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Including Special Needs Planning

IN THIS ISSUE

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Building Relationships With Clients— Using A Care Plan to Reduce the Medicare Readmission Rate

By Justin L. Scott Esq.

Marketing and community outreach are imperative to a successful elder law practice. Many clients come to elder law attorneys from hospital and sub-acute care referrals. You can build strong relationships and increase trust and respect with the medical providers in your network by helping them to reduce their former patients' Medicare readmission rates.

Medical issues increase with aging. One of the biggest challenges facing older men and women is a hospital admission. Many Americans lack adequate health insurance. Those who have health insurance and Medicare face another challenge. Hospitals are being penalized by Medicare for readmission of patients once they have been discharged. Also, hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across *all* of their Medicare admissions—not just those resulting in a readmission. Fortunately, Medicare issues present a marketing opportunity for the elder law practice.

Navigating the Medicare process and understanding all of its benefits can be tricky. The application process alone can be intimidating, and many elder law firms can assist with this process. Many elderly individuals (and their adult children) are under the misimpression that Medicare will pay for their long-term care indefinitely. Others do not appreciate the importance of avoiding "observation status" or the availability of the Medicare home care benefit.

Community education events provide valuable information and serve an important marketing function. As our clients age and their medical needs change or increase, elder law attorneys will be the best choice in guiding them through the process of dealing with medical bills, insurance battles, social security complexities, and other common yet difficult legal issues.

How is this significant to the practice of elder law? Did your client put into place all of this important documents while still coherent and cognizant of the gravity of his medical decision making? Do your clients truly understand who they should select as their power of attorney, what should be included in their Will, or who should make healthcare or financial decisions on their behalf?

What if your aging client has a chronic illness? This medical situation is not unique. There has been a trend toward greater accountability in outcomes through measurement by the Centers for Medicare and Medicaid Services (CMS). CMS

assesses penalties for hospital readmissions or deaths within 30 days of the date of discharge from an initial hospital stay for patients suffering acute myocardial infarctions (heart attacks), heart failures, and pneumonia. CMS linked pay-for-performance based on hospitals' outcomes for patients with these chronic conditions by means of the Hospital Readmissions Reduction Program (HRRP), which took effect in 2012. Payments to hospitals experiencing a higher than expected readmission rate, given their case mix, were reduced. As of October 2016, patients undergoing coronary artery bypass graft surgery and elective hip or knee replacement, together with patients diagnosed with chronic, obstructive pulmonary disease (COPD), were added to expand the HRRP program. Last year, one more addition was made subject to Medicare readmission penalties—the types of pneumonia cases that were assessed and calculated for readmissions after coronary artery bypass (CABG) surgery. The goal of the program is to ensure a net benefit to the patient through accountability brought about by the adjustment of payments to the providers. The patient can go to any hospital; it does not need to be the original one that treated him. However, the penalty is applied to the first hospital from which the patient was originally discharged.

What else is factored into the penalties that Medicare imposes on hospitals? The Congress Medicare Payment Advisory Commission recently announced that by pressuring hospitals to reduce patient readmissions by imposing these Medicare hospital readmission penalties, the federal government helped save Medicare about $2 billion dollars a year. Anyone reading this should be fearful that there may be a chilling effect on patient readmissions, which could ultimately negatively impact patients and, in an extreme case, possibly result in death. If patients are NOT being hospitalized for fear of penalties, what is happening? Who is advocating for them? Who will help the patients, families, caregivers, and loved ones navigate this scary medical puzzle?

Elder law attorneys can help educate hospital discharge staff on strategies that hospitals can implement to lower the rate of readmissions. Such strategies can include clearer and more detailed patient discharge instructions and the coordination of post-acute care. The hospital staff (nurses, social workers, doctors, etc.) often know the best treatment facilities for specific illnesses or medical issues. Typically, the staff has relationships or connections with the local rehabilitation facilities and skilled nursing facilities. By easing the transition post hospital admission, hospital staff can work as a team with the patient's family to help ensure that the patient may not return to the hospital under a readmission. With the proper plan in place to make the patient successful after a hospital release, patient readmission rates should decrease. This would also likely lower the penalty rate for the hospital in question.

The elder law attorney can also add value to the relationship between hospitals and CMS by supporting and monitoring financially insecure patients post-discharge. There have been reports from hospitals in less affluent areas that some patients are more likely to be readmitted due to complications. This is through no fault of the hospital or the patient, but simply that the cost of medications or maintaining follow-up medical appointments are too cost prohibitive. An elder law attorney who focuses on both traditional tools of an elder law practice (wills, trusts, estates, powers of attorneys, living wills and applications for Medicaid and Veteran's Benefits) as well as care management can help recently discharged patients obtain financial aid for expensive medications through grant programs and can help obtain care in the home, frequently paid for with public benefits. Continuum of care plans can help reduce the reoccurrence of a readmission. Preparing in advance with a legal team with a medical staff on deck can help reduce readmissions.

Care plan. The elder care lawyer can assist clients in lowering the trend of hospital readmission rates. Many elder law practices are adopting the model of a continuum of care plan. Such a care plan is completely customized to a client's personal, medical, financial, and legal needs. The care plan is an individually crafted document that protects the older adult in need while allowing for the best care possible. This can mean drafting several

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New Ethics Rules for Digital Security

Law firm leadership should proactively develop a cyber security incident response plan with specific plans and procedures to respond to a data breaches. An appropriate plan will identify and evaluate potential network anomalies or intrusions, assess the nature and scope of such intrusions, determine if any data or information may have been accessed or compromised, quarantine the threat or malware, prevent the exfiltration of information from the firm, eradicate the malware, and restore the integrity of the firm's network. When an attorney fails to undertake reasonable efforts to avoid data loss or to detect cyber-intrusions, and a data breach occurs due to the lack of reasonable effort on the part of law firm management to avoid the breach, the potential for an ethical violation occurs. American Bar Association Formal Opinion 483 requires attorneys to develop and implement data privacy and security programs to protect their clients against data breaches involving exposure of material client confidential information, or a substantial likelihood of such exposure.

Issued on October 17, 2018, the new guidance expands upon Formal Opinion 477R, which delineated attorneys' ethical responsibility to use reasonable efforts to protect confidential client information when using the Internet. Formal Opinion 483 states that attorneys must understand the basic features of technologies (such as e-mail and creating an electronic document) used to deliver legal services to clients, and "…must use and maintain those technologies in a manner that will reasonably safeguard property and information entrusted to the attorney."

Under existing guidance, law firm leadership is already required to establish and implement internal policies and procedures designed to provide reasonable assurance that all law firm attorneys and staff will conform to the Rules of Professional Conduct. The new opinion expressly requires law firm management to assume an active role in implementing a cyber security program, engaging the assistance of an informational technology team, if necessary, to protect and monitor the safety of electronically stored client property and information.

The new guidance recognizes that cyber-intrusions or losses of electronic information may not be immediately detected, despite reasonable or even extraordinary efforts by the attorney, due to the covert nature of cyber crimes. *To access Formal Opinion 483, go to https://www.americanbar.org/content/dam/aba/administrative/professional_responsibility/aba_formal_op_483.pdf*

scenarios for different future possibilities (like rehabilitation stays, need for nursing homes, or at home care and assistance). A successful care plan can greatly reduce the stress of a "what-if" situation for clients. This preventative measure should cut down on hospital visits and, ultimately, readmissions.

Consider what Medicare may penalize next. There is some speculation that nursing homes will also be targeted for hospital readmissions as well. If a resident of a nursing home needs more targeted, individualized care and is sent from a nursing home to a hospital, Medicare will be tracking this. What happens from a Medicare perspective if the long-term care resident cycles back and forth between the hospital, rehabilitation, or a nursing home, and returns to the hospital again? Ultimately, a decision was made to put a loved one in a nursing home because he needs more skilled medical care. If a decision was subsequently made in the best interests of the resident to get him more specific, medical help at a hospital, this should not be an immediate red flag for a potential penalty to the hospital for purposes of CMS' payments to the hospital. This provides yet another reason why it is imperative to have an elder law attorney and medical care plan in place ahead of time.

How can a care plan do this? A continuum of care plan will be established during a meeting with the client and any family or caregivers involved. Many elder law firms are employing nurses, social workers, and gerontologists as part of the legal team. These professionals are involved every step of the way in coordinating varied components of the care plan. By staying on top of medical issues, or ahead of them, the need for hospitalizations can be decreased. This positive approach has helped many elder law clients be proactive in their medical care while creating peace of mind for all involved.

When a caregiver or older client chooses to hire an elder law attorney, he should receive continuous care moving forward. The elder law team, including the doctor, nurse, geriatric care manager, or social worker, in concert with the lawyer, will make sure that their clients are having

Audit Uncovers $90.5 Million In Payments for Deceased Medicaid Enrollees

In October 2018, the Office of Inspector General (OIG) released a report finding that the Ohio State Medicaid agency made an estimated $90,500,000 on behalf of deceased Medicaid beneficiaries in monthly capitated payments to the state's six Medicaid Managed Care Organizations (MCO's). The estimated overpayments were extrapolated from a random sample audit of 100 capitation payments totaling $195,233 during the period from July 1, 2014 through June 30, 2016. The report concluded that Ohio had probably failed to recover approximately $38,000,000 in payments due to the federal government. The report recommended that Ohio be required to recoup the costs and reimburse the federal government.

The report concluded that even though the state Medicaid agency regularly accessed death information reported in the Social Security Death Master File, county caseworkers did not consistently receive notification of the Medicaid beneficiaries' deaths and that failure resulted in payments to the MCO's made at least a month after the enrollees' deaths. The report, focusing on inefficiencies in the Ohio capitated payment system for Medicaid enrollees, follows on the heels of audits of Medicaid capitation payments by the Tennessee, Texas, and Florida Medicaid agencies.

Ohio is appealing the OIG report and denies that any provider was paid for services to a deceased person. The author anticipates that the new OIG report may trigger a renewed focus on Medicaid and Medicare provider fraud investigations and additional scrutiny of long-term care, home-, and community- based services and other Medicaid applications by Medicaid agencies, especially in Ohio, but possibly also other states, in expectation of closer federal government oversight of joint federal and state public benefit programs. *To access an OIG summary of the report https://oig.hhs.gov/oas/reports/region5/51700008RIB.pdf*. The full report can be found at *https://oig.hhs.gov/oas/reports/region5/51700008.pdf* .

regular medical appointments, follow-up meetings, and that progress is being monitored. If there is an unfortunate incident where needs are regressing or deteriorating, the care plan will be referenced to find out what the client's wishes are. This could be something basic like invoking a power of attorney. Or it could be more complex, like choosing a new home that includes medical staff. Using an elder law firm before medical issues turn into an insurmountable crisis is essential in maintaining an upper hand with a client's finances, his personal wishes, and the care giver's involvement. By establishing strong relationships with hospitals and post-acute care facilities, an elder law team will help reduce hospital readmissions and so also Medicare penalties.

KEEPING CURRENT

Long Term Care Insurance Policy Definitions Subject to State Law

Van Dusseldorp v. Continental Casualty Company and Long Term Care Group, Inc., No. Civ. 16-5073-JLV (Dist. S.D., September 19, 2018) (unpublished). In this federal court lawsuit alleging breach of a long-term care insurance contract, insurance bad faith, and misrepresentation, the district court grants defendants' motion for summary judgment. The court sustains defendants' denial of payment for care in a registered residential care facility, which was not licensed by the state of South Dakota as an assisted living center. The state Department of Health issued a binding rule prohibiting residential living centers from offering health or habilitative care, *i.e.*, assistance with activities of daily living, which are required to be provided within either an assisted living or skilled nursing facility.

Defendant Continental Casualty, issued a long-term care insurance policy to the plaintiff, a South Dakota resident. Defendant Long Term Care Group, Inc., serviced the policy. The policy provided that an insured is eligible for benefits when certified as chronically ill by a licensed

New Poms Requires Direct Deposits of Electronic Payments

GN 02402.001, a new Program Operations Manual System (POMS), requires that as part of the Department of the Treasury's Fiscal Service, federal payments must be made electronically. Unless an exemption is obtained, all Social Security beneficiaries or recipients are now required to receive their payments electronically. Foreign beneficiaries who refuse electronic payments are not required to apply for an exemption.

The United States Treasury Department is responsible for determining if an individual is eligible for an exemption from the electronic payment requirement. Automatic exemptions from the electronic payment requirement are available when the payee was born prior to May 1, 1921 and continues to receive the benefit payment by check, the payment is ineligible for direct deposit to a Direct Express prepaid debit card account, or the payee's Direct Express debit card has been suspended or cancelled.

If the payee resides in a remote geographic area lacking the infrastructure to receive payments electronically, the payee may request an exemption via a certified application to the United States Treasury Department. The application must be signed before a notary public under penalty of perjury. The new guidance also provides that the Treasury Department may award an exemption to mentally impaired payees who are unable to handle their payments electronically and are not assisted by a representative payee.

The new guidance is intended to increase usage of Direct Express debit card. Direct Express debit card users complain of difficulty in resolving consumer issues with Direct Express, including difficulty reaching Direct Express personnel by telephone due to high call volumes, delays in the deposit of benefit payments on the cards, alleged failure to satisfactorily resolve disputes with merchants, and inability to obtain copies of Direct Express account statements required to complete pending Medicaid applications.

It is anticipated that elder and disability lawyers will need to increase advocacy and assistance to Direct Express debit card holders in response to requests for verification of Direct Express account statements by Medicaid caseworkers. Once determined eligible for Medicaid, clients residing in long-term care can be encouraged to automate payments electronically to the facility and to use a personal needs account, which can facilitate good record-keeping and ease of prompt access to the personal needs account statements.

health care practitioner. The benefit is paid for each day that qualified long term care is received in a long-term care facility or assisted living center. The policy did not specifically require that long-term care facilities must be licensed by the state as an assisted living center to qualify for benefits, but the policy language tracked the statutory language almost verbatim and required assisted living centers to offer habilitative care.

The district court rules that the residential care facility was not an assisted living center, as defined in the policy as "…institution, rest home, boarding home, place, building or agency which is maintained and operated to provide personal care and services which meet some need beyond basic provision of food, shelter and laundry to five or more persons in a free-standing, physically separate facility which is not otherwise required to be licensed under Chapter 34-12 of South Dakota statutes." The policy tracks South Dakota law and the residential care facility, which was not licensed as an assisted living center, could not legally offer habilitative care under the state's binding rule. The plaintiff's reading of the policy terms would render superfluous the policy's home and community- based care benefit.

For the full text of this decision, go to http://business.cch.com/elr/Dusseldorp_1118.pdf

Disability Benefits Termination Upheld Based on Video Surveillance and Records Review

O'Leary v. AETNA Life Insurance Co., No. 17-15162 (11th Cir., October 1, 2018) (*per curiam*). In this ERISA action challenging the termination of the plaintiff's long-term disability benefits, the Eleventh Circuit Court of Appeals affirms the district court's grant of summary judgment, sustaining the termination.

The plaintiff was injured in a serious motorcycle accident in 2006. He was determined disabled by the Social Security Administration and received 24 months of long-term disability insurance benefits under a policy issued through his employment. He continued to receive benefits until 2015, when his benefits were terminated based on video surveillance showing the plaintiff driving, carrying a garbage can to his garage, and dancing at a nightclub, as well as a medical records review.

The policy terms gave Aetna discretion to determine whether and to what extent employees and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms of the policy. Aetna was entitled to rely on the surveillance evidence and its assessments of the plaintiff's capabilities by independent physicians who reviewed his medical file, so the termination decision was not arbitrary and capricious.

For the full text of this decision, go to http://business.cch.com/elr/OLeary_1118.pdf

Medicaid Penalty For Post-Mortem Homestead Transfer To Carry Out Marital Agreement

Hallam v. Missouri Dep't. of Social Services, No. WD81466 (Ct. App. Mo., W. Dist., October 9, 2018). The Missouri appeals court affirms the trial court's ruling sustaining a $607,000 Medicaid transfer penalty upon the transfer of the couple's homestead to the applicant's step-children, pursuant to a post-marital agreement, after the death of the applicant. The assets disposed of during the look-back period were for less than fair market value to qualify the husband for Medicaid. The appellate court rejects the contention of the plaintiff that the phrase "disposes of assets" as used in 20 C.F.R. Sec. 416.1246(a)(1)(A) is limited only to inter vivos transfers. The fact that the transfer was completed upon death does not change its character as an uncompensated transfer. Title 42 USC §1396(p)(d)(2)(A)(ii) is not limited in application to trusts that are funded during the lifetime of the settlor. Although the wife could have established a testamentary trust, which would have been properly beyond the purview of the Medicaid estate recovery program, the plain language of 42 U.S.C. § 1396p(d)(2)(A), which excludes testamentary trusts as transfers resulting in a Medicaid penalty but not other trusts created during the spouses's lifetime and funded after her death, is binding.

In 2011, the applicant and his wife entered into a postnuptial agreement giving each spouse the power to dispose of their share of the marital assets at their death free of any statutory or other spousal claims. At that time, the applicant's wife also created a revocable trust, naming her daughter as trustee. Each spouse created a single member limited liability company, transferring a one-half interest in their homestead, which included the home and adjoining farmland. The operating agreement of the wife provided that upon her death, her limited liability interest would be transferred to her daughter, Hallam, as trustee. In 2013, the husband/Medicaid applicant transferred his one-half interest in the homestead to his wife. The wife then transferred her husband's former one-half interest in the homestead into her trust, with the transfer to be effective upon the death of the wife.

In 2014, the wife died, and the real estate which had previously been the homestead vested in the trust. The trust assets were distributed pursuant to the terms of the trust to the children. On December 14, 2014, a Medicaid application was filed on behalf of the husband, who was then residing in skilled nursing care. A Medicaid transfer penalty, which expired on September 15, 2025, was imposed on the Medicaid application. The director of the Family Support Division of the Missouri Department of Social Services upheld the penalty period, as did the circuit court of Vernon County.

For the full text of this decision, go to http://business.cch.com/elr/Hallam_1118.pdf

Responsible Party Who Signed Arbitration Agreement and Jury Trial Waiver Not Required to Arbitrate

Amos v. North Hill Nursing and Rehabilitation Center, L.L.C., No. 2-18-cv-0217-AKK (N.D.Ala., Southern Div., October 10, 2018). In this negligence action against a nursing home filed by a plaintiff/daughter on behalf of her incapacitated mother, the district court denies the motion of the defendant/nursing home to compel arbitration.

The plaintiff's mother was declared an incapacitated person and was under the protective services of the Mobile County Department of Human Resources due to dementia and severe cognitive impairment. The plaintiff was not appointed as her mother's guardian and did not hold any power of attorney for her mother. Nevertheless, the plaintiff admitted her mother into long-term care in defendant/North Hill Nursing and Rehabilitation Center and signed the admissions paperwork as "authorized agent," leaving the signature line for her mother (as the resident) blank. The admissions paperwork included an arbitration agreement and jury trial waiver, which the daughter signed as her mother's authorized representative.

Three years after her mother entered the facility, the plaintiff obtained temporary letters of guardianship over

her mother's estate and filed this lawsuit in the Jefferson County, Alabama Circuit Court. The defendants removed to the federal district court and moved to compel arbitration and to stay the district court action pending arbitration.

The district court noted that the duties of an authorized representative differed from those of a guardian, and that at the time of signing the admissions agreement, the daughter lacked legal authority to bind her mother to the terms of the agreement. There was no apparent authority exerted by the daughter on behalf of her mother, due to the mother's incapacity. The daughter was wholly without any authority to enter into a binding contract with respect to the mother's property at the time of signing the agreement and, therefore, the mother/nursing home resident with mental impairments could not be compelled to arbitrate based on the daughter's signing of the arbitration agreement.

For the full text of this decision, go to http://business.cch.com/elr/Amos_1118.pdf

Arbitration agreement unenforceable where Signed Without Authority

Stephen, as Personal Rep. of the Estate of Bobby Gene Hicks v. Millenium Nursing and Rehab Center, Inc., No. 1170524 (S.Ct. Alabama, October 5, 2018). Where the daughter of an incapacitated nursing home resident signs the arbitration agreement in the "family member or legal representative," block, but lacks authority to sign the document, the circuit court's order granting the motion to compel arbitration is reversed by an eight-judge majority of the Alabama supreme court, which remands for further proceedings.

The matter arose in the context of an action for the wrongful death of a former nursing home resident. Under state law, a nonsignatory to an arbitration agreement cannot be forced to arbitrate claims. The daughter who signed the agreement apparently never held any general durable power of attorney for her father. She submitted an affidavit to the trial court that she was granted "no legal authority" by her father or anyone else to enter into an arbitration agreement on his behalf. The state supreme court further reasoned that the daughter lacked apparent authority to sign the agreement because at the time the contract was signed, the resident was recovering from reconstructive hip surgery after a fall and was "pleasantly demented," suffered from confusion, and frequently lacked orientation to date, time, and place; was heavily medicated; and was recuperating from surgery and did not have the capacity to understand the nature and effect of his daughter's signing of the arbitration agreement.

One judge dissented and would have affirmed the circuit court's decision enforcing the arbitration agreement, reasoning that the daughter should not have been permitted to induce the facility to accept her father as a resident by agreeing to submit to arbitration and then in her capacity as personal representative, repudiating her own actions on the grounds that her father was incompetent and she lacked apparently authority to bind his estate to arbitrate the wrongful death issue.

For the full text of this decision, go to http://business.cch.com/elr/Stephan_1118.pdf

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may also be includible in gross income, if the premiums were not included in computing the taxpayer's income and the benefits are based on a percentage of the taxpayer's compensation, rather than being computed on the basis of the taxpayer's injury. [*Id*]. Fees paid to compensate for a disability attorney's services in recovering income for the taxpayer are generally includible in the taxpayer's income even if paid directly to the attorney from the recovered amounts, and may even be deducted as a miscellaneous itemized deduction.

PRACTICE TIPS

Evaluating and Winning Social Security Disability Claims

By Douglas M. Greene, Esq. and Jane M. Fearn-Zimmer, Esq.

Douglas M. Greene, Esquire, the founder of SSDI Lawyers of NJ,, generously shared his insights on how to win difficult claims for disability benefits, including claims involving serious mental illness and/or drug and alcohol abuse. In Mr. Greene's experience, there can be a subjective element at each stage of these claims, given that a human being is making a decision. Claims involving serious and persistent mental illness are most likely to be granted when there is a psychiatrist or psychologist whose opinion backs up the diagnosis of the plaintiff based on the provider's own meetings with the claimant. It can also help if the progress notes, like the provider's report, indicate that the plaintiff's condition is significant and disabling. It is best if the medical opinions must be presented in reports that are acceptable medical sources. For example, a report prepared by a social worker, and co-signed by a physician who has not treated the patient, is not an acceptable medical source and was insufficient in one case to prove an ongoing treatment relationship with the plaintiff. [*See DeCepeda v. Berryhill*, No. 17-cv-30080-KAR (Dist. Mass., August 6, 2018)]. Mr. Greene advises that claimants with a string of jobs over a period of at least 5 or 6 years may have stronger claims. Such claims can often be successful at the administrative law judge level, especially with documentation of the condition in progress notes in visits twice a week over a period of at least 6 months. Reports of medical providers who have examined and treated the patient consistently over a period of time will be given greater weight than an expert who evaluated the patient once.

Another area of subjectivity can involve claims brought by a young claimant with multiple inpatient hospitalizations. Such claims are more likely to be awarded than are claims brought on behalf of claimants struggling to overcome drug and alcohol abuse. He also noted that prescription opiate use is becoming less prevalent among claimants, as many have been weaned off, but the abuse of prescribed opiates on the part of the claimant may raise credibility issues.

Increasingly, claimants are prescribed cannabis for pain control. There is a list of conditions for which cannabis is an acceptable treatment. Claims are less likely to be denied outright due to cannabis use, as "drug and alcohol decisions" but if substance abuse is material to the claimant's disability, denial is likely. One strategy to fight a "drug and alcohol" denial determination is to show evidence that the disability persists during a clean period if the claimant is not using the substance but, as a practical matter, it is difficult to get that kind of longitudal evidence.

Mr. Greene suggests that some agency experts can be successfully cross-examined by challenging the vocational experts' use of outdated occupational codes. For example, if the agency expert's report states that the claimant can perform one of three jobs in the national economy and one of those jobs is an optical lens assembler, well, most of those jobs are performed at an unskilled level in China—and even if performed in the United States, chances are the job is performed by an ophthalmologist and, as such, it is a skilled job, not an unskilled job.

Another fertile ground for cross-examination of the agency expert is the job that used to be sedentary but now is not. An example of this is a surveillance system monitor, which used to be a sedentary government desk job, where one watched people entering and exiting a building, but now tends to require more physical movement such as a Transportation Security Administration agent who will have to scan passengers by moving his arms, and may need to pick up a back pack to perform the job. So, the attorney can effectively cross-examine the agency's expert opinion that the claimant is able to perform such jobs in the national economy.

When a claimant prevails on a claim for SSDI benefits, they may be includible in the plaintiff's taxable income under IRC 86. *Clay v. C.I.R.*, [T.C. Memo 2018-145 (September 10, 2018)]. Long-term disability benefits from insurance

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