to have a chance to prevail] introduce expert opinion evidence that the employee is unable to benefit from vocational rehabilitation or that the same is not feasible." This testimony comes from a vocational expert. Because many injured employees who seek odd-lot benefits are older, have marginal educations, and have impairments that would have to be accommodated in any vocational rehabilitation program, an insurer will usually not defend a case on the ground that the employee can be rehabilitated. But an injured worker's attorney who fails to introduce this required evidence will lose regardless of the merits.

If an injured worker meets these requirements, the worker is entitled to compensation for permanent total disability, even if the worker still can perform work that pays less than the worker's weekly benefit rate. *Capital Motors, LLC v. Schied,* 2003 S.D. 33. And an injured worker who "retires" after an injury is eligible for compensation for permanent total disability. The word "retire" often means "stopped working because of my disability." In addition, many people "retire," but later return to work, and a disabled person has lost that option. *Pallett v. U.S. Hotel & Resort Management,* 2016 SD Wrk. Comp. Lexis 6, aff'd Hughes County Circuit Court Civ. 16-136 (December 1, 2016).

Compensation for permanent total disability consists of the injured employee's compensation rate for the rest of the employee's life, not just until the employee's possible retirement age, with an annual cost of living increase not to exceed three percent, compounded annually. SDCL 62-4-7. The Department on request will compute a present value for future lump sum payments under ARSD 47:03:01:07. But that regulation shortchanges injured workers by using a 1% reduction as a setoff (discount) for the cost of living increase, although the average cost of living increase in the 32 years since it was created is 2.37%. https://dlr.sd.gov/workers_compensation/documents/cola_rates_historical. pdf.

The difference between a 1% discount rate and a 2.37% discount rate may not sound like much, but makes a substantial difference in the amount of the lump sum. A permanently totally disabled person cannot force an employer to pay a lump sum. SDCL 62-7-6. But the unfairly low lump sum is typically the starting point for settlement negotiations, thereby wrongly taking money out of the pocket of an injured worker with a lifetime disability.

6. Mandatory prejudgment interest at 12%, and the rarely-applied 10% penalty

Your client is entitled to prejudgment interest on all past-due benefits, regardless of whether the insurer is at fault. *Johnson v. Skelly Oil Co.,* 359 N.W.2d 130, 133 (S.D. 1984). The rate is 12%. *Blenner v. City of Rapid City,* 2003

S.D. 121, ¶ 48. This can be a substantial amount of money, running well into five figures.

SDCL 62-4-10.1 entitles your client to "an automatic penalty equal to ten percent of the unpaid amount" if an insurer fails to pay compensation benefits within ten days of when due. But it applies only if there was no "good faith dispute." *Tischler v. UPS,* 1996 S.D. 98, ¶ 76.

7. Death benefits

Workers' compensation benefits are payable if a person dies because of a work injury. Because these cases are relatively rare, and involve unique issues, I won't address them here. The relevant statutes are SDCL 62-4-8 and 62-4-12 to 22.

VIII. Vocational expert testimony

No claim for rehabilitation benefits or total permanent disability benefits can be successful without a vocational expert. To find the best one for your case, talk to other workers' compensation lawyers who represent injured people. Be sure you give the vocational expert complete and accurate information, so the vocational expert has a strong foundation for all opinions. Your vocational expert will meet with your client. I always prepare the client carefully for these meetings, and sit in on them, both to track the process, to help the vocational expert with facts that I have documented but that the client may not remember, and because I always learn something. Your expert needs to produce a report that addresses the relevant issues. Be sure you review a draft before it is finalized. Draft reports are privileged, just as in civil litigation. SDCL 15-6-26(b)(4)(B).

Your vocational expert may have your client take vocational tests. It may be obvious to you that your disabled construction worker cannot adapt to a desk job, but the more you prove with testing, the stronger your case. Vocational testing can identify the client's skills and aptitudes. Most of your clients will be former blue-collar workers with few skills or aptitudes for paperwork. They have about as much chance of adapting to a paperwork job as I would have of adapting to a job repairing cars, which is zero, because I lack mechanical aptitude as surely as many of my clients lack the aptitude to work with paper.

The defense vocational expert may ask to meet with your client, even though the expert has no right to do so. *Clarke v. The Car Connection,* HF No. 28, 2006/07, (Letter Decision and Order, August 8, 2008). In my naive early years, I allowed the defense expert to meet with my client, with me always being present. I discovered that my presence did not deter the defense expert from distorting what my client said, and of course I couldn't testify. So I stopped allowing such meetings. Now when I get such a request, I write the defense attorney that the expert is welcome to attend my client's deposition, and to have the defense attorney ask whatever the vocational expert wants to know. I haven't had one actually show up at a deposition yet.

IX. A critical issue: your client's job search

In any rehabilitation or total permanent disability claim (except in a total permanent disability claim in which you are sure you can prove that your client's total permanent disability is "obvious"), your client must make a job search. It must be a real, bona fide job search. The defense will examine it closely to try to prove that your client was just going through the motions.

Your client will find this really difficult. None of us like rejection—especially repeated rejection, over and over again—and your client will be rejected for the vast majority or all jobs applied for. These rejections will be particularly hard because your client already is struggling with the injury, its physical and emotional consequences, and loss of income for the client's family. So your client needs your support throughout this process, and your instructions on what to do, and how to document it.

Begin by carefully educating your client about why a job search is essential, which is because the law says it is, and why the law makes sense, which is to separate people who can't work from those who can. Be sure you instruct your client on the minimum number of job contacts per month (I require fifteen, and spread over the month, not all in one or two days); how to find jobs to apply for (the SD Works website, plus any possibilities your vocational expert can suggest, plus anything else your client can think of or find); and critically, what your client's documented limitations are, so when asked, the client can state them accurately, and not state perceived limitations that can't be proven.

Your client's documented limitations are important for another reason. A client who disregards the limitations imposed by a physician, and is injured as a result, has committed "willful misconduct" and receives no benefits for the injury or any resulting disability. *Fenner v. Trimac Transp.,* 1996 S.D. 121, ¶ 15. The definition of "willful misconduct" in Fenner was overruled in *Holscher v. Valley Queen Cheese Factory,* 2006 S.D. 35, ¶ 48 n.2, but it is unclear whether this would lead to a different result in another case like Fenner. So reasonable lawyers will advise their clients never to exceed the limitations imposed by their physician, both to avoid reinjury and to avoid a defense of willful misconduct.

Your client will want to know the minimum wage that the client must accept. The answer is that for a rehabilitation claim, the client needs to take any job that pays at least 85% of the client's pre-injury earning capacity, or the earnings set out in SDCL 62-4-55(2). For a total permanent disability claim, the client needs to take any job that pays at least the client's compensation rate. SDCL 62-4-52(2).

The client must keep a careful record of the job search, to document every job applied for, and to provide accurate information about it in discovery and at trial. I give the client a form to complete with boxes to fill in the date, the name of the potential employer, the potential employer's address, the job

applied for, the name of the person contacted, the pay, and the results of the contact, such as whether the client was interviewed.

Your client may ask if it will hurt the case if the client actually finds a job. The answer is that it will hurt the case, but the client will be happier in the long run, and make more money, if able to return to work. And by taking the job, the client will find out whether it's really possible for the client to do it.

The strong majority of workers' compensation clients are not used to keeping careful records, and need your help and support to do so. I see the client once every month and obtain the completed form, and any supporting paperwork, such as a job description, for the previous month. I review the form to be sure it is completed fully, to answer the client's questions, to support the client emotionally, and to get the form in my file, so I can disclose it to the defense and have it ready to use as an exhibit at trial. I calendar a specific day of the month to call the client if I haven't heard from the client. When the client comes in, if everything is in good shape, the appointment may take just a few minutes.

These appointments are an essential part of gathering the evidence you will need to prove the job search requirement of a claim for rehabilitation or total permanent disability benefits. Such appointments are always time well spent. If you forego them because you think you're too busy, you may lose your case, and you will reduce its settlement value.

Be sure your client applies promptly for any jobs the defense vocational expert claims that the client can do. Doing so proves whether the jobs actually are available to your client or not. Be sure your client documents these applications on the job search form.

X. Discovery you need

In theory, the Rules of Procedure in Circuit Courts apply only in "suits of a civil nature." SDCL 15-6-1. This does not include workers' compensation cases, although the Department can adopt the rules for use in particular cases. *Sowards v. Hills Materials Co.,* 521 N.W.2d 649, 652 (S.D. 1994). But in practice, the civil discovery rules, SDCL 15-6-26 to 15-6-37, are used by all parties in every workers' compensation case without any specific authorization.

You need the following discovery.

1. Standard subjects

a. Defense experts and their opinions and reports as allowed by SDCL 15-6-26(b)(4).

b. All reports from defense nursing, rehabilitation, or vocational consultants.

c. The names and identifying information of persons with knowledge about any issue in the case.

d. All relevant photographs and tape recordings.

e. The injured employee's personnel file. You'll often find useful information here. If the employee has a good work record, it's hard for the insurer to argue that the employee lacks credibility. If the employee has had problems, you want to know what they are, so you can hear your client's story about them, decide whether they are relevant (usually they aren't), and if they are relevant, plan how to deal with them at trial.

f. All information you need to compute the injured employee's average weekly wage, including pay documents for the year before the injury.

2. Jobs the defense claims your client can do

a. Where the injured person's ability to work is relevant, which is in any case seeking rehabilitation or total permanent disability benefits, you need to discover the jobs that the defense contends are suitable and regularly and continuously available to your client.

b. The written job description for all these jobs, which virtually all employers now have because of the Americans with Disabilities Act. These job descriptions will often show that the job requirements are beyond your client's abilities. The defense will usually not have the job description. You can get it directly from the employer, or if the employer is uncooperative, by using the 2019 amendment to SDCL 15-6-45(b), which allows you to subpoena documentary evidence from non-parties.

c. All information about contacts between the defense vocational expert and these employers. This information is essential to investigate whether the defense expert has complied with *Eite v. Rapid City Area Sch. Dist. 51-4,* 2007 S.D. 95, ¶ 27, by informing the employers of all the injured worker's limitations. Of course, you are not bound by what the defense expert claims he told these employers. You can investigate this subject directly with the potential employers.

d. Whether the defense claims the injured employee is able to benefit from vocational rehabilitation, or that it is suitable for the employee, and if so, all details about such programs.

3. The defense's surveillance of your client

In most significant workers' compensation cases in which your client's physical abilities are relevant, the defense will secretly videotape your client. Always request disclosure of all surveillance videotapes and reports.

The defense need not give you these until after your client's deposition. The defense often claims that it need not give you this information even after your client's deposition, unless the defense plans to use it at trial. You must fight this argument, and you can win it. If the defense is not going to use the surveillance, it means that it supports your client's claims. This can be powerful evidence.

"[M]ost jurisdictions hold both the existence and contents of surveillance tapes to be freely discoverable." *Lagge v. Corsica Co-op,* 2004 S.D. 32, ¶ 23. In *Krause v. Sutton Bay Golf, L.L.C.,* 2008 SD Wrk. Comp. Lexis 17 * 2, the Department compelled discovery of surveillance videotapes that the defense was not going to use at trial. It rejected insurer's workproduct defense, noting that "Any evidence of [claimant's] physical abilities is certainly relevant and claimant has substantial need of any surveillance materials in preparation of his case." Likewise, in *Peterson v. Regional Health, Inc.,* HF No. 117, 2016/17 (Letter Decision, September 28, 2018), the Department compelled disclosure of surveillance information after the injured employee's deposition.

4. The insurer's pre-litigation file

You are entitled to the insurer's claim file until it received the petition for hearing, except for privileged material. *Dudash v. City of Rapid City and Berkley Risk Administrators Co., LLC,* HF No. 181, 2012/13 (Letter Decision and Order, November 14, 2013); *Little v. Probuild Co. LLC,* HF No. 176, 2014/15 (Letter Decision, March 23, 2016); *Petersen v. Regional Health, Inc.,* HF No. 117, 2016/17 (Letter Decision, September 28, 2018). This information may support the injured employee's case as to whether an injury occurred, whether the employer or insurer had notice of the injury and the possibility that it was work-related, and whether any affirmative defenses lack merit.

5. Your client's medical records the defense has

Although you will have gathered all your client's medical records, you must obtain all additional medical records the insurer has. The insurer may have these because you overlooked a medical provider, or because the medical provider's staff has inadvertently not given you a copy of every record.

An insurer could have obtained these records in two ways. One is because it is entitled to relevant records. SDCL 62-4-45. The other is because it is entitled to a release to obtain relevant records, although on request it is supposed to provide you with a copy without charge. SDCL 62-4-1.3. You need these records so that you are not surprised at your client's deposition, or worse at trial, by records that you didn't know existed.

XI. Preparing your client for deposition

It is impossible for your client to remember every relevant fact, and to learn not to guess at facts, unless you prepare the client carefully for deposition. Careful preparation is critical because the defense can argue that facts that your client gets wrong are evidence that the client is not credible. If you think that your client, unaided, should be able to remember the last ten years of medical treatment, what the client complained of to each medical provider, and what treatment the client was prescribed, try doing the same yourself. If you're really brave, get your own medical records, and see how your memory differs from what your medical providers recorded.

You cannot effectively prepare your client for a deposition by giving the client a list of deposition "rules." Such a list is meaningless. No one can keep more than one idea in their head at a time while talking. I can't. You can't. Our clients can't.

It's critical that you work with your client until the client understands and internalizes the tactics that defense attorneys use. Your client also must understand and internalize the difference between an ordinary conversation and testimony. The client doesn't have your familiarity with how the two differ, or understand not to give casual answers, and not to agree with leading questions that do not fully state the truth.

XII. Preparing your medical evidence

SDCL 19-19-803.2 allows either side to have a medical practitioner's "written report" admitted into evidence, in lieu of a deposition or in-person testimony, if the party offering it complies with a few requirements set out in the statute. Even though the statute allows a "report"—not just medical records—into evidence, defendants have argued that a "report" may include only medical records. The Department has issued contradictory decisions on this issue, and it has never been resolved by the Supreme Court.

Put significant medical opinions into evidence by deposition. A deposition is given more weight than a record or report, because it is subject to cross-examination. *Paulson v. Black Hills Packing Co.,* 1996 S.D. 118, ¶ 13. Unlike civil litigation, in which an initial deposition typically precedes trial testimony, in workers' compensation cases, only one deposition of a medical provider is ordinarily taken, and it is used at trial. Bringing a doctor to a workers' compensation trial to testify live is unusual but not unheard of.

XIII. Preparing your client to see the defense medical examiner, then preparing to cross-examine the defense medical examiner

SDCL 62-7-1 requires an injured worker who is entitled to receive disability payments to undergo examination by a medical practitioner selected by the employer. The defense rarely selects a physician who actually practices medicine in South Dakota. Almost always the defense uses a physician who, in addition to having an out-of-state medical practice, works for a company like ExamWorks, whose business is to provide insurance companies with witnesses who reliably will testify in favor of the defense on any subject.

You need to prepare your client carefully before any such examination, the same way you prepare your client for a deposition. This includes a careful review of the client's medical history, the facts of the work injury, and the facts of any other relevant injuries. Just as in a deposition, if your client gets these facts wrong, the defense will argue that the client lacks credibility. In a case with a complicated medical history, or a client who tends to get confused easily, I draft a letter for the client to give to the examiner which outlines the client's medical history, with citations to medical records.

In cases involving neck or back injuries, all examiners assess "Waddell signs," which are based on several simple tests. If the client has "positive" signs, the examiner will testify that the client's physical responses are "inconsistent," suggesting that the client is exaggerating. You can find the "Waddell signs" on the internet. I prepare my client for these tests by administering the tests in my office, so the client knows what to expect. If the doctor finds "Waddell signs," I cross-examine the doctor with Dr. Waddell's own writings, in which he repeatedly says that these signs show there is a psychological component to the client's symptoms, not that the client is faking. Dr. Waddell's writings can be read into evidence if the defense doctor or the treating physician testifies the writings are a reliable authority. SDCL 19-19-803(18). A defense doctor's credibility is reduced if the doctor won't admit that Dr. Waddell's own writings about the signs he originated, and that are named after him, are not a reliable authority.

Warn your client that many of these examiners will have the client surveilled or videotaped arriving in the doctor's parking lot for the examination, walking from the parking lot into the building, and walking out of the building at the end of the examination. I once had an insurer who arranged for an investigator to drop a twenty-dollar bill as the investigator walked by the client, while another investigator videotaped the transaction, trying to prove that my client could bend easily, and that he was a thief.

Never expect to hear an unbiased, fair opinion from a defense medical examiner. The insurance company is paying these people good money, and expects a good result in exchange. These witnesses may not be consciously lying, but they know what team they're playing for, and will do everything possible to help their team. They may have negative attitudes toward injured people, and believe that almost all injured people could work if they wanted to. According to a lawyer who is a national expert in cross-examining such doctors, a doctor who reports or testifies contrary to what the insurer wants to hear more than once will no longer be asked to conduct such exams.

Before you prepare your cross-examination, find out as much as you can about the defense medical examiner. Prior depositions may be available online, or you may be able to obtain them from other lawyers who represent injured workers. These can be invaluable in educating you as to what the witness will admit, where the witness will fight you, and how the witness fights.

If your client has a significant psychological impairment, the defense may require that the client be examined by a psychologist of its choosing. In my experience, these people are even more biased against injured workers than physician medical examiners. But if you are willing to put the work in to prepare to show why their testimony is wrong, you can often severely undercut their credibility.

The bible for cross-examining a defense medical examiner is Exposing Deceptive Defense Doctors by Dorothy Clay Sims, available from James Publishing for $219. It is equally useful in tort cases. It contains a remarkable wealth of information, strategy, and tactics for cross-examining defense doctors or psychologists.

XIV. Trying a workers' compensation case

A workers' compensation trial is called a "hearing," but in the interest of clarity, in this article I call it what it is: a trial. It is an administrative contested case, subject to SDCL 1-26-16 to 1-26-37. The rules of evidence apply, with a seldom-used exception that "[w]hen necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not otherwise admissible thereunder may be admitted except where precluded by statute if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs." SDCL 1-26-19.

An injured employee's lawyer's typical witnesses are the client, any other fact witnesses, the vocational expert if it is a rehabilitation or total permanent disability case, and the medical evidence put in under SDCL 19-19-803.2 or by deposition. The defense may try to introduce, through its vocational expert, evidence about alleged job openings that it did not disclose in discovery, to which you need to object.

Ordinarily neither side has deposed the other side's vocational expert, because it telegraphs the attorney's planned cross-examination, thereby better preparing the witness to testify. If you have done the discovery and gathered the evidence recommended above, you should have the material you need to cross-examine the defense vocational expert without a deposition.

XV. If you lose a case you should have won, don't be shy about appealing to circuit court

The Department's Administrative Law Judges may commit reversible error in denying workers' compensation claims. Circuit court judges usually have a more reasonable and balanced view of the law and facts than the Administrative Law Judges, and more legal and life experience, which enables them to understand the case better.

The loser at the Department level has a statutory right of appeal to circuit court. SDCL 1-26-30 and 1-26-30.2. An injured employee may appeal to the circuit court of the employee's residence, or to the circuit court of Hughes County. SDCL 1-26-31.1(1). Usually appeals are brought in Hughes County. The court there sees far more workers' compensation appeals than the courts in any other county. One Sixth Circuit judge handles all workers' compensation appeals, so that judge gains significant expertise.

The rules for taking and perfecting an appeal are SDCL 1-26-30.3 to 1-26-35. Read them carefully, then read them again. Some are jurisdictional, so

failure to follow them will cause your appeal to be dismissed. An appellee has the right to obtain review of any decision, ruling, or action that may adversely affect the appellee by filing a notice of review in the form prescribed by SDCL 1-26-36.1.

The circuit court's standard of review is set out in SDCL 1-26-36. Legal issues are reviewed de novo, and factual issues are reviewed for whether they are "clearly erroneous in light of the entire evidence in the record," but with one exception: if factual issues were decided based on documentary evidence, including depositions and medical records, those issues are reviewed de novo. *Darling v. West River Masonry, Inc.,* 2010 S.D. 4, ¶ 10.

This exception is critical because medical issues in workers' compensation cases are typically decided based on depositions and medical records, so such decisions, which often go to the heart of the case, are reviewed de novo. *Brown v. Douglas Sch. Dist.,* 2002 S.D. 92, ¶ 10; *Jewett v. Real Tuff, Inc.,* 2011 S.D. 33, ¶ 14.

XVI. If you lose an appeal in circuit court, don't be shy about appealing to the Supreme Court

A party that loses in circuit court has the right to appeal to the Supreme Court. The appeal is taken as in any other civil case. SDCL 1-26-37. The Supreme Court reviews the Department of Labor's decision using the same standard of review that the circuit court used, giving no deference to the circuit court's decision. *Peterson v. Evangelical Lutheran Good Samaritan Society,* 2012 S.D. 52, ¶ 13. The Supreme Court has made a lot of reasonable, fair decisions in workers' compensation cases.

A recent example of such a decision is *Billman v. Clarke Machine, Inc.,* 2021 S.D. 18, ___ N.W.2d ___, which reversed based on clear error the Department's factual findings, which the circuit court had affirmed, that the injured worker was not obviously disabled, and that suitable employment was regularly and continuously available to him.

XVII. Social Security Disability Insurance and Supplemental Security Income

If you're going to represent injured workers in workers' compensation cases, it is essential that you learn at least the basics of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) law, or that you develop a working relationship with someone who knows it. Here's why:

- Your client may be eligible for SSDI, SSI, or both;
- A client who has adequate representation is far more likely to receive these benefits;
- Receiving SSDI or SSI or both may be essential to tide your client over until the workers' compensation case is resolved, and will

pay your client benefits after it is resolved, subject to the workers' compensation offset discussed below;

- Receiving SSI entitles your client to Medicaid immediately, which the client may need to obtain medical care;
- Receiving SSDI entitles your client to Medicare, beginning 30 months after the disability began, which the client may need to obtain medical care; and
- The workers' compensation insurer is going to get all your client's SSDI and SSI application papers from you in discovery, and you have to be sure that your client, who is not used to dealing with paperwork, and does not understand the need to be precise in completing forms, does not make mistakes that will allow the insurer to paint the client as not credible.

My article A Practical Approach to Social Security and SSI Claims, The Practical Litigator (May 1991) is available in the corresponding appendix to this issue. My 2010 update to that article is available in the corresponding appendix to this issue. Confused about the differences between SSDI, SSI, Medicare, and Medicaid? My 2010 Barrister article "Social Security Disability, SSI, Medicare, and Medicaid: What's the Difference—And Why Would You Care?" should be helpful. It is available in the corresponding appendix to this issue. The dollar amounts in the article have changed, but the basic concepts remain the same. Current dollar amounts are available on Google or the Social Security Administration website.

XVIII. The Social Security Administration's workers' compensation offset, and how to minimize it

If your client receives both workers' compensation benefits and SSDI or SSI, and you fail to coordinate them, you may cost your client a huge amount of money. The bad news is that, until you understand it, this is a fairly complex subject. But the good news is that—as with your client's applications for SSDI and SSI benefits—you can work with a lawyer who understands it. My article Minimizing the Social Security Workers' Compensation Offset, Workers' Injury Law & Advocacy Group (Spring 2010) is available in the corresponding appendix to this issue.

XIX. Settling a workers' compensation case

In a workers' compensation case in which the employee has not gone back to work, and does not expect to go back to work, a critical issue is whether a settlement will be paid in a lump sum or over a period of time.

Settlement of a disputed permanent total disability case for a lump sum often is contrary to the best interests of the injured worker. (The Social Security workers' compensation offset may change this so that a lump sum settlement is in your client's interests, but you can never know this without analyzing how it applies in your particular case.) Professor Larson writes:

"In some jurisdictions, the excessive and indiscriminate use of the lump-summing device has reached a point at which it threatens to undermine the real purposes of the compensation system. Since compensation is a segment of a total income insurance system, it ordinarily does its share of the job only if it can be depended on to supply periodic income benefits replacing a portion of lost earnings. If a partially or totally disabled worker gives up these reliable periodic payments in exchange for a large sum of cash immediately in hand, experience has shown that in many cases the lump sum is soon dissipated and the worker is right back where he or she would have been if workers' compensation had never existed." 13 Larson's Workers' Compensation Law § 132.07[1] (2021).

South Dakota is one of the "some jurisdictions" about which Larson writes. Larson plainly states the answer to the problem: "The only solution lies in conscientious administration, with unrelenting insistence that lump-summing be restricted to those exceptional cases in which it can be demonstrated that the purpose of the Act will best be served by a lump-sum award." Id. The South Dakota Department of Labor, as the administrator of the system, must approve any settlement in order for it to be valid. SDCL 62-7-5. It approves every settlement agreement it receives. I have never seen it consider whether a lump sum settlement serves the purpose of the Act.

An insurance company, in settling a case, will want to settle for a lump sum, because this allows the insurer to close its file. The worker's attorney often puts up no resistance, because the attorney is getting paid. The injured worker, who will inevitably spend the money far faster than the worker's disability will last, will be the loser.

There are two solutions to this problem. One is not to settle the case for a lump sum, instead to insist that the money be paid by insurer over the injured worker's lifetime, as contemplated by SDCL 62-4-7. Virtually all of these cases will be tried, because insurers hate paying over a claimant's lifetime. If the attorney wins, the attorney still gets paid in a lump sum, based on the present value of future benefits, under SDCL 62-7-6.

The other is to accept a lump sum, and use it to purchase a Section 130-Exempt Structured Settlement Administration Trust. Such a purchase does not require the approval or even the knowledge of the insurer. I explained how this product works in Protecting Plaintiffs with a Section 130-Exempt Structured Settlement Administration Trust, available at in the corresponding appendix to this issue. It prevents the client from dissipating the settlement funds, allows the client some flexibility for special needs, is a far better investment than an annuity sold by an insurance company, and prevents the client from selling the payment stream to one of the companies that advertise on daytime and late-night television to buy the annuity for what amounts to about 50 cents on the dollar.

In every case, including cases in which the injured employee has gone back to work, or expects to go back to work, there are at least three settlement issues, in addition to how much money the insurer will pay:

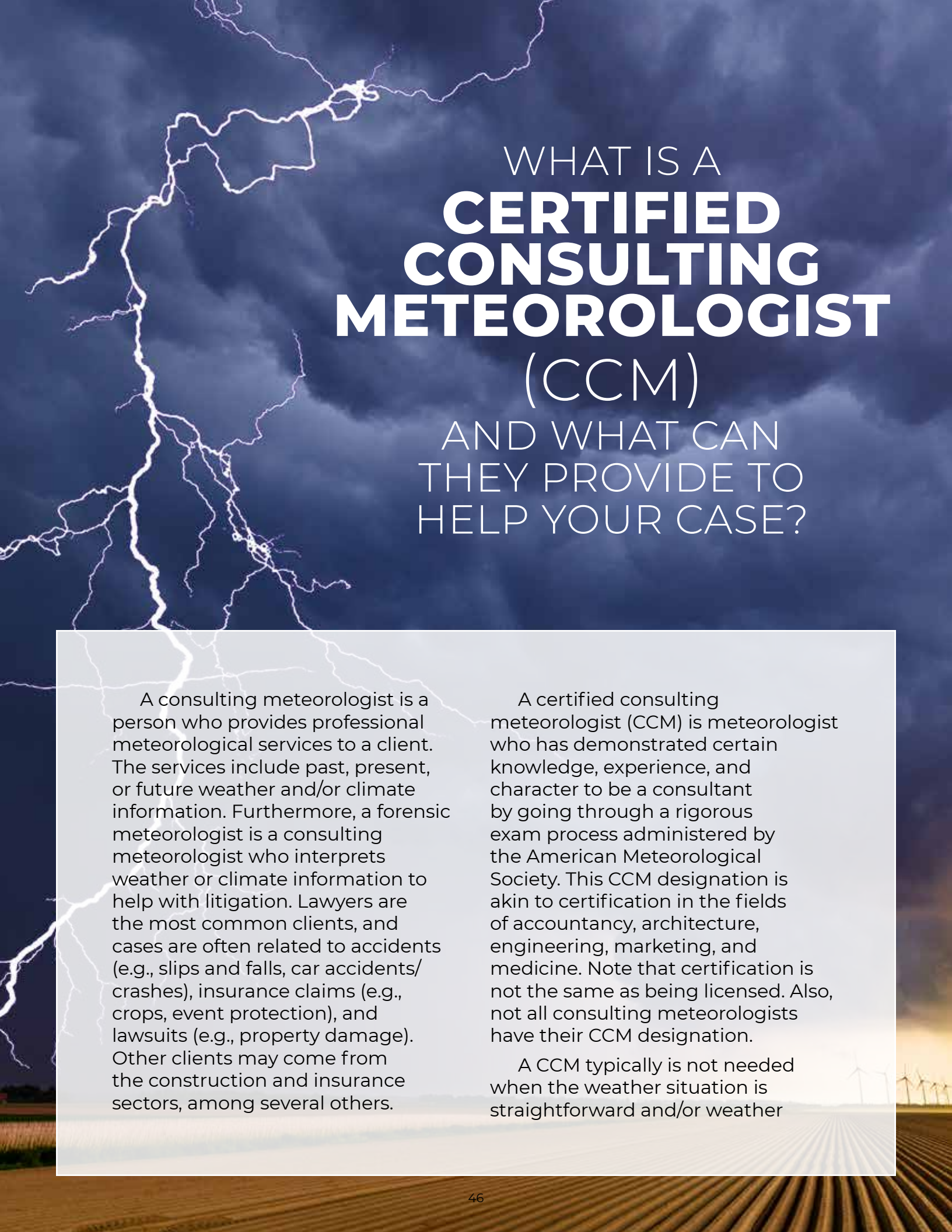
- Will the insurer admit—if it has not done so already—that an injury occurred? This is important because if the insurer admits that an injury occurred, (a) the lower causation standard of SDCL 62-1-1(7)(c) may apply to future work injuries, and (b) the insurer remains liable for future medical expenses under SDCL 62-4-1 and 62-7-33, unless those rights are specifically released. *Johnson v. UPS,* 2020 S.D. 39, ¶¶ 36-45.
- Are all subrogation interests satisfied?
- If the client may have future medical expenses for the work injury, be sure they are not improperly shifted to Medicare or Medicaid. If this improper shifting occurs, you and your client may become personally liable to the government. The insurer and defense attorney may also become liable to the government, so defense attorneys are usually very careful about this issue. This can be a complicated subject. There are national law firms that are expert in it. I'm not an expert, so I won't try to explain it here.

The Department offers mediation of workers' compensation claims. SDCL 62-7-37. But the insurer will virtually never offer fair value for the case until and unless the employee's attorney has developed the case and it is headed toward trial. At that point, private mediation is far more likely than mediation by the Department to result in the case being settled.

XX. What do you want to do with your life?

Each of us has the choice, within limits, of what to do with our limited time on this earth. Maybe you want to help people who are far less fortunate than you, who are suffering, and who face long odds against powerful insurance companies, their well-paid lawyers, and their inexhaustible money. If so, you can be of enormous service to these people. Representing injured workers, and helping them put their lives back together, is frustrating and hard at times, but also can be wonderful and incredibly fulfilling.

Appendix follows on page 53



WHAT IS A **CERTIFIED CONSULTING METEOROLOGIST** (CCM) AND WHAT CAN THEY PROVIDE TO HELP YOUR CASE?

A consulting meteorologist is a person who provides professional meteorological services to a client. The services include past, present, or future weather and/or climate information. Furthermore, a forensic meteorologist is a consulting meteorologist who interprets weather or climate information to help with litigation. Lawyers are the most common clients, and cases are often related to accidents (e.g., slips and falls, car accidents/crashes), insurance claims (e.g., crops, event protection), and lawsuits (e.g., property damage). Other clients may come from the construction and insurance sectors, among several others.

A certified consulting meteorologist (CCM) is meteorologist who has demonstrated certain knowledge, experience, and character to be a consultant by going through a rigorous exam process administered by the American Meteorological Society. This CCM designation is akin to certification in the fields of accountancy, architecture, engineering, marketing, and medicine. Note that certification is not the same as being licensed. Also, not all consulting meteorologists have their CCM designation.

A CCM typically is not needed when the weather situation is straightforward and/or weather

information is readily available at the location and time of interest. However, CCMs become especially valuable when weather information has to be pieced together (i.e., extrapolated or interpolated) from various sources and times to a specific location where weather information generally is lacking. In this case, a CCM uses her/his experience and expertise to interpret all available information and recreate the weather that happened for the case of interest.

There are many resources at the CCM's disposal. Common datasets include surface observations, climate reports, severe storm reports, radar data, lightning data, and satellite imagery. Other datasets include numerical weather prediction models, surface road temperature data, and flood frequency analyses (among others). There also are several tools to evaluate these various input datasets in order to seek out potential relationships in the data.

The time a CCM spends on a case can be as little as 2–4 hours if only some basic data and analyses are needed. In other cases where more detailed analyses and a formal report are needed, time invested can be from 6–14 hours. If site visits, extra analyses, affidavits, depositions, and/or trials are involved, a CCM can spend considerably more time on the case. In most cases, an initial assessment on the potential role the weather played can be made fairly quickly, helping the client determine whether retaining a CCM would be worthwhile for their case of interest.

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UNIVERSITY OF SOUTH DAKOTA
KNUDSON SCHOOL OF LAW

STUDENT UPDATES

Pursuit of Happiness:

Pursuit of Happiness, a club focusing on maintaining both the physical and mental health of law students, recently collected the various ways law students manage their stress levels. POH is now compiling all responses in a list to share with the students in mid-April. The goal of this is to provide students with healthy ways to cope with stress as they enter finals season. In addition, POH is currently planning a fundraiser to benefit the Lawyers Assistance Program the week of April 19-23. This fundraiser will have people vote by donation to see their favorite members of the law school faculty and staff do a specified task ranging from performing a TikTok dance to getting pied. The person with the most donations will have to perform their task and share it with the law school. For more information about this fundraiser, including how to cast your vote, please email samantha.j.merrill@coyotes.usd.edu or erin.ballard@coyotes.usd.edu.

Environmental Law Society:

The Environmental Law Society will be hosting our spring event in coalition with Earth Day 2021 on April 21st, 12 - 1:00 p.m. at the University of South Dakota Knudson School of Law and on Zoom. The "Water Law Panel: Issues in Tribal Water Rights," will feature four regional experts, attorneys, and advocates in this area. A Q&A session will take place after the panel discussion. Anyone who would like to tune in can contact berkley.fierro@coyotes.usd.edu for a Zoom link. ELS is also pleased to announce its 2021-2022 officers. Congratulations are extended to: President, Lillian Moravek, rising 2L (Sioux City, IA); and Secretary/Treasurer, Gabriele Sayaloune, rising 2L (Saint Paul, NE).

Women in Law:

Women in Law recently hosted a mini lecture series entitled “A Day in Her Heels.” The WIL Board would like to thank the amazing women that shared their stories with us, including Kristie Fiegen, Sharla Svennes, Hannah Kagey, Tamara Nash, Revathi Truong, Judge Francy Foral, Justice Judith Meierhenry. Sabrina Meierhenry, and Mae Meierhenry. Speakers focused on a wide array of topics, including diversity, women attorneys and their “pathway through the law,” and JD alternatives for women in the legal field. Recently, Women in Law also facilitated a clothing order and opened applications for a WIL scholarship.

Public Interest Network:

USD Knudson School of Law Public Interest Network (PIN) is a student-led organization with a focus on public interest work within the legal community. The mission of PIN is to provide support for University of South Dakota law students who volunteer their time working unpaid summer internships with public interest organizations such as government agencies, nonprofit organizations, Native American legal services, and prosecutor and public defender offices. Each year, PIN hosts an auction to raise money for the stipends offered to those volunteering their time within the public interest community.

PIN is proud to announce that the 2021 Auction will take place online from April 6-11. Bidding is set to begin at 9:00 AM on Tuesday, April 6. All proceeds will be distributed to those students working pro bono with public interest organizations this summer. To make a bid or donate to the cause, visit our auction site at www.32AUCTIONS.COM/PIN2021. Thank you for supporting PIN!

Interested in finding out more about PIN? You can reach the PIN President, Melanie Dumdei, at melanie.dumdei@coyotes.usd.edu, and the PIN Faculty Advisor, Wendy Hess, at wendy.hess@usd.edu.

Family Law and Child Advocacy:

FLCA facilitated a holiday easter egg hunt around the law school in the last week of March with American Sign Language (ASL) fun facts and candy in each egg. FLCA is also in the process of planning an educational Zoom conference on the Indian Child Welfare Act - co-sponsor with NALSA and departments at the main university including: Indian Studies, Criminal Justice, and Social Work. The date is tentatively set for April 15, 2021. Please contact Marcus.Hause@coyotes.usd.edu if you have any questions.

Veterans’ Legal Education Group (VLEG):

The Veterans Legal Education Group (VLEG) is an organization dedicated to providing pro bono services to veterans, service-members, and their families by hosting two legal clinics each semester. The VLEG board organize these clinics, partner with the

State Bar of South Dakota and its committees (such as the Young Lawyers Section and the Veterans Committee), the Dep't of Veterans Affairs, and various local veterans groups. In November of 2020, fifteen law students, one professor, and five attorneys assisted over fifteen veterans virtually, even amidst the uncertainty of the pandemic. In March of 2021, fifteen students, one professor, and eight attorneys assisted over thirty veterans in the Sioux Falls and Brookings legal clinics.

VITA:

The University of South Dakota Volunteer Income Tax Assistance (VITA) program offers free services during the tax season to help low- and moderate-income earners prepare their tax returns. Students are able to obtain a hands-on experience in a practice environment. This semester, law students have been preparing taxes and educating taxpayers at the Vermillion Public Library. After completing the required training, students started preparing taxes on February 20th and will continue to assist taxpayers until April 6th. Through the VITA program, law students will provide over 270 hours of tax preparation at the Vermillion Public Library.

Agricultural Law Society:

The Agricultural Law Society works to bring together students with an agricultural background as well as educate students on the widespread impact of agricultural law. This semester, students in the Ag Law Society have done fundraising in preparation for the AALA Annual Educational Symposium and promoted agricultural law events, including the Big Ag & Antitrust Conference. Election of officers for the 2021-2022 school year will take place on April 13th. Be sure to follow the Agricultural Law Society on Facebook (@usdaglawsociety).

Native American Law Students Association (NALSA):

NALSA hosted a Native American Day Event featuring Mr. Lynn Hart that was inspiring and timely. In February, NALSA sent two teams to National NALSA Moot Court to compete virtually. On Friday, April 2, 2021, NALSA hosted a virtual symposium. NALSA is excited to welcome Patina Park as the keynote speaker, as well as the panelists on the McGirt v. Oklahoma and Tribal Checkpoints and the Pandemic panels. Additionally, there will be a poetry reading by Professors Pommersheim and Tweedy. On April 22, Professor Pommersheim will be delivering a special lecture that will be open to the public virtually as well.

NALSA remains very proud of 3L Josey Blare as she represents the region at National NALSA. Further, 1L and 2L members are stepping into leadership roles for the symposium, and the Board looks forward to seeing the directions in which they lead our chapter in the years to come.

South Dakota Law Review:

The Volume 66 Board of Editors is pleased to announce that two student authors will be published in Issue II of Volume 66 this year. Joshua Liester, a Volume 66 Staff Writer and incoming Volume 67 Production Editor, will publish his article, *Risking Suffering: How Bucklew v. Precythe Weakened Eighth Amendment Protections*. Samantha Merrill, a Volume 66 Staff Writer and the incoming Volume 67 Editor-in- Chief, will publish her article, *The Chronic Effect of "Kill the Indian Save the Man": An Analysis of Dreaming Bear v. Fleming*.

The board is also pleased to announce that Jenika Arens, a Volume 66 Associate Editor, will publish her article, *Cowtown Cartel: How the Beef Cartel has Manipulated the Industry to Exploit Beef Producers and Consumer,* in Volume 26 Issue II of the Drake Journal of Agriculture Law.

Due to COVID-19, the annual Law Review Banquet has become an online event this year. We are looking forward to honoring former Chief Justice David Gilbertson and Professor Jonathan Van Patten.

Moot Court Board:

Due to COVID-19, the Moot Court Board competed in virtual competitions hosted by schools around the nation. During the spring semester, Courtney Buck, Emily Herbert, and Benjamin Hummel won the second "Best Brief" award and advanced to the top 16 round at the Domenick L. Gabrielli National Family Law Moot Court Competition hosted by Albany Law School. The Board also sent teams to the William E. McGee National Civil Rights Moot Court Competition hosted by the Mitchell Hamline School of Law, the William B. Spong Tournament hosted by William and Mary Law School, and Touro Law Center's National Moot Court Competition in Law & Religion. In March, the Board hosted the annual Sam Masten Intramural Moot Court Competition for the 1L students. The tournament occurred virtually and over 90 attorneys and judges volunteered their time to judge the rounds. The Board would like to extend its appreciation to all those who judged and participated in this year's Sam Masten Tournament.

Moot Court Board is also pleased to announce the 2021-2022 executive board: President Madelyn Braun, Vice President Emily Herbert, and Business Manager Zachary Schmidt.

Alternative Dispute Resolution Board:

The spring semester has brought great success in competition for the Alternative Dispute Resolution Board. In January, Board members Brett Bradshaw (2L), Hannah Honrath (2L), John Nelson(3L), and Bryton Syverson (3L) competed in the ABA Regional Client Counseling Competition. Both teams advanced to the semi-finals, where Bradshaw and Honrath took home third place, and Nelson and Syverson made the final round and took second place. The following month, in February,

Board members Alyssa Horn (2L) and Erik Wehlander (2L), competed in the ABA Regional Representation in Mediation and made it to the final round, bringing home second place. To close out the spring competition season, board members also competed in the William and Mary Law School Negotiation Competition. Board members Joshua Baumgart (2L), and Jennifer Nelson(2L) advanced to the final round where they took home second place.

In February, the Board also hosted its annual 1L Intraschool Negotiation Competition, again with competitors in person and judges present via zoom. Members of the 1L class were able to showcase the advocacy skills they have been able to learn their first year and greatly impressed the judges. First place went to Jaquilyn Waddell Boie and Sara Locke, second place went to Chelsea Schlauger and Gabrielle Unruh, and third place winners Emily Easton and Sidney Hardy. Most improved went to Damian Vacin, and best advocate went to Jaquilyn Waddell Boie. A sincere thank you again to all of our wonderful judges this year who volunteered their time to help the next generation of lawyers become the best that they can be.

Finally, the board is excited to announce the following leadership for next year: Joshua Baumgaart- President, Brett Bradshaw- Vice President, Erik Wehlander and Alyssa Horn- Negotiation Competition Coordinators, and Hannah Honrath and Jennifer Nelson- Client Counseling Competition Coordinators. We look forward to another successful year with excellent leadership.

Barrister

March/April 2021 Appendix

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to the Court's attention in this brief, except those defects of a jurisdictional nature, "may be deemed waived [by the Court]." An example of this kind of waiver is found in *Oklahoma City v. Tuttle,* 471 U.S. 808, 815-816 (1985).

REPLY, SUPPLEMENTAL, AND AMICUS BRIEFS, AND PETITIONS FOR REHEARING • Under Rule 15.6, the petitioner may file a reply to the brief in opposition, but it must be confined "to arguments first raised in the brief in opposition." The reply must not exceed 10 printed pages.

Any party at any time while a petition for certiorari is pending may file a supplemental brief calling attention "to new cases or legislation or other intervening matter not available at the time of the party's last filing." Rule 15.7. But the brief must be restricted to such new matter.

Rule 37.2 authorizes amicus curiae briefs in support of or in opposition to a petition for certiorari. These briefs require either the written consent of the parties or, if consent is refused, a Court order granting a motion for leave to file — a motion which "is not favored." Rule 37.1 states that even the filing of such a brief "is not favored" unless it "brings relevant matter to the attention of the Court that has not already been brought to its attention by the parties." Complying with this rule will often require advance consultation between the amicus and the party being supported, so that the amicus won't repeat arguments already made.

The Court permits but obviously discourages petitions for rehearing orders denying petitions for certiorari. Rule 44.2. These petitions must be filed within 25 days after the date of the order of denial. It can be no longer than 10 printed pages, and it must be confined "to intervening circumstances of a substantial or controlling effect or to other substantial grounds not previously presented." To discourage such petitions, virtually all of which are routinely denied, the Court has increased the filing fee to $200. Rule 38.

CONCLUSION • Fully complying with every rule won't guarantee that the Court will grant your petition for certiorari. This is always a discretionary matter for the court. But presenting your case in its best possible certiorari light and following the rules to the letter will ensure that the Court is fully informed of the certworthiness of your case.

If you are in doubt about any of the Court's procedures, there are two informational resources at hand. First, call the ever-helpful Clerk's office (202-479-3011). Second, check Stern, Gressman and Shapiro, *Supreme Court Practice* (6th ed. 1986 with 1990 supplement).

A Practical Approach to Social Security and SSI Claims

James D. Leach

How to spread the safety net under your disabled client.

ONE REASON many of us went to law school was to learn how to use the law to help people less fortunate than ourselves. Representing social security disability and SSI claimants offers us a way to fulfill that goal.

EDITOR'S NOTE: The author wishes to thank Catherine Enyeart, Esq., for her valuable suggestions and assistance.

With social security disability benefits, a disabled person can put food in her stomach, clothes on her back, and a roof over her head. Without such benefits, disabled people often will become utterly dependent on others, lose their homes, their spouses, and all vestiges of their self-respect.

SOCIAL SECURITY DISABILITY AND SUPPLEMENTAL SECURITY INCOME CONTRAST • Many lawyers erroneously use the terms "social security disability" and "SSI" interchangeably. In fact, the social security disability insurance program, created under Title II of the Social Security Act, 42 U.S.C. §301 et seq., and the Supplemental Security Income ("SSI") program, created under Title XVI of the Act, are two separate programs. Both are administered by the Social Security Administration ("SSA").

Title II Eligibility

The two fundamental eligibility requirements for social security disability benefits are that:

- The claimant be disabled, as that term is defined by social security law; and
- The disability began while the claimant was insured for social security disability benefits.

Who Is Insured . . .

Generally, to be insured for social security disability benefits, a claimant who is 31 or older must have 20 covered quarter-years out of the past 40 quarter-years before he or she became disabled. 20 C.F.R. §404.130 (1990). The amount of income necessary to earn a covered quarter increases each year. In 1979, a covered quarter was credited for each $260 earned; in 1987, a covered quarter was credited for each $460 earned. A maximum of four covered quarters can be earned per year. Different rules apply for claimants who became disabled before age 31.

. . . and When

You must determine at the outset of each case the date the claimant was last insured, called the "DLI." SSA will tell you what the client's DLI was; or, if you get a copy of your client's social security earnings record, it should show the client's DLI. As a general rule, if your client was steadily employed until becoming disabled and has not worked since, your client's DLI will be five years after he or she became disabled. But if you prove your client became disabled beginning on a date after your client's DLI, you lose the claim, because you haven't proved that the disability began while the client was insured for benefits.

Title II Benefits

Social security disability benefits include:

- A monthly disability check (with yearly cost of living increases) until the earlier of the end of the disability (which in most cases will be never), or the disabled person reaches age 65;
- At age 65, monthly retirement benefits without deduction for lack of earnings during all the years the person has been disabled;
- Past-due benefits beginning with the sixth month after the claimant became disabled, but not more than one year before the application for disability insurance benefits was filed;
- Past-due and current benefits for the disabled person's minor children, and in some cases his or her spouse; and
- Medicare beginning the 25th month after disability benefits begin.

All benefits are inalienable, exempt from state process, and tax-exempt except in the rare situation where total yearly income exceeds $25,000 for a single person or $32,000 for a couple. The value of all benefits in many cases will be in excess of a quarter of a million dollars.

Title XVI Eligibility

The two fundamental requirements for eligibility for SSI benefits are that:

- The claimant be disabled, as that term is defined by social security law. This definition is the same as the definition of "disabled" in the social security disability program. The same standard applying to adults applies to children. *Sullivan v. Zebley*, 110 S. Ct. 885 (1990); and
- The claimant has less income and fewer resources than the maximums allowed.

Maximum Allowed

Currently, the maximum unearned income a single person can have for SSI eligibility is $406 per month; the maximum resources is $2,000. This excludes a home and up to $4,500 equity in a vehicle (unless the vehicle is regularly used for transportation for medical care, in which case it is excluded entirely regardless of equity).

The maximums vary according to the source of the income, the person's living situation, and whether or not the person is married. Likewise, the amount of SSI benefits also varies according to income. SSA can give you specific information on this subject as it relates to your client.

Title XVI Benefits

SSI benefits are often lower than Title II disability benefits, but can be lifesaving to those who have no other resources. SSI benefits are better than social security disability benefits in two ways. First, SSI benefits include Medicaid, which begins on the date of eligibility for SSI benefits and pays 100 per cent of medical expenses. Second, there is no waiting period for beginning payment of SSI benefits.

Title II Contrast

For social security disability benefits, there is no maximum resource limitation; for SSI benefits, there is no

requirement that the person be "insured." A disabled person may be eligible for both social security disability benefits and SSI benefits, for neither, or for one but not the other.

WHO IS "DISABLED"? • "Disability" means "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. §416-(i)(1).

20 C.F.R. Parts 404 and 416 implement this statute; thousands of federal court decisions interpret it. Additionally, SSA has promulgated Social Security Rulings which are binding on SSA. *Sullivan v. Zebley,* supra.

Five-Step Evaluation

Fundamental to deciding who is "disabled" for social security purposes is the five-step sequential evaluation process set out at 20 C.F.R. §404.1520 (1990). This sequential evaluation process, which you must understand and apply in preparing and presenting every case, is as follows:

- Is the claimant engaged in "substantial gainful activity"? If "yes," the sequential analysis is over, and the claimant must be found not disabled. If "no," go to the next step.
- Does the claimant have a "severe" impairment? If "no," the sequential analysis is over, and the claimant must be found not disabled. If "yes," go to the next step.
- Does the claimant's impairment meet or equal an impairment listed in 20 C.F.R. Part 404, Subpt. P, App. 1? If "yes," the sequential analysis is over, and the claimant must be found disabled. If "no," go to the next step.
- Can the claimant return to his or her prior relevant work? If "yes," the sequential analysis is over, and the claimant must be found not disabled. If "no,"go to the next step.
- Can the claimant do any other work which exists in substantial numbers in the national economy? If "yes," the claimant is found not disabled; if "no," the claimant is found disabled.

Step 1: Is the Claimant Engaged in Substantial Gainful Activity?

"Substantial gainful activity" ("SGA") is a term of art. From January 1, 1979 to December 31, 1989, work producing an average of less than $190 per month was not SGA; work producing between $190 per month and $300 per month was judged case by case; and work producing greater than $300 per month was considered SGA. 20 C.F.R. §404.1574 (1990). Effective January 1, 1990, the $190 per month figure rose to $300 per month, and the $300 per month figure rose to $500 per month. 54 Fed. Reg. 53600 (December 29, 1989).

What To Look For

Even if your client earns an average of more than $300 per month (up to December 31, 1989) or more than $500 per month (after January 1, 1990), there are several ways to show that there was no SGA.

- If the earnings average less than $300 per month (up to December 31, 1989) or less than $500 per month (starting January 1, 1990) for less than a full calendar year, this should not constitute SGA. 20 C.F.R. §404.1574 implies that a full calendar year is the test. See Social Security Ruling 83-35.
- 20 C.F.R. §404.1576 allows certain impairment-related work expenses to be deducted from earnings (including the cost of medicine the claimant takes to enable him or her to work) before determining whether those earnings are SGA.
- Social Security Ruling 84-25 provides that the following are "unsuccessful work attempts," which by definition are not SGA: work which is terminated in three months or less due to the claimant's impairment; and work which lasts three to six months, was done under "special conditions," and ended or was reduced below the SGA level due to the claimant's impairment.
- Social Security Ruling 83-33 recognizes the concept of subsidized earnings and that "[a]n employer may, because of a benevolent attitude toward a handicapped individual, subsidize the employee's earnings by paying more in wages than the reasonable value of the actual services performed. When this occurs, the excess will be regarded as a subsidy rather than earnings." Government subsidies also are excluded.

Step 2: Does the Claimant Have a "Severe" Impairment?

"Severe impairment" is also a term of art. All it means is that the claimant must have a physical or mental impairment which "significantly limit[s]" his or her ability to do any basic work activity required in competitive employment, such as lifting, standing, sitting, carrying, seeing, hearing, understanding and remembering simple instructions, using judgment, responding appropriately to supervision, or dealing with changes in a routine work setting. 20 C.F.R. §404.1521 (1990).

You will rarely find anyone who is applying for social security disability or SSI benefits who does not have at least one physical or mental impairment meeting this standard. Furthermore, Social Security Ruling 85-28 provides that ineligibility findings should be made at step two only "when medical evidence establishes only a *slight* abnormality or a combination of *slight* abnormalities" [emphasis added], and that "[i]f an adjudicator is unable to determine clearly the effect of an impairment or combination of impairments on the individ-

ual's ability to do basic work activities, the sequential evaluation process should not end with the not severe evaluation step." *See Bowen v. Yuckert,* 482 U.S. 137 (1987).

Step 3: Does the Claimant's Impairment Meet or Equal a "Listed" Impairment?

20 C.F.R. Part 404, Subpt. P, App. 1 lists most types of physical and mental impairments, defined by medical criteria such as clinical and radiological findings, laboratory test results, and psychological test results. These include listings for the musculoskeletal system, special senses and speech, the respiratory system, the cardiovascular system, the digestive system, the genitourinary system, the hemic and lymphatic system, the skin, the endocrine system, multiple body systems, the neurological system, malignant neoplastic diseases, and mental disorders. If the claimant's impairment meets one of the impairments listed in App. 1, or is as severe as one of the listings, the claimant is disabled.

This is so simple that the inexperienced practitioner might think that SSA on its own, without the intervention of a lawyer, would carefully check whether or not the claimant meets a listing. Unfortunately for claimants, SSA does no such thing. In every case, examine the listings carefully and obtain additional medical information or testing as necessary.

Step 4: Can the Claimant Return To His or Her Prior Relevant Work?

"Prior relevant work" is yet another term of art. It means work the claimant performed within the past 15 years, and which was SGA (discussed under step 1 above). 20 C.F.R. §404.1565 (1990).

Because the claimant will be ineligible if he or she can return to past relevant work, you must know what the claimant's past relevant work was and why the claimant can no longer perform it. At the hearing, you must present evidence, usually in the form of testimony from the claimant, about what the prior relevant work involved and why the claimant cannot do that work now. Whether or not the claimant could return to a particular prior employer, or whether or not the work is available in the claimant's community, is irrelevant.

Once you establish that the claimant cannot return to his or her former work, the burden of proof shifts to SSA to show that your client is not disabled. The ALJ's failure to explicitly shift the burden is error. *See Jelinek v. Heckler,* 764 F.2d 507, 509 n.1 (8th Cir. 1985). A reviewing court must remand the case if it "cannot say for certain what the outcome would be irrespective of who shouldered the burden." *Rainey v. Bowen,* 814 F.2d 1279, 1282 (8th Cir. 1987).

Step 5: Can the Claimant Do any Other Widely Available Work?

20 C.F.R. §404.1566 (1990) provides: "We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether (1) Work exists in the immediate area in which you live; (2) A specific job vacancy exists for you; or (3) You would be hired if you applied for work." The claimant's inability to hold a job, however, is evidence of his or her inability to work on a sustained basis. *Gamber v. Bowen,* 823 F.2d 242, 245 (8th Cir. 1987); *Tennant v. Schweiker,* 682 F.2d 707, 710 (8th Cir. 1982).

SSA Guidelines

SSA has promulgated a set of Medical-Vocational Guidelines, which are found at 20 C.F.R. Part 404, Subpt. P, App. 2. These Guidelines are divided into three tables, one for claimants who can perform a full range of work at the "sedentary" exertional level, one for claimants who can perform a full range of work at the "light" exertional level, and one for claimants who can perform a full range of work at the "medium" exertional level. For each exertional level, the Guidelines are structured according to the claimant's age, education, and prior relevant work. For each of the three exertional levels, inserting the claimant's age, education, and prior relevant work into the Guidelines produces a "disabled" or "not disabled" conclusion.

In placing the claimant in an exertional category, what matters "is not the ability merely to lift weights occasionally in a doctor's office; it is the ability to perform the requisite physical acts day in and day out, in the sometimes competitive and stressful conditions in which real people work in the real world." *McCoy v. Schweiker,* 683 F.2d 1138, 1147 (8th Cir. 1982) *(en banc).* Furthermore, "most jobs have ongoing work processes which demand that a worker be in a certain place or posture for at least a certain length of time to accomplish a certain task. Unskilled types of jobs are particularly structured so that a person cannot ordinarily sit or stand at will." Social Security Ruling 83-12. This language is extremely helpful for claimants with back impairments, who often must avoid maintaining any one position for a prolonged period.

Taking Your Client Out of the Guidelines

In every case, you must determine what outcome the Guidelines lead to if applied to your client. If the conclusion is "disabled," you may only need to prove the underlying facts showing which Guidelines category your client fits. But if the conclusion is "not disabled," you must find a way to take your client out of the Guidelines. Usually, this is not difficult if you give it some thought and preparation. In *McCoy v. Schweiker,* supra, the court wrote a primer on how to take the claimant out of the Guidelines:

• The Guidelines apply only if the claimant's ability to work and individual characteristics match the Guidelines "identically," "precisely," and "exactly." *Id.* at 1146.

• If the claimant cannot do a full or wide range of work at a particular exertional level, or if the claimant can work only intermittently at that exertional level, the Guidelines for that exertional level do not apply. *Id.* at 1147.

• Any nonexertional impairment that "diminish[es] the claimant's residual functional capacity to perform the full range of activities listed in the Guidelines," (*Thompson v. Bowen,* 850 F.2d 346, 349-50 (8th Cir. 1988)), takes the claimant out of the Guidelines. Nonexertional impairments include "mental, sensory, or skin impairments"; "environmental restrictions" such as restrictions on ability to tolerate dust, fumes, or excessive heat; psychiatric impairments; and alcoholism. *McCoy v. Schweiker,* supra, at 1148. A person with IQ scores in the 80s has a nonexertional impairment. *Webber v. Secretary, Health & Human Services,* 784 F.2d 293, 298 (8th Cir. 1986).

• Pain can be a nonexertional impairment. *McCoy v. Schweiker,* supra, at 1148.

If the Guidelines apply to your client, they can satisfy SSA's burden of proof at step 5. But when you take your client out of the Guidelines, SSA can satisfy its burden of proof only through a legally adequate hypothetical question addressed to a vocational expert. *Id.* at 1146. This is of great practical significance because many ALJs rarely have a vocational expert at the hearing. In such cases, if you are at step 5 and you have taken your client out of the Guidelines, and the ALJ rules against you, the ALJ has erred.

THE ADJUDICATION PROCESS • Whether the claimant is disabled is adjudicated at up to six procedural levels.

Level 1: Application

The claimant begins by filing an application for disability benefits. This is made by completing an initial set of forms at an SSA office. It usually takes SSA about two months to reach an initial decision. If the decision is in the claimant's favor, the disability adjudication process ends.

Level 2: Reconsideration

If the initial decision is against the claimant, the claimant will be notified of his or her right to file a "request for reconsideration" within 60 days by completing the appropriate forms. A decision on a request for reconsideration usually takes another one to two months. If the decision is in the claimant's favor, the disability adjudication process ends.

Level 3: Request for Hearing

If the reconsideration decision is against the claimant, as it probably will be, the claimant will be notified of the right to file a Request for Hearing within 60 days. The request for hearing is filed on SSA forms. The same day the request for hearing is filed, review and copy the entire claim file at the local SSA office. Know what is in the file well in advance of the hearing. After the request for hearing is filed, the file is sent to the Office of Hearings and Appeals, and it will not be available locally.

De Novo Hearing

About five months after the request for hearing is filed, an administrative hearing is held. Everything in the file up to that point remains in the file, but otherwise the hearing is de novo, so you are not limited to the evidence already in the file, and you do not have to show grounds for overturning the prior denials. The hearing is held by an ALJ, a quasi-independent employee of SSA.

The hearing is the only face-to-face hearing your client receives. It will be tape recorded to make a record for future review and about two months after the hearing, the ALJ issues a written decision.

Level 4: Appeals Council

The last level of the administrative process is the Appeals Council. If the ALJ's decision is against the claimant, you have 60 days to file an appeal with the Appeals Council. This is your last opportunity to get evidence into the administrative record. For many years, the Appeals Council did not conduct meaningful reviews. Recently, however, it became concerned about the large number of federal court cases SSA was losing, and implemented a more genuine review process. The Appeals Council now reverses ALJ denials of benefits in approximately 27 per cent of all cases. The last four appeals I have filed with the Appeals Council have yielded reversals, so it is worthwhile to present informed argument to the Appeals Council.

Record

Request that the Appeals Council send you a copy of the tape recording of the hearing before you file your brief. 20 C.F.R. §404.974 (1990) requires the Appeals Council to comply with this request. This is the only record of the hearing you will have when you prepare your brief. The Appeals Council is authorized by 20 C.F.R. §404.969 (1990) to review on its own motion ALJ decisions favorable to a claimant within 60 days of the date of decision, but it rarely does so.

Level 5: Federal District Court

If you lose at the Appeals Council, you have exhausted your administrative remedies and may sue in federal district court. 42 U.S.C. §405(g). Given the four previous levels of review, you might wonder whether federal district court review is likely to

produce a favorable result. The answer is that if there is some error or unfairness in the ALJ's decision, a federal district court case is quite winnable.

The Complaint and Answer

The complaint must be filed within 60 days of receipt of the Appeals Council's denial, which is rebuttably presumed to occur five days after mailing. I have included a sample complaint as Appendix 2. In many cases, you can successfully move the court to allow the complaint to be filed in forma pauperis under 28 U.S.C. §1915. The government has 60 days to answer and to file the administrative record, including the government's transcription of the tape recording of the hearing.

Bad Records

SSA's transcriptions of the tape recording of the hearing are often grossly inaccurate. You should compare the tape recording of the hearing previously obtained from the Appeals Council with the government's transcript and if there are material errors, file an affidavit detailing them. Only by doing so will you protect your client from the incredibly sloppy way that SSA prepares these transcripts.

"The court . . . may at any time order additional evidence to be taken before the Secretary, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding . . . ." 42 U.S.C. §405(g). After the government has answered, both sides move for summary judgment with supporting memoranda, and the court decides the case.

Standard of Review

The standard of judicial review of findings of fact is whether the findings are "supported by substantial evidence on the record as a whole." The Eighth Circuit has repeatedly emphasized that this standard is far stricter than a mere "substantial evidence" standard, and requires a detailed evaluation of the entire record. *See Gavin v. Heckler,* 811 F.2d 1195, 1199 (8th Cir. 1987).

The court also reviews the decision for legal error: "it is the court's duty to review the disability benefit decision to determine if it is based on legal error (i.e., erroneous legal standards, incorrect application of the law)." *Nettles v. Schweiker,* 714 F.2d 833, 835-36 (8th Cir. 1983). Every federal district court has decided numerous social security disability and SSI appeals. You can obtain these decisions through the clerk of court and learn what issues the court has found persuasive in the past. Thus you can avoid reinventing the wheel.

Level 6: Circuit Courts

If you lose in the district court, but still think you're right, the circuit court of appeal is a viable avenue for relief. The Eighth Circuit generally has been quite fair to disability claimants.

PREPARING FOR THE ADMINISTRATIVE HEARING • Preparation is no less important in social security disability and SSI cases than in any other legal work. Even if you are not successful at the hearing, this is the primary place you make your record. Thus, the hearing is all-important.

Get the Exhibits Well in Advance of the Hearing

The notice of hearing you receive from SSA will inform you that the ALJ will allow you to examine the exhibits if you arrive at the hearing 30 minutes before it starts.

None of us would consider arriving at a civil or criminal trial 30 minutes ahead of time to see the documentary evidence for the first time. Yet this is exactly how SSA encourages you to proceed and it is exactly what will happen to you unless you take the initiative to get the exhibits in advance of the hearing.

How To Get the Exhibits

Copy the entire file from your local Social Security office at the time the request for hearing is filed, as discussed above. The papers in the file will not have exhibit numbers on them because this is done at the Office of Hearings and Appeals several weeks before the hearing.

Alternatively, you could arrange with the Office of Hearings and Appeals to get a copy of all the exhibits as soon as they are marked. This should get the copies to you at least four weeks in advance of the hearing.

Included in the exhibits will be the claimant's earnings record. This vital document shows the date last insured for disability benefits (DLI), and lifetime earnings by year. You can use the earnings record to refresh the claimant's recollection about his or her work history, and to show when the claimant last performed substantial gainful activity.

Requests for Reopening

In your initial interview, find out whether the client ever filed an unsuccessful application for disability benefits before. If so, and if you are within the time limits discussed below and can make a credible argument that the client was disabled at that time, file a request for reopening of the prior unfavorable determination.

The regulations concerning reopening a prior application are set out at 20 C.F.R. §404.987-404.989 (1990). Basically, these regulations provide that a prior determination may be reopened within 12 months of the date of the notice of the initial determination (for any reason) or within four years of the date of the notice of the initial determination if there is good cause—which exists when "new and material evidence is furnished," clerical error exists, or when "the evidence that was considered in making the determination or decision clearly shows on its face that an error was made."

Requesting reopening of a prior unfavorable determination is important for two reasons:

- If the prior denial is relatively recent and your client's condition has not worsened since the prior denial, the ALJ could deny the current claim based on administrative res judicata. 20 C.F.R. §404.957(c)(1) (1990). Some ALJ's take administrative res judicata seriously; others ignore it. Two grounds for avoiding the application of res judicata are set out in *Dealy v. Heckler,* 616 F. Supp. 880, 881 (W.D. Mo. 1984): (1) that the prior decision was rendered without an administrative hearing, and (2) that the notice received by claimant of the prior denial stated "[i]f you do not request a hearing within the prescribed time period, you still have the right to file another application at any time."

- If the ALJ reopens a prior application and finds your client disabled, this greatly increases the past-due benefits your client will receive, often by many thousands of dollars. This will also substantially increase your fee.

Hearings on Reopening

A claimant has the right to a hearing on an application for disability benefits. 42 U.S.C. §405(b). But there is no right to a hearing on a request for reopening, and there is no right to judicial review of denial of a request for reopening. This rule, however, is subject to two important limitations:

- If the ALJ reconsiders the merits of the claimant's original application, the ALJ has reopened it as a matter of law. *Jelinek v. Heckler,* 764 F.2d 507, 508 (8th Cir. 1985).

- Judicial review is available when SSA refuses to hear a request for reopening which is based on colorable constitutional grounds, for example, when a claimant contends that because of mental impairment the prior notice he or she received, and failed to appeal, was not meaningful notice.

SSA has no forms on which to file a request for reopening. A sample is attached as Appendix 3.

Medically Determinable Impairments

Your client's primary impairment may be obvious at your first interview. But you also need to identify and understand all the rest of your client's medically determinable impairments, physical and mental. "Medically determinable" is part of the statutory definition of disability in 42 U.S.C. §416(i)(1). Every impairment is relevant at steps 2, 3, 4 and 5 of the sequential evaluation: "[i]n determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity." 20 C.F.R. §404.1523 (1990).

Medical and Non-Medical Records

SSA gathers some of the claimant's medical records. These will be placed in the file and marked as exhibits. Effective representation absolutely demands that you get all the medical and non-medical records relating to your client's impairments. In every case I have ever handled, I found helpful records SSA failed to collect. Often, these have been the keys to winning the case.

SSA often ignores medical records predating the alleged onset of disability. Yet it is exactly those records that may show how an impairment began, how it developed, the treatments attempted, and how the claimant fought the impairment over the years. Such evidence is extremely persuasive. Furthermore, SSA makes no attempt to obtain the medical records that come into existence in the five or six months between when SSA denies the request for reconsideration and the date of the hearing. You must obtain these yourself.

Medical Records

Consider requesting a medical report from your client's treating physician. Better yet, interview the physician, then send him or her a written statement to sign. Your theory of the case determines what you need the physician to say.

A report or statement from a treating physician is usually extremely persuasive. The opinion of a treating physician or therapist is entitled to special weight. *Bailey v. Bowen,* 827 F.2d 368, 371 (8th Cir. 1987). The ALJ must give "full consideration" to such evidence. *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984).

Non-medical Records

Non-medical records can also be vital. If your client is a Vietnam veteran with post-traumatic stress disorder, he may have a history of violence; document this through court records and request his military health records through his Veterans' Service Officer. If your client is of low intelligence, get the results of any intelligence testing your client has taken, or if your client has not taken any, arrange it. If your client has taken the General Aptitude Test Battery (GATB), get the results.

Psychological Evaluation

In every case, consider getting a psychological evaluation of your client. Documenting psychological impairment will strengthen your case, take your client out of the Medical-Vocational Guidelines at step 5 of the sequential evaluation, and often allow you to cite Social Security Ruling 88-15. This ruling sets out how psychological limitations can justify a disability finding.

Finalize Your Theory and Prepare a Brief

You will begin to form your theory of the case in the first interview with your client. After you understand all of your client's impairments, have obtained your client's relevant medical history and pertinent non-medical records, have obtained a psychological evaluation if appropriate, and have reviewed the SSA file and the pertinent regulations and law, you are prepared to finalize your theory of the case and write a brief for the ALJ for delivery before or at the hearing.

Preparing the brief in advance forces you to think through the entire case, including all five steps of the sequential evaluation process, while there is still time to do something about it. My briefs typically include an introduction setting out the procedural history, a list of new exhibits, an analysis of the medical evidence including a chronological medical history, my version of the correct sequential analysis, and a conclusion.

Choose and Prepare Your Witnesses

In virtually every hearing you will call the claimant as a witness.

In many cases it helps to call the claimant's spouse or other close companion to corroborate the claimant's testimony. The ALJ must consider the testimony of such witnesses in reaching a decision, *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984), *(Polaski I)* and 751 F.2d 943, 949 (*Polaski II)* (8th Cir. 1984), and if the decision does not show that the ALJ did so, this may well be reversible error.

You also may wish to introduce evidence from other witnesses. For example, to avoid a finding that the claimant engaged in SGA, you may need to show that work was done under special conditions. In such cases, a statement from a former employer is extremely helpful. It is easier and more efficient to have the witness sign a statement than to ask the witness to appear at the hearing and then hold your breath to see whether he or she actually shows up.

Vocational Expert?

I rarely call a vocational expert to testify at the hearing. If you do so, be sure the vocational expert understands that the issue at step 5 in the sequential evaluation process is whether the claimant could perform work that "exists in the national economy" as discussed in 20 C.F.R. §404.1566 (1990), not whether work exists for the claimant in the local labor market.

Preparing Your Client To Testify

Generally, the client's testimony at the hearing will cover the following areas:

- Background including education and training;

- Work experience in the past 15 years, including the physical demands of each job, why the client left the job, and why the client cannot do that type of work now;

- A description of each physical or mental impairment the client has, when it started, how it impairs the client's ability to perform work-related activity (lifting, sitting, standing, bending, walking, feeling, seeing, hearing, attending work all day regularly, interacting with supervisors and coworkers, etc.) on a sustained, day-in day-out basis, any pain it causes, any medications the client has taken for it, and any side effects of medication;

- The client's typical daily activities, with emphasis on limitations caused by the client's impairments and how the client's activities have changed since the disability began; and

- The client's recreational and social activities, and a description of how these have changed since the client became disabled.

Many claimants have back impairments preventing them from sitting for prolonged time periods. Be sure your client understands that he or she can get up and move around during the hearing. Otherwise the ALJ will not believe the claimant's testimony that his or her ability to sit is limited, and the claimant may be in so much pain as to find it impossible to testify effectively.

Finally, prepare your client for possible cross-examination by the ALJ.

Prepare To Cross-Examine the ALJ's Vocational Expert

Some ALJs use vocational expert witnesses frequently; others use them almost never. The vocational expert may testify about whether the claimant has any transferable work skills, and whether the claimant can perform jobs that exist in substantial numbers in the national economy.

The notice of hearing, which you receive about four weeks in advance of the hearing, will advise whether a vocational expert will testify. These vocational experts are under contract to SSA. Many seem to feel that their mission is to provide testimony that will allow the ALJ to deny benefits.

Preparing to cross-examine a vocational expert witness at a social security hearing, like preparing to cross-examine any expert witness, takes time. To complicate matters, SSA instructs the vocational expert not to talk to you before the hearing, and the vocational expert does not prepare a report, so you have little idea of what the vocational expert will say.

Hypothetical Questions

Innumerable cases discuss the proper role of a vocational expert in a social security case. Read some of these cases to understand the law in this area.

For your own use in cross-examination, write out all the claimant's impairments and limitations. The law is clear that the ALJ's hypotheticals should include all impairments and

limitations. Often, however, the ALJ's hypotheticals fail to do so. If this happens, you will need to decide whether to ask your own hypothetical question on cross-examination. The advantage is that the vocational expert may testify that with the additional restrictions you pose, there is no work existing in substantial numbers in the national economy that the claimant could perform. The disadvantage is that if the vocational expert testifies that even with the additional restrictions, such work does exist, you may have given the ALJ a legally sufficient basis to rule against your client that did not exist before you cross-examined.

Skill Transferability

Read the provisions of the Code of Federal Regulations dealing with skills and transferability of skills, especially 20 C.F.R. §404.1568 (1990) and 20 C.F.R. Pt. 404, Subpt. P, App. 2 §§201.00 and 202.00. The vocational expert will frequently use these terms in ways that are inconsistent with these regulations.

Labor Department References

Become familiar with the Dictionary of Occupational Titles (U.S. Dept. of Labor, 4th ed. 1977, supp. 1986) and with Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (U.S. Dept. of Labor, 1981). Both are available from the Government Printing Office, and together will set you back about $30. 20 C.F.R. §404.1566(d) (1990) provides that SSA takes administrative notice of the information in these books. These books often directly contradict vocational expert testimony. Even if you can't leaf through these books quickly enough at the hearing to cross-examine based on them, you can cite them in a post-hearing brief.

Real-World Demands

Think about how the jobs the vocational expert claims your client can perform are actually performed in competitive employment. Mentally compare this with your client's actual limitations and cross-examine the vocational expert about any part of the jobs your client would have difficulty with.

THE HEARING • An ALJ will conduct the hearing. The ALJ "is in the peculiar position of acting as an adjudicator while also being charged with developing the facts." *Landess v. Weinberger,* 490 F.2d 1187, 1189 (8th Cir. 1974). Most ALJs are courteous and professional. There are exceptions. No opposing attorney is present and the hearing is not open to the public.

Making the Record

At the outset of the hearing, the ALJ will ask if you have any objections to the exhibits that have been previously marked in the file. If you have no objections the ALJ will receive the exhibits into evidence. Before the hearing you can request the ALJ to issue a subpoena for testimony or documents. 20 C.F.R. §404.950 (1990). If you properly request a subpoena for an adverse physician and the ALJ fails to issue the subpoena, you may in some circumstances have a valid objection to receipt of the physician's report into evidence. *Richardson v. Perales,* 402 U.S. 389, 402 (1971).

You will then offer, and the ALJ will receive into evidence, any additional exhibits you have. No foundation is required for your exhibits and the rule against hearsay does not apply.

Most ALJs allow you to conduct the direct examination of your client; others want to do it themselves. If the ALJ does it, you can be sure he or she will miss important areas or fail to develop some areas thoroughly. Return to these areas after the ALJ is done.

The ALJ will allow you to present an opening statement and a closing argument, but impassioned oratory does not win these cases. The substance of your argument should be in the brief you file before or at the hearing.

At the conclusion of the hearing, if there is additional evidence you still need time to obtain and submit, ask that the record remain open for 30 days. ALJs routinely grant these requests.

About two months after the record is closed, you and the claimant will receive the ALJ's decision.

IF THE ALJ FINDS YOUR CLIENT NOT DISABLED • If the ALJ rules against your client, you should strongly consider filing an administrative appeal with the Appeals Council, and if that is unsuccessful, a complaint in federal district court. These steps have been discussed above.

Some of the most frequently successful grounds for federal court appeal are:

- The ALJ erred by using the Guidelines;
- After finding that the claimant could not return to his or her prior work, the ALJ erred by failing to explicitly shift the burden of proof to SSA;
- The ALJ improperly evaluated the claimant's complaints of pain;
- The ALJ failed to evaluate all the evidence;
- The ALJ failed to develop the record fully and fairly;
- The ALJ's decision is not supported by substantial evidence on the record as a whole;
- The ALJ ignored some of the claimant's impairments; and
- The ALJ's hypothetical to the vocational expert was inadequate or erroneous.

Another option is to have the claimant file a new application for disability benefits. If a federal court appeal is foregone or lost, the disad-

vantages are that the claimant will lose the possibility of obtaining a substantial amount of past-due benefits, and administrative res judicata may be applied to the new application if the claimant's condition has not significantly worsened. On the other hand, the second time around the claimant's case may be heard by a more reasonable ALJ who may award benefits and who may even reopen a prior denial.

IF THE ALJ FINDS YOUR CLIENT DISABLED • If the ALJ rules in favor of your client and he or she may be financially eligible for SSI benefits, the next step is an interview at the local social security office to establish financial eligibility for each month of disability.

SSA district office employees generally are well-meaning, but they have a large caseload and tend to explain complicated matters so fast that the client doesn't understand the ramifications of choosing one option instead of the other. Deal with this by getting the SSA employee who will conduct the interview to explain these issues to you ahead of time, then go with your client to the interview to be sure the client makes a careful, informed decision.

If your client has minor children and is eligible for social security disability benefits, be sure that SSA actually pays the benefits. In several of my cases, SSA totally ignored payment of benefits to minor children until I called this to SSA's attention.

Workers' Compensation Offset

If your client has received or will receive workers' compensation benefits, you must be sure that SSA correctly computes the workers' compensation offset, set out in 20 C.F.R. §404.408 (1990). The basic rule is that up to age 62 (if the claimant became disabled between June 1, 1965 and March 1, 1981, or if the claimant takes something called the "RIB option") or otherwise up to age 65, the claimant's social security disability benefits, when added to his or her workers' compensation benefits (excluding medical and legal fees), may not exceed 80 per cent of his or her highest year's earnings in the five years before the year in which he or she became disabled. This area is complex, and dealing with it is essential to your client receiving the maximum social security disability benefits to which he or she is entitled.

If you handle a workers' compensation settlement for a client who also receives social security disability benefits or who may receive such benefits in the future, understanding this area is essential to structure the workers' compensation settlement so that your client receives the maximum total benefits possible. Pertinent materials include Social Security Rulings 81-20, 81-32, and 87-21c, SSA's Programs Operations Manual (POMS) §11501.048-11501.428, and §8.04 of Matthew Bender's Social Security Practice Guide.

GETTING PAID • Unlike civil litigation, how and when you get paid in social security disability cases requires following the government's guidelines.

Staying Out Of Jail

At the beginning of the case, before SSA will recognize you as your client's attorney, you must complete an SSA Form 1696. Form 1696 informs both you and your client that you cannot charge or collect a fee until your representation is concluded, you have filed a fee petition, and your fee has been approved by SSA or, in cases filed in federal district court, until the court has awarded a fee. Violating these provisions is a federal crime punishable by a fine of $500 and free room and board in a federal correctional institution for one year. 42 U.S.C. §406.

Withholding of Benefits by SSA for Payment of Your Fee

In a social security disability case SSA will pay directly to the claimant's attorney the smallest of:

- 25 per cent of total past-due benefits;
- The amount of the fee approved by SSA; or
- The amount agreed upon between the claimant and his or her attorney. 20 C.F.R. §404.1730(b) (1990).

In an SSI case, SSA will withhold nothing for possible payment of an attorney's fee. This means that your client will receive all past-due benefits. Thus, your fee agreement should provide that if the client receives past-due SSI benefits, the client will immediately deposit the estimated fee and sales tax in your trust account. The fee agreement should also provide that you will hold all such funds in your trust account until SSA or a court has acted on your fee petition and if the amount deposited is more than the amount finally approved as a fee, you will promptly refund the difference to the client. Social Security Ruling 82-39 provides that if you follow these rules, you can place the anticipated fee in your trust account without violating 42 U.S.C. §406.

If you have any desire to actually get paid in an SSI case, you must get the money in your trust account as soon as the client receives the past-due benefits check. My experience has been that the vast majority of clients come in with the estimated fee as soon as they receive their SSI past-due benefits check, so long as this responsibility was clearly explained to them orally and in the written fee agreement.

From Favorable Decision to Filing Your Fee Petition

In the simplest SSI case, it takes approximately one month before SSA computes and pays past-due benefits; in the simplest Title II disability case, about two months to do so; and in any case involving concurrent Title II and SSI benefits, about a month to compute and pay the SSI benefits and

about five months to compute and pay Title II benefits. SSA is supposed to send notices of its determinations about past-due benefits to both you and the claimant. Always review these notices carefully, because they frequently contain errors.

After you are satisfied that SSA has correctly computed all past-due benefits due your client and his or her dependents, you can file your fee petition on SSA Form 1560. Attach to Form 1560 a complete recapitulation of your time records, your fee agreement, copies of all notices showing the amount of past-due benefits received, and if you wish, a statement of why your fee is reasonable. It is vital to attach notices of past-due SSI benefits.

The ALJ's Action on Your Fee Petition

After receiving the fee petition, the ALJ waits at least 20 days for comments by the claimant. After the time for client comment expires, the ALJ decides what fee to approve. An ALJ has authority to approve a fee up to $4,000. Above $4,000, the ALJ determines a recommended fee, and forwards it to the Regional Chief ALJ, who decides what amount to approve. The attorney or the client can appeal the decision on the fee petition to another SSA official, who makes a final decision. 20 C.F.R. §404.1720(d) (1990).

For fee determinations beginning July 1, 1991 SSA will approve fee agreements if signed by attorney and claimant when past-due benefits are awarded and the fee is less than the lesser of $4,000 or 25 per cent of the past-due benefits.

Attorney Fees in Federal Court Cases

Whenever you sue in federal court and prevail, the federal court has authority under 42 U.S.C. §406 to award up to 25 per cent of past-due benefits as a fee for your services before the court. *Fenix v. Finch,* 436 F.2d 831 (8th Cir. 1971).

EAJA Motions

You also may file a motion for attorneys' fees and costs under the Equal Access To Justice Act, 28 U.S.C. §2412 ("EAJA"). EAJA fees include compensation for your time beginning when you first prepared the case for filing in federal court, for your time at the administrative level on a court-ordered remand, *Sullivan v. Hudson,* 109 S.Ct. 2248 (1989), and for your time preparing the EAJA motion, *Kelly v. Bowen,* 862 F.2d 1333 (8th Cir. 1988). EAJA costs include "those customarily charged to the client where the case is tried." *Id.* at 1335.

The grounds for an EAJA motion are:

- The claimant is the prevailing party;
- The government's position was not substantially justified;
- The claimant's net worth does not exceed $2 million (this is not a problem for any of my clients); and
- No special circumstances make such an award unjust.

Generally, the main issue on an EAJA motion is whether the government's position was substantially justified, which means whether it had a "reasonable basis both in law and fact." *Pierce v. Underwood,* 487 U.S. 552, 565 (1988). The government bears burden of proof on this issue. *Gamber v. Bowen,* 823 F.2d 242, 244 (8th Cir. 1987). This burden entails "proving that its position was substantially justified at both the administrative and litigation levels." *Gowen v. Bowen,* 855 F.2d 613, 618 (8th Cir. 1988). EAJA motions are frequently granted, and if denied, are appealable. *Gamber v. Bowen, supra,* 823 F.2d 242; *Bailey v. Bowen,* 827 F.2d 368 (8th Cir. 1987).

If a fee is awarded for the same work under both the EAJA and 42 U.S.C. §406, the attorney is entitled to receive the larger of the two, and the client receives the smaller of the two. *Cotter v. Bowen,* 879 F.2d 359, 361 n.2 (8th Cir. 1989).

CONCLUSION • Social security disability and SSI cases give you the opportunity to represent the truly needy and deserving, and to obtain for them an inalienable monthly income, usually for life, plus medical insurance. Few areas of the law, and for that matter few areas of life, offer the opportunity to do so much for the disadvantaged with such a small investment of ourselves.

APPENDIX 1 — RESOURCES

The following resources not previously mentioned are extremely helpful in representing social security disability and SSI claimants:

(1) The one-volume 20 C.F.R. Parts 400 to 499, which is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. This year it costs $24;

(2) "A Disability Appeal Primer" by Arthur J. Fried, a concise, handy booklet available from West Publishing Co. (1-800-328-2209) for $2.50; and

(3) Membership in the National Organization of Social Security Claimants' Representatives (NOSSCR), 19 E. Central Ave., Pearl River, NY 10965, tel. (800) 431-2804. This costs $100 per year. In exchange, you receive a monthly newsletter containing invaluable information about developments in law and new strategies, and free access to experts in the area and materials prepared by experts.

APPENDIX 2 – SAMPLE COMPLAINT

UNITED STATES DISTRICT COURT
DISTRICT OF _____
_____ DIVISION

**********		
Plaintiff,	*	Civ. 91-
v.	*	
Louis W. Sullivan, M.D.,	*	
Secretary of Health &	*	
Human Services,	*	
Defendant.	*	
	*	
**********		

COMPLAINT

JURISDICTION

I

This is an action to review a final decision of the Secretary of Health and Human Services of the United States of America. This court has jurisdiction under 42 U.S.C. §405(g).

PARTIES

II

Plaintiff is a claimant for social security disability and SSI benefits. Plaintiff's social security number is _____.

III

Defendant is the Secretary of Health and Human Services of the United States and is sued in his official capacity.

CAUSE OF ACTION

IV

Plaintiff is dissatisfied with the Secretary's final decision finding him not disabled.

V

Plaintiff suffers from impairments of such a nature and severity that he is disabled within the meaning of the Social Security Act, and has been disabled at all pertinent times.

VI

At all pertinent times, plaintiff has been unable to engage in any substantial gainful activity by reason of medically determinable impairments. Plaintiff's impairments lasted for a continuous period of more than 12 months.

VII

Plaintiff has exhausted his administrative remedies.

VIII

Defendant's position is not supported by substantial evidence, is contrary to law, and is not substantially justified.

IX

If the case is remanded for another hearing, it should be remanded to a different Administrative Law Judge.

WHEREFORE, PLAINTIFF PRAYS:

1. That this Court review defendant's final decision denying plaintiff disability benefits, and reverse that decision;

2. That if this Court remands this case for another hearing, the Court remand it to a different Administrative Law Judge;

3. That this Court award plaintiff a reasonable attorney's fee and costs pursuant to the Equal Access To Justice Act;

4. That this Court determine and allow a reasonable attorney's fee pursuant to 42 U.S.C. §406(b)(1);

5. That this Court award plaintiff his costs of suit; and

6. That this Court grant such other and further relief as it deems just.

Dated: _____ __, 1991

_____
[Name]
Attorney for Plaintiff
[Address & Telephone]

APPENDIX 3 — SAMPLE REQUEST FOR REOPENING
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

In re: _____ *
SSN _____ *
*
*

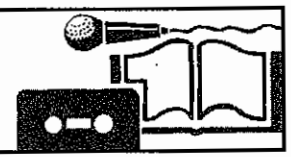
REQUEST FOR REOPENING

Pursuant to 20 C.F.R. §404.987-404.989, the due process clause of the fifth amendment, and relevant case law, _____ requests reopening of the disability determinations of _____ __, 19__ and _____ __, 19__, on the following grounds:

1. This request is made within 12 months of the date of the notice of the initial determination of _____ __, 19__, and that decision therefore may be reopened for any reason;
2. The prior determinations finding Mr. _____ not disabled were clearly incorrect;
3. The evidence that was considered in making the prior determinations clearly shows on its face that an error was made;
4. The Social Security Administration in making the prior decisions denied Mr. _____ due process of law by failing to follow clearly established law;
5. The equities justify tolling of the 60-day appeal periods;
6. Mr. _____ was entitled to believe that the Social Security Administration had faithfully performed its duties and followed the law, *see, e.g., Bowen v. City of New York,* _____ U.S. _____, 106 S.Ct. 2022, 90 L.Ed.2d 462 (1986); and
7. The Notice of Reconsideration of _____ __, 19__, advised Mr. _____ that "If you do not request a hearing of your case within the prescribed time period, you still have the right to file another application at any time."

Dated: _____ __, 199__ _____
Attorney for Claimant

PROGRAMS PUBLICATIONS and PLAYBACKS



COURSES

Evidence for the Litigator

The newest ALI-ABA Professional Skills Course, *Evidence for the Litigator,* will be cosponsored by and presented at the Philadelphia Bar Association, in Philadelphia, on May 31, 1991.

This one-day program uses live trial vignettes portraying typical trial situations. The vignettes demonstrate many common evidence problems that confront litigators, including:

- The do's and don'ts of making objections;
- Responses; and
- Laying foundations.

Through a combination of lecture, demonstration, and discussion, the course teaches participants to analyze evidentiary problems in the battlefield context of trial situations.

The leader of this program/workshop is David A. Sonenshein, Professor of Law at Temple University School of Law in Philadelphia, and a recognized trial advocacy and evidence expert.

Negotiation and Settlement

ALI-ABA's popular one-day Professional Skills Course, *Effective Legal Negotiation and Settlement,* will be presented June 7, 1991, at the Embassy Suites, Times Square, in New York.

Negotiation is a vital skill that occupies a position of great importance for every litigator. This lecture/workshop helps attorneys understand and apply general negotiating principles to maximize personal strengths in future negotiations. This course takes a practical approach to the negotiation process and uses videotaped segments to demonstrate some of the concepts. Participants also engage in negotiation exercises to improve their negotiation skills.

The conductor of the lecture/workshop is Charles B. Craver, Professor of Law at the George Washington University National Law Center.

To register or to obtain further information, write to Alexander Hart, Director, Office of Courses of Study, ALI-ABA Committee on Continuing Professional Education, 4025 Chestnut Street, Philadelphia, Pennsylvania 19104-3099, or call (215) 243-1630. Usually, detailed announcements are not ready until three months before the scheduled date of a course. Earlier inquiries will be acknowledged immediately and printed announcements will be sent as soon as they are available.

3/30/10 Update to Social Security Article - Jim Leach

Some of the numbers in the article have changed since 1991. For example, the dollar amount needed to earn a covered quarter (page 72) has changed, and the monthly amount of earnings that constitute substantial gainful activity (page 74) has changed. The new numbers are readily available through Google. The system moves more slowly now: I say it takes about 5 months to get a hearing (page 79), but now in most places it's more like 14 to 16 months. The maximum fee an attorney can receive based on a fee agreement (page 90) is now $6,000.

But in all significant respects, the system is the same now. SSDI (Title II) and SSI (Title XVI) (p. 72-74) work the same; the five-step disability evaluation (p. 74-78) is the same; the six levels of adjudication (p. 78-80) are the same; preparation for the administrative hearing (p. 81-86) is the same, with the exception that some case records are now electronic rather than paper; hearings (p. 86-87) are the same; the Appeals Council (p. 87-88) works the same; the workers' compensation offset (p. 88) works the same (if this subject interests you, I wrote an article on it, also published in the Practical Litigator, which I can e-mail you on request), and attorney's fees (p. 89-91) work the same, except that the potential fee agreement maximum has been increased as noted above. Most attorneys now use fee agreements (p. 90) rather than fee petitions.

SOCIAL SECURITY DISABILITY, SSI, MEDICARE, AND MEDICAID: WHAT'S THE DIFFERENCE—AND WHY WOULD YOU CARE?

by Jim Leach[1]

About once a month a lawyer calls me for help sorting out how social security disability, SSI, Medicare, and Medicaid affect a client. This article explains the basics of these programs, and how they affect our clients, in a way that I hope is helpful to many lawyers who encounter them occasionally.

Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)

To be eligible for SSDI, a person must be (a) "insured" and (b) "disabled." A person is "insured" if the person has earned a minimal amount of wages for 20 of the past 40 calendar-year quarters, or to put it more simply, 5 of the past 10 years. Different rules apply to people who are under 31 years old. Most disabled people are older than 31, so these rules rarely come up, so I won't discuss them. The minimal amount of wages required to earn coverage for a quarter changes every year. In 2010, it's $1,120.

For example, a person who has worked continuously from January 2000 to December 2009, then is injured and unable to continue working, will be insured for disability benefits until December 31, 2014, and therefore entitled to benefits if disabled within that period. And if disabled within that period, benefits continue for as long as the person remains disabled.

It's called "insured" because the program is funded by F.I.C.A. and self-employment taxes. The more a person has earned, the higher the person's potential benefit will be. I've seen monthly SSDI benefits as low as $100 and as high as $2,300. The Social Security Administration sends a summary of lifetime earnings to every worker once a year, or on request. The summary includes an estimate of the disability benefit amount.

Unlike SSDI, SSI eligibility does not require that a person be insured. To be eligible for SSI, a person must (a) have very limited income and financial resources and (b) be disabled. The maximum income that a person can have and be eligible for SSI depends on whether the income is unearned or earned. If it's unearned, the maximum for a single person is $694 per month; if it's earned, the maximum for a single person is $1,433 per month. For a married person, the maximum family unearned income is $1,031 per month, and the maximum earned income is $2,107 per month. An example of unearned income is workers' compensation benefits or unemployment insurance payment. The maximum amounts increase a little most years.

The SSI financial resource limitation is $2,000 for an individual and $3,000 for a couple. Other than a home, the land the home is on, and one vehicle, almost everything else counts as a resource, excluding only life insurance policies with a face value of no more than $1,500, burial plots, or burial funds of no more than $1,500. SSDI and SSI use the same definition of "disabled." I wrote an article about what "disabled" means in Social Security cases that I'll be glad to e-mail to you on request.

Medicare and Medicaid Eligibility

A person who is entitled to SSDI becomes eligible for Medicare 29 months after the person became disabled. For example, if the Social Security Administration decides on January 1, 2012, that a person became disabled on January 1, 2010, the person is eligible for Medicare beginning June 1, 2012. SSA automatically notifies the person when eligibility begins. A person who is entitled to SSI benefits in any amount—even $1 a month—receives Medicaid coverage, with no waiting period.

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[1]Catherine Ratliff of Hot Springs made many helpful suggestions during the preparation of this article.

Medicare is described at www.medicare.gov. Medicaid is described at http://www.cms.gov/home/medicaid.asp. I tried to write a summary of the programs, but found it impossible to be both accurate and succinct.

How SSDI and SSI are affected by personal injury and workers' compensation recoveries

Because SSDI is an "insurance" program, and has no resource limitations, a personal injury settlement has no effect on SSDI benefits. So if you recover a personal injury settlement of a million dollars for your client, your client's SSDI benefits are not affected (although your client's Medicare benefits may be affected, as discussed below).

A workers' compensation settlement, unlike a personal injury settlement, must be reported to the Social Security Administration, and can significantly affect your client's SSDI benefits. A workers' compensation settlement may reduce your client's SSDI benefits not at all, a little, a lot, or it may completely eliminate them. The reduction is because of the Social Security workers' compensation offset (not to be confused with the South Dakota workers' compensation offset for some people of retirement age, described in the second paragraph of SDCL 62-4-7). The good news is that how you draft the settlement documents can significantly reduce the workers' compensation offset, thereby putting more money in your client's otherwise empty pocket. I wrote an article about how to reduce the workers' compensation offset that I will e-mail to you on request.

SSI, because it is a needs-based (sometimes called "welfare") program, is drastically affected by a personal injury settlement. Any money your client receives counts as a "resource," unless it is used to buy an asset that isn't counted as part of "resources" (as discussed above, a home and one vehicle). So if your client receives more than $2,000 (if single) or $3,000 (if married) in a personal injury settlement, your client is disqualified from receiving SSI benefits that month, and every following month until the client's resources are again below the allowable maximum. And if your client loses SSI benefits, your client automatically loses Medicaid too, a substantial and frightening loss.

Be sure your client keeps receipts to show how the settlement money is spent. SSA is well aware that some SSI recipients would like to park their money with a friend or relative and get back on SSI, so SSA may require receipts to show that the money was spent for goods that have been consumed, or for assets that are not counted as part of the client's resources. Because one vehicle is not counted as part of the client's resources, the client can use the settlement money to buy a good vehicle and become eligible again for SSI.

SSI recipients who receive workers' compensation settlements, unlike SSDI recipients, are not subject to the workers' compensation offset. But the workers' compensation settlement counts as a resource, just like a personal injury settlement, so it disqualifies a person from receiving SSI and Medicaid until the person is under the resource limitation again.

SSDI and SSI subrogation

The SSDI and SSI programs do not have a right of subrogation for disability benefits. For example, assume that your client is injured and becomes disabled as a result of a tortfeasor's negligence, and receives monthly SSDI or SSI disability benefits. You eventually recover a million dollars in your client's lawsuit against the tortfeasor. None of the million dollars goes back to the government to reimburse it for the SSDI or SSI disability benefits that it paid because of the tortfeasor's negligence.

Unfortunately for our clients, Medicare and Medicaid have a right of subrogation. Under Medicaid, the South Dakota Office of Recoveries and Fraud Investigations, once it becomes aware that you client has a claim, will correspond with you, keep you aware of the amount of its subrogation interest, and remind you of your duty to pay its subrogation claim. Ordinarily, the Office of Recoveries and Fraud Investigations will pay you a 25% attorney's fee out of the amount you recover for it.

Medicare subrogation works differently. When Medicare has paid medical expenses incurred because of someone's negligence or because of a work injury, or if your client asks Medicare to pay for such expenses in the future, the federal government's Medicare reporting and set-aside rules apply. The federal government has a right to recover past Medicare expenses it paid as a result of a third-party's conduct. And the government can deny payment of Medicare benefits in the future if a Medicare recipient recovers funds that could be used to pay future related medical expenses, but that aren't used for that purpose.

On these Medicare subrogation issues, all I can tell you is not to call me. I have never had to do a Medicare set-aside agreement, and remain blissfully ignorant on this subject. I don't waive future medical costs in workers' compensation settlements, so the workers' compensation carrier continues to pay them, they aren't shifted to the government, and I don't have to worry about a Medicare set-aside agreement.

How to find out whether your client receives SSDI, SSI, or both

As you know by now, the SSDI and SSI programs differ in several important respects. Accordingly, it makes a big difference whether your client receives SSDI or SSI. (Or your client may receive both, which can happen when the client's SSDI check is small enough that the client qualifies for SSI.) How can you find out whether your client receives SSDI, SSI, or both?

The worst way to determine this is to ask your client. Your client doesn't know. Even if the client thinks he knows, the client is probably—in my experience—wrong. If your client has all his or her social security papers, the papers should tell you. If your client's social security benefit in 2010 is more than $674 per month (if the client is single) or $1,011 per month (if married), then the benefit is SSDI, not SSI. If it's less than those amounts, it could be SSDI, SSI, or some of both, so you need to see the client's papers, or you may be able to find out from your local social security office.

A word on terminology

SSDI is synonymous with "Title 2," and sometimes is called "disability." SSI is synonymous with "Title 16." Clients will tell you they are on "Social Security" or "disability." This tells you nothing, because both SSDI and SSI are "Social Security," and both require disability.

Resources for further information

The Social Security Administration has a toll-free telephone number that gives free advice on all these subjects. I find it worse than useless. Studies show that the call center gives the correct answer perhaps 70% of the time. For complicated questions, I'm sure the percentage is much lower. When the call center gives you misinformation that you rely on to your client's detriment, you have no recourse.

Social Security Administration publications, which are readily available on the internet, are an excellent source of information. Another good resource can be your local social security office, especially if you can learn who has expertise in particular areas.

A final thought

SSDI, SSI, Medicare, and Medicaid, although alphabet-soup confusing at first, are capable of being understood. When we understand them, we can help our clients obtain all the benefits to which they are entitled by law.

MINIMIZING THE SOCIAL SECURITY WORKERS' COMPENSATION OFFSET

James D. Leach[1]

This article was published in The Practical Litigator in 1994. At the request of WILG, I updated it in 2010 to take account of any changes in the law since 1994.

Q. [Anonymous lawyer] I handle worker's compensation cases. Some of my clients receive social security disability benefits. I've never understood how Social Security computes the workers' compensation offset. Why should I care?

A. There are three reasons to care about the workers' compensation offset: improving your professional abilities, obtaining more benefits for your clients, and avoiding malpractice.

Q. Okay, you have my attention. But are you saying that what I do can affect how Social Security applies the offset?

A. That's exactly what I'm saying. Attention to a few details can make a big difference in how much Social Security pays your client.

Q. Maybe you'd better tell me more.

The Basics

A. Congress provided that a disabled person shouldn't collect both social security and workers' compensation benefits which together totaling more than 80 per cent of her pre-

[1]The author is a WILG member who practices law in Rapid City, South Dakota. His e-mail address is jim@southdakotajustice.com. WILG member Angelo Paul Sevarino of Windsor, Connecticut, kindly reviewed this article prior to publication. His book, *Practitioner's Guide to Settlements, Offsets and Set-Asides*, is available from his web site, http://sevarino.lawoffice.com.

injury earnings. 42 U.S.C. § 424a.

Q. Sounds pretty straightforward.

A. I wish it were. The Social Security Administration ("SSA") implemented the law with regulations found at 20 C.F.R. section 404.408, and SSA issued a couple hundred pages of POMS on the subject.

Q. What's a "POMS"?

A. That's SSA terminology for Program Operations Manual System.

Q. What difference does SSA's operations manual make to me?

A. SSA uses the POMS in determining how the offset applies. And although the POMS are not law, they are "administrative interpretations" which "warrant respect." *Wash. St. Dept. of Soc. & Health Services v. Estate of Keffeler*, 537 U.S. 371, 385 (2003). As a practical matter, SSA follows them and federal courts routinely cite them.

Q. Where can I find them?

A. They're online. Just put "SSA POMS" into your favorite search engine.

Computing the Offset

Q. Basically, how does the offset work?

A. To begin with, SSA computes your client's "ACE," which stands for "average current earnings." Two methods for computing it apply in the vast majority of cases. Under the first method, SSA looks at your client's earnings during the year in which she became disabled and the five previous years. From those years it takes the highest single year's

earnings, and divides by 12 to get a monthly average. Under the second method, SSA looks at your client's five highest consecutive years of earnings in her lifetime, and from those five years divides by 60 to get a monthly average.

Q. Which of the two methods of computing the ACE does SSA use in determining the offset?

A. The one which produces the highest number, which is usually the first.

Q. What does SSA do after it figures the ACE?

A. Reduces the social security benefits for the client and her family so that the total of (1) non-excludable workers' compensation benefits plus (2) social security benefits for the client and her family does not exceed 80 per cent of the ACE.

The Exception

Q. Is there any exception to this rule?

A. The exception is in the unusual situation in which the total family social security benefits payable before offset exceed 80 per cent of the ACE.

Q. In that case, how does SSA compute the offset?

A. It uses the total family social security benefits payable before offset, rather than 80 per cent of the ACE, as the upper limit on the total of the two benefits. 20 C.F.R. § 404.408(c)(ii).

Non-Excludable Benefits

Q. You just referred to "non-excludable workers' compensation benefits." What

does that mean?

A. Legal costs (attorney's fees and costs) and medical costs (past and future) are excluded, meaning that they are not counted as workers' compensation benefits in computing the offset. 20 C.F.R. §404.408(d). So "non-excludable workers' compensation benefits" means workers' compensation benefits excluding legal and medical costs.

Q. What if the settlement waives future medical costs and allocates a substantial amount to future medical costs? Won't this increase excludable expenses and thereby decrease the offset?

A. Yes, but it may make your client ineligible for Medicare benefits otherwise payable for treatment of the work-related injury (42 C.F.R. sections 411.46(b)(2) and (d)(2)), and SSA can disallow any expenses which are excessive (POMS DI ["Disability Insurance"] 52150.050.E), so in my opinion this approach is not wise.

Q. What about Medicare set-aside issues with this kind of settlement?

A. Medicare set-aside issues are beyond my area of expertise.

The Effect of the Offset

Q. I think I understand excludable expenses. Let's talk about the big picture. Does the offset usually result in my client's social security benefits being reduced?

A. It depends on the client's age, her earnings record, her social security benefits, her workers' compensation benefits, and in many cases on how you draft the workers' compensation settlement or award documents.

Q. Can't you just give me a rule of thumb?

A. Some clients have their social security benefits totally offset, meaning that because of their workers' compensation benefits they receive no social security benefits; some have a partial offset; and some have no offset. There is no rule of thumb. In each case, you have to analyze how the rules apply to the particular client.

Q. Can you give me an example?

The Primary Insurance Amount

A. Sure, but first I have to explain two more social security terms. One is the "PIA," a Social Security acronym which stands for "primary insurance amount," which means the monthly social security payment the client will receive on her own social security account, excluding any benefits for spouse or children, if there is no offset The other is the "FAM MAX," another acronym which stands for "family maximum," meaning the maximum social security benefits for the client and her family, if there is no offset.

A Bad Deal for Jane

Q. OK, now the example.

A. Let's say Jane Smith has an ACE of $1,000. Her workers' compensation benefit before attorney's fees and costs is $750 per month; after attorney's fees and costs, it is $600 per month. Her social security FAM MAX is $500 per month. Eighty per cent of her ACE is $800. SSA will reduce her family social security benefit by $300, to just $200 per month, so that the total of her non-excludable workers' compensation benefits ($600 per

month) and her social security benefits ($200 per month) does not exceed 80 per cent of her ACE ($800). So Jane loses $300 per month – money she really needs for rent, food, clothing, and shelter for herself and her children.

Q. But the PIA and FAM MAX increase every year because of the cost of living allowance, so what date does SSA use?

A. In computing the offset, SSA uses the PIA and FAM MAX as of what it calls the "first considered" date. An example is the best way to explain what SSA means by the "first considered" date. If your client first received both disability and social security benefits in January, 2009, and SSA addressed the offset issue in January, 2010, and found that no offset should have been imposed until July, 2009, the offset could have been "first considered"in January, 2009, so it is the January, 2009 PIA and FAM MAX that are used in computing the offset. POMS DI 52150.020.A. This means that cost of living increases are not taken into account, so your client keeps 100% of SSA cost of living increases.

Reducing the Offset

Q. If I were Jane's lawyer, how could I reduce the offset?

A. While workers' compensation benefits are being paid weekly, you couldn't. But when a lump sum settlement is negotiated (or paid after a hearing), there's a lot you can do.

Get the Earnings Record

Q. Where do I start?

A. First, you need a copy of her earnings record ("ER"), which will show her PIA and Family Maximum (FAM MAX), and from which you can easily compute her ACE.

Q. How do I get the earnings record?

A. Send a completed SSA Form 1696 (Appointment of Representative) to SSA. Then keep after SSA until you get an ER showing the PIA. (If you went to a hearing with your client on your client's social security disability application, the earnings record was one of the exhibits in the SSA hearing file.)

Q. What if I can't get it?

A. If your client has the summary of lifetime earnings that SSA out every year, you can use that to compute her ACE, but it won't have the PIA or FAM MAX.

Life Expectancy and Proration

Q. What do I do after I get the earnings record?

A. Two sections of the POMS are critical. One is DI 52150.060.D.3. It provides four rules which are used in the "priority," meaning in the order in which they are given; as soon as a rule applies, that rule is used, and no other rules are considered. The four rules are:

(1) *The rate specified in the Lump Sum award.*

(2) If no rate is specified in the Lump Sum award, and the claimant received weekly benefit payments before the Lump Sum award was made, use the most recent weekly benefit rate.

(3) If no rate is specified in the Lump Sum award, and the claimant did not

receive any weekly benefit payments before the Lump Sum award was made, and the language of the Lump Sum award "implies a compensation rate," use it.

(4) Otherwise use the State's workers' compensation maximum payment in effect on the date of injury.

Q. Why do you emphasize that first sentence?

A. It's the key here. Let's say Jane's lawyer settles her workers' compensation case for a lump sum of $60,000, and the settlement documents don't say anything about the rate at which the lump sum award is to be prorated. SSA will use method "2" and will continue to reduce her monthly social security benefits by $300.

Q. How will SSA ever find out about the terms of the workers' compensation settlement?

A. When Jane applied for social security disability benefits, one of the forms she was required to sign, under penalty of perjury, included her promise to tell SSA about any workers' compensation benefits she receives. She will have long ago forgotten this–no one remembers all that fine print anyway–but you will know that she signed it, because all SSA applicants must do so, and to help keep her out of trouble, and maybe increase her benefits, you will advise SSA of the workers' compensation settlement.

Q. Why might her benefits increase?

A. In many instances, a lump sum settlement, if properly drafted, will increase a client's social security benefits. A 2001 GAO report found payment errors in 52% of

workers' compensation offset cases, and 85% of those errors occurred when beneficiaries did not report a change in their workers' compensation benefits.

Q. How long will SSA continue the $300 per month offset? And didn't you say that some expenses (medical and legal costs) are excluded?

A. Good questions, but you're getting ahead of the story. First let's see how to get Jane the extra $300 per month she needs for herself and her family.

Q. You have my full attention.

Put Life Expectancy Into Settlement Agreement

A. Let's say Jane is 50 years old, and that a standard table shows her life expectancy as 31.2 years. Use the following language in the settlement agreement:

"Claimant's date of birth is 1/1/60. Claimant's life expectancy is 31.2 years. Based on claimant's life expectancy, insurer agrees to pay claimant a lump sum settlement of sixty thousand dollars ($60,000), representing $1,923.07 per year ($160.25 per month) for her life expectancy of 31.2 years. This lump sum settlement of benefits is intended to provide benefits of $160.25 per month to claimant over the balance of her lifetime."

Q. Under POMS DI 52150.060.D.3, SSA prorates the lump sum at $160.25 per month, because that is the amount specified in the award, right?

A. Right.

Q. So how does that help Jane?

A. Because now her social security benefits of $500 per month and her workers'

compensation benefits of $160.25 per month total $660.25 per month, which is less than 80 per cent of her ACE (80 per cent of $1,000 = $800), so instead of reducing her social security benefits by $300 per month, SSA no longer reduces them at all.

Q. *So using the language you've given above to prorate the lump sum settlement over her lifetime is critical in reducing the offset?*

A. *It is. It's the most important thing we've discussed. Remember it even if you don't remember anything else.*

Amending Existing Agreements

Q. If I amend the workers' compensation settlement agreements I've already done to add this language, will SSA go by the original document or the amended document?

A. No. SSA promulgated Social Security Ruling 97-3, which provides that SSA "is not necessarily bound by the terms of a second, or amended, stipulation . . . . SSA will evaluate both the original and amended stipulations and disregard any language which has the effect of altering the terms in the original lump-sum settlement where the terms in the amended document are illusory or conflict with the terms of the first stipulation concerning the actual intend of the parties." So unless the amended document reflects the original intention, SSA will not consider it.

What About Annuities?

Q. What if my client receives a lump sum that is to be used to purchase an annuity?

A. Social Security Ruling 81-32 says: "a worker who chooses to receive a lump-sum amount is considered to have been paid that amount regardless of whether he or she uses it to purchase an annuity." And see POMS DI 52150.065.D., "Structured Settlements."

Other Considerations

Q. What about a case that involves mainly issues of temporary total disability and rehabilitation?

A. If the settlement agreement will extinguish your client's claim for total permanent disability benefits, use the language I gave you in the example so that benefits are prorated over the client's lifetime.

Q. Do the POMS have anything to say about this?

A. POMS DI 52150.060 says that a lump sum "is a final settlement, award, compromise and release, or other approved agreement that represents a final WC/PDB [workers' compensation/public disability benefit] payment" due the worker.

Q. Can these rules for lump sum payments be applied to a lump sum payment of past-due benefits?

A. No, these rules apply to payments of future benefits only. POMS DI 52150.060.D.3.

Q. What if I have a case where even if I use this technique, there still will be a substantial offset?

A. One thing you could do is use a longer life expectancy in the settlement

agreement, because the longer the life expectancy, the lower the prorated monthly benefit. There are several accepted life expectancy tables, and some project longer life expectancies than others.

Life Expectancy of the Offset

Q. How long does the offset last?

A. Here's the second critical section of the POMS. POMS DI 52150.060.E sets out three methods for prorating excludable expenses where there is a lump sum. The three methods are:

- Method A. Divide the excludable expenses by the weekly rate (as determined pursuant to POMS DI 52150.060.D.3, discussed above), resulting in a number of weeks, and do not offset for this number of weeks;
- Method B. Divide the lump sum, less excludable expenses, by the total lump sum, then multiply this percentage times the weekly rate, resulting in a reduced weekly rate; and
- Method C. Reduce the lump sum by the amount of excludable expenses before the proration.

Q. How does SSA decide which of the three methods to use?

A. POMS DI 52150.060.E says it will "use the method that is most advantageous." A previous version of the POMS said that SSA would "use the method most advantageous

to the total family." Although the current version does not specify "most advantageous *to whom*," I think there is no doubt that it still means "most advantageous to the total family," because that same concept is found in other POMS.

Choosing a Method

Q. Which method usually is most advantageous to the family?

A. It depends on the situation. You have to run all three to see.

Method A

Q. How about an example?

A. Let's go back to Jane Smith and use Method A. Let's say that her attorney didn't consider the social security offset, so the settlement agreement doesn't include a lifetime proration, and the $60,000 lump sum is prorated at $825 per month pursuant to DI 52150.060.D.3, because $825 per month was her gross workers' compensation benefit before she received the lump sum. Let's say that excludable expenses (attorney fees and costs) are $20,000. Under Method A, divide the excludable expenses of $20,000 by the weekly rate of $190.53 ($825 per month divided by 4.33 weeks per month = $190.53 per week), which yields a figure of 104.97 weeks. SSA would not impose any offset for 104.97 weeks, but after that period was up, SSA would consider that Jane receives $190.53 per week ($825 per month) in workers' compensation benefits, and impose a complete offset of her social security benefits of $500 per month for the next 209.94 weeks ($40,000 divided by $190.53 per week = 209.94 weeks), because $825 per month in workers' compensation benefits is

more than 80% of her FAM MAX of $800. So under Method A, SSA would not reduce Jane's social security benefits for two years, then it would eliminate them for four years.

Q. It would eliminate them completely for four years?

A. Yes, except for any social security cost of living increases effective after the offset began. Since social security COLAs are not taken into account in determining the offset, Jane gets to keep them.

Method B

Q. What would happen under the other two methods for Jane?

A. Under Method B, divide $40,000 by $60,000, which yields a percentage of 66.66, then multiply this percentage by the weekly rate of $190.53, resulting in a reduced weekly rate of $127.02, which is equivalent to $550 per month, which would mean Jane would receive only $250 per month in social security disability benefits (80 per cent of her ACE is $800 per month less $550 = $250). Since her FAM MAX is $500, she loses $250 per month due to the offset. The offset continues for 109 months ($60,000 divided by $550/month).

Method C

Q. And Method C?

A. Under Method C, SSA would reduce the lump sum of $60,000 by the excludable expenses of $20,000 prior to proration, then prorate by dividing $40,000 by $825 per month, meaning that the offset begins immediately, and lasts 48.48 months, and during

that time Jane receives nothing, because her workers' compensation benefits of $825 per month is greater than 80% of her FAM MAX.

Q. Which method is best for Jane and her family?

A. I think it's up to Jane. I don't know of any cases on this subject.

Method A for Older Workers

Q. Is there a time when one of the methods would clearly be best?

A. If the employee is 50 years old or more (and many are), Method A may be the best.

Q. Why?

A. Because it delays the start of the offset, and at age 62 or 65, the offset can be eliminated.

Q. What does age 62 or 65 have to do with it?

A. Because the offset applies only when your client is receiving disability insurance benefits. It does not apply when your client changes from disability insurance benefits to retirement benefits. Your client can start retirement benefits at age 62. And it ends at age 65, in accordance with 42 U.S.C. § 424a(a), even though the full retirement age now depends on date of birth.

Q. But if the client takes social security retirement benefits at age 62, the client receives only a percentage of the retirement benefits she otherwise would receive at full retirement age, right?

A. Right, but with a twist. Ordinarily, an election to take retirement benefits at age 62 locks the client in for life at a percentage of the benefits she otherwise would receive (the percentages are set out in http://www.ssa.gov/retire2/agereduction.htm). The twist is that if prior to age 62 the client has been found disabled by SSA, the client can take age 62 retirement, then at full retirement age receive 100 per cent. SSA calls this an increase due to previous "technical entitlement to DIB" (disability insurance benefits).

Q. This is some kind of trick you play on SSA, right?

A. Not at all. POMS DI 52150.030 specifically instructs SSA employees to consider using this procedure if it will increase benefits.

Q. Will SSA on its own suggest this to my client?

A. It is supposed to do so. Call me cynical, but I wouldn't assume that what is supposed to happen always happens.

Q. Can you give me an example of how this works?

A. Let's use Jane again, but let's say that instead of being 50 at the time of the settlement, Jane was 60. Delaying the offset for two years could mean no offset at all, since she would be age 62 before an offset would be imposed, and at that age she could take age 62 retirement, which might cost her less until her full retirement age than the offset would cost her.

Second-Guessing SSA

Q. What if I believe SSA hasn't computed the offset correctly?

A. You have the same procedural rights you have with respect to an unfavorable decision on disability: you can request reconsideration; if that is denied you can request a hearing with an administrative law judge; if you don't like the ALJ's decision you can appeal to the Appeals Council; and if you don't like its decision you can appeal to federal district court and then to the court of appeals.

The Offset in Non-Title II Cases

Q. We've been talking about how the offset applies to disability insurance (title II) benefits. Does the workers' compensation offset apply to SSI benefits?

A. For purposes of SSI, workers' compensation benefits are considered "unearned income," so any workers' compensation benefits (not counting excludable expenses, per Social Security Ruling 94-2p) over $20 per month reduce SSI benefits on a dollar-for-dollar basis.

A Few Final Matters

Q. Has the United States Supreme Court ever said anything about the workers' compensation offset?

A. It held it constitutional in *Richardson v. Belcher,* 404 U.S. 78 (1971).

Q. Are there any Social Security rules that apply in particular states.

A. Yes. The POMS issues that have arisen in individual states. For state rules in the critical subject of how SSA characterizes lump sum settlements for the purpose of applying the workers' compensation offset, see POMS DI 52120.001.

Q. I have found the people in my local Social Security office pretty helpful. Are they a useful source of information in this area?

A. I have found some of them helpful, but generalizations are difficult. SSA has added a section to the POMS advising its employees to "Exercise caution in situations when attorneys or claimants seek assistance in the preparation of a WC settlement prior to the WC court approving the settlement . . . . we should not assist the attorney or claimant in determining a specific weekly rate low enough to avoid offset. This would be considered a conflict of interest." POMS DI 52140.001.G.

Q. Does SSA try to flag settlement agreements that do not make sense, and which seem to be written solely to defeat the offset?

A. Yes, if the language is "unreasonable" or "contradictory," SSA employees are supposed to seek guidance before proceeding. POMS DI 52150.065.A.2. So use the same good sense in drafting a settlement agreement that you would use in drafting any other kind of document.

Q. How can I learn more about everything you've talked about here?

A. There have been quite a few cases decided by federal courts over the years. An electronic search will find the cases.

Protecting Plaintiffs with a Section 130-Exempt Structured Settlement Administration Trust

by Jim Leach

Professor Tom Simmons's excellent article, "Protecting Plaintiffs Post-Settlement With a Trust" in the March/April 2020 *Barrister*, addresses a vital subject too often neglected by attorneys for plaintiffs: after an attorney helps an injured client obtain a significant settlement, how can the attorney protect the client from squandering it?

The best data available shows that 90% of people who receive a large sum of money (by inheritance, lottery, a lawsuit, or otherwise) will spend it within five years. Examples abound. I had a client recently who received a substantial six-figure settlement in a personal injury case. Despite my best efforts, I could not talk her into a structured settlement. Within a year, all the money was gone, leaving her to live on social security disability benefits—and with the regret that she had lost the best chance she would ever have to live the rest of her life more comfortably.

John Steinbeck's classic little novel *The Pearl* describes how sudden wealth can ruin a person's life. As amazon.com summarizes: "For the diver Kino, finding a magnificent pearl means the promise of a better life for his impoverished family. His dream blinds him to the greed and suspicions the pearl arouses in him and his neighbors, and even his loving wife cannot temper his obsession or stem the events leading to the tragedy."

Clients who receive a large sum of money and promptly spend it are doing what our consumer society tells them to do: use it for material goods that supposedly will improve their lives and make them happy. Such clients are often under substantial pressure from family members and friends, who may have completely legitimate financial needs, to "help them" by "loaning" or giving them money. Or, never having owned or run a business, they may think that starting or buying one will be an easy way to increase their wealth.

Professor Simmons's article described a potential solution to this problem: an Asset Protection Trust. This article describes another potential solution that has great flexibility; is suitable both where the client receives a large recovery, and where the client receives as little as $50,000; and costs relatively little to set up and maintain: a Section 130-Exempt Structured Settlement Administration Trust ("SSAT"). (The term "Section 130-Exempt" refers to it being exempt from § 130 of the Internal Revenue Code).

But wait, I hear you say, a "structured settlement" is completely inflexible, and does not pay much of a return. Worse, people who have them are subject to a barrage of television commercials imploring them to "get the money you need now" by selling the structured settlement—without disclosing that doing so will result in them getting cents for every dollar of present value they sell.

For a standard structured settlement, all that is true. But the SSAT is different. Created over 40 years ago by the late Richard Halpern of The Halpern Group, an expert on financial negotiation and plaintiff recovery, the SSAT provides a plaintiff with a way to protect a recovery by promoting safety and growth, while also providing flexibility for medical, educational, and lifecare needs, and preventing the client from selling her future income stream after hearing the siren song of a predatory buyer.

The Halpern Group, which survives him, continues his work.[1] An SSAT has tremendous substantial advantages over a traditional structured settlement:

- The return will likely be significantly better.
- A plaintiff can receive money for reasonable unexpected needs.
- If the plaintiff dies before the money is paid out, the remainder of the money goes to the plaintiff's estate.
- The client *cannot* sell the structure without a court order—not after seeing endless late-night television commercials, not after having been pressured by a spouse or relatives, and not after deciding that they have a "better plan" for the money.

I hear those of you who are familiar with structured settlements say something like: those bullet points don't square with what I know about structured settlements. So I'll address them, one-by-one.

The return will likely be significantly better than with a traditional structured settlement because the plaintiff's money will be invested, not by itself, but with a great deal of other money in the Plaintiffs' Common Trust Fund, using proprietary

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investment software that diversifies investments between stocks and bonds. Unlike a traditional structured settlement, a specific return is not guaranteed. I've been helping my clients fund their own SSAT's for more than twenty-five years, through stock market plunges and financial crises, and I've never had a bad result.

The Halpern Group uses its proprietary investment software to prepare sample illustrations with payment and duration options chosen by the client, based on the settlement money available. These options illustrate conservative returns. All excess earnings generated by the investment belong to the client's SSAT.

Some clients, upon being told that their money will have exposure to the stock market, choose not to purchase an SSAT. That is their right, but it is almost always unwise. Any company that sells a traditional structured settlement with a "guaranteed" return does so only by promising a return that can be earned through extremely conservative, low-paying investments. And a traditional structured settlement requires the client to sell the rights to the principal in exchange for a "guaranteed" immutable string of payments, thus losing all flexibility and the potential of additional earnings. I put "guaranteed" in quotation marks because the Great Recession of 2008-09 showed that even triple-A rated companies can fail. We have yet to see how this same risk will play out with the so-far-unknown financial consequences of COVID-19. By purchasing an SSAT, the client is likely to receive significantly more money than from a traditional structured settlement.

What about a beneficiary's ability to receive money for reasonable unexpected needs? This ability is established by the papers that create the Trust. "Reasonable unexpected needs" might include the unexpected need for a vehicle, emergency home repairs, or temporary rent or mortgage payments after a lay-off. They do not include luxuries or unnecessary consumer goods. The Halpern Group works directly with the national-bank Trustee on a case-by-case basis to analyze these requests. They review the circumstances surrounding the request, the terms of the Trust, prepare new illustrations to show how the account will be affected, and review the trend of disbursements made from the Trust.

I say above "If the plaintiff dies before the money is paid out, the remainder of the money goes to the plaintiff's estate." In a traditional structured settlement, when the beneficiary or beneficiaries die, the money stops, subject to a "20 year certain" or "30 year certain" provision that keeps it coming for that long. But in an SSAT, when the beneficiary dies, the remaining money in the Trust passes to the beneficiary's estate. This is a huge benefit over a structured settlement.

The final benefit bullet-pointed above, that the client cannot sell the structure, is the most important. People, especially the financially unsophisticated, are often drawn to exchange a future cash stream for money now. An SSAT makes this legally impossible unless a court so orders.

In any case in which an SSAT may be appropriate, the attorney should begin to educate the client very early in the case. Put yourself in the client's shoes. As soon as the client believes she has a significant case, she—often with the help of family members—will start thinking about how she is going to spend the money. Before long, the money may be effectively "spent" in the client's mind, for a new home, a new car, a big vacation, etc. And the client may become mesmerized by the opportunity, for once in her life, of having control over a large sum of money and the power to spend it as she wishes. Once this psychological shift has occurred, an attorney will have a hard time changing the client's mind.

In cases in which I believe that an SSAT may be appropriate, I talk to the client about this subject in the same visit in which I agree to take the case and the client signs a fee agreement. I continue to discuss the subject with the client as the case proceeds.

An SSAT can be particularly appropriate for minors. As with any settlement for a minor, it requires court approval to be established. The Halpern Group works with the attorney in this process. I settled a case recently for a 5-year-old child in which the child's portion of the settlement was $50,000. Her parents are poor. With the court's approval, they agreed to put the entire $50,000 into the structure, with no payout until the child reaches age 25, then $1,000 per month until the money is gone. All the money, as in any structured settlement, will be tax-free. An SSAT is also well-suited for workers' compensation cases, where the client's loss of earning capacity will last a lifetime.

I don't recommend an SSAT in every case. If the client is in her fifties or older, has a track record of being responsible with money, does not have family members who seem to be waiting to get their hands on her recovery, and does not have family or friends who think they are financial experts, I will offer the client the option, but not necessarily recommend it.

The Halpern Group can provide services in Spanish when needed. It does not charge to provide sample proposals. Its service is always prompt. It can provide as many different proposals as the client wants, or as you want to show the client. So it costs nothing to provide the client with options that, for many clients, will be highly beneficial in the long run. The money to establish the Trust is paid from the defendant to your trust account and from there by you to a trustee, so you do not need the defendant's approval. The defendant will not even be aware that your client has chosen this option.

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And if the client is determined to have some money immediately, as some are, the entire recovery need not go into the Trust.

I believe that lawyers should consider an SSAT for any client who receives a substantial recovery. It has many benefits over a traditional structured settlement or annuity. And for many clients, it is the only thing that will stop them from wasting by far the largest sum of money they will ever see.

[1] In the interest of full disclosure, I do not have any relationship with The Halpern Group. I have worked with them and recommend them to other plaintiff lawyers.