Social Security Disability Appeals

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Social Security Disability Appeals

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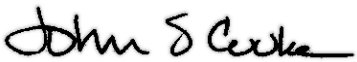
Foreword

This pocket guide arose from the dedication of Magistrate Judge David A. Sanders (N.D. Miss.). It began as an outline accompanying his presentations at Federal Judicial Center workshops for U.S. magistrate judges and federal judicial law clerks. After receiving feedback from members of the judiciary about drastic increases in Social Security disability caseloads, the Center asked Judge Sanders to expand his outline into a guide for district and magistrate judges.

I am pleased to present this pocket guide as a resource to the judiciary and hope that it helps judges who are handling Social Security disability cases.



John S. Cooke
Director, Federal Judicial Center

Preface

This pocket guide is a primer on Social Security disability appeals filed in U.S. district courts. It addresses issues that regularly arise in these appeals and highlights relevant provisions in the U.S. Code, the Code of Federal Regulations, and the Federal Register.

I designed this material over the past ten years as I sought to resolve issues that rely on what I viewed as obscure federal regulations. As I gained more expertise, I learned that although many core legal concepts in Social Security disability seem straightforward, applying these concepts is not. Social Security law is not uniform; it varies from circuit to circuit. Each case is unique and offers a new learning opportunity. Please keep in mind that I am located in Mississippi, and this guide therefore relies heavily on the law developed in the Court of Appeals for the Fifth Circuit. The law in your circuit may or may not mirror the law in my circuit.

For additional help, the Appendix provides definitions for several terms and frequently used concepts in the law of Social Security disability.

I would like to thank Judge James L. Robart (W.D. Wash.), Magistrate Judge Brian Tsuchida (W.D. Wash.), and Magistrate Judge Steven E. Rau (D. Minn.) for their invaluable assistance in reviewing the drafts of this pocket guide. I would also like to thank Magistrate Judge Tim A. Baker (S.D. Ind.) for his help over the years.

Hon. David A. Sanders
U.S. Magistrate Judge
Northern District of Mississippi

Overview

This pocket guide is a primer for judges deciding Social Security disability appeals at the district court level. It is not a comprehensive guide on the substantive law or on case management and does not attempt to provide citations from every circuit. The U.S. Code provides for federal court review of Social Security agency decisions. In practice, that review differs widely from district to district. Judges are therefore encouraged to consult the law in their circuit and their local procedural rules.

Focus and Scope of District Court Review

Social Security disability cases are baffling to many judges and lawyers. Disability claimants typically initiate review by filing a civil complaint. Procedurally, a Social Security disability case is more akin to an appeal. This is because, except in limited circumstances, 42 U.S.C. § 405(g) requires the court to enter judgment upon the pleadings and transcript of the administrative record.

Exactly what is before the court when a disability case is filed is worth considering. Under section 405(g), federal courts are authorized to review the final decision of the commissioner of Social Security. In most cases, the commissioner's final decision is the administrative law judge's (ALJ's) written decision. What is usually before the district court is whether the decision of the ALJ should be affirmed or should be remanded for further administrative proceedings or for an award of benefits.

Federal courts review the commissioner's decision under the substantial evidence standard.[1] So Social Security opinions invariably begin with an explanation of the standard.[2] It is imperative for judges to remember that they are not reweighing evidence but determining whether substantial evidence supports the commissioner's opinion.

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1. *See, e.g.,* Hagans v. Comm'r of Soc. Sec., 694 F.3d 287, 292 (3d Cir. 2012); McKinzey v. Astrue, 641 F.3d 884, 889 (7th Cir. 2011); Washington v. Shalala, 37 F.3d 1437, 1439 (10th Cir. 1994).

2. *See, e.g.*, Revels v. Berryhill, 874 F.3d 648, 654 (9th Cir. 2017); Craig v. Chater, 76 F.3d 585, 589 (4th Cir. 1996).

An agency's factual findings must be upheld if supported by substantial evidence in the record.

Here is an example of how the substantial evidence standard is explained in an opinion from the Fifth Circuit:[3]

> Our review of the Commissioner's decision, like the district court's review, is limited under 42 U.S.C. § 405(g) to two inquiries: (1) whether substantial evidence of record supports the decision; and (2) whether the decision comports with proper legal standards. *Greenspan v. Shalala*, 38 F.3d 232, 236 (5th Cir. 1994). "Substantial evidence is that which is relevant and sufficient for a reasonable mind to accept as adequate to support a conclusion; it must be more than a scintilla, but it need not be a preponderance." *Anthony v. Sullivan*, 954 F.2d 289, 295 (5th Cir. 1992). It is the role of the Commissioner, and not the courts, to resolve conflicts in the evidence. *Brown v. Apfel*, 192 F.3d 492, 496 (5th Cir. 1999). As a result, this court "cannot reweigh the evidence, but may only scrutinize the record to determine whether it contains substantial evidence to support the Commissioner's decision." *Leggett v. Chater*, 67 F.3d 558, 564 (5th Cir. 1995). A finding of no substantial evidence is warranted only "where there is a conspicuous absence of credible choices or no contrary medical evidence." *Johnson v. Bowen*, 864 F.2d 340, 343–44 (5th Cir. 1988) (internal quotation marks and citation omitted).

In other words, if the administrative record contains any evidence—*any* evidence at all—to support each substantive portion of the ALJ's decision, the decision may be affirmed. Even so, plenty of ALJ decisions will have no evidence to support a portion of the ALJ's opinion and should be reversed and either remanded or awarded benefits—unless the error was harmless. (More on that later.)

After explaining the substantial evidence standard, Social Security opinions in the federal courts lay out the five steps for determining disability, following the sequential process for determining

3. Ramirez v. Colvin, 606 F. App'x 775, 777 (5th Cir. 2015).

whether a plaintiff is disabled under 20 C.F.R. § 404.1520. Judges who plan to write detailed opinions rather than rule from the bench may want to develop a template to use as a starting point. Both parties will do this at the beginning of their briefs as well. Here is a typical introduction to the disability determination in a district court opinion:

> In determining disability, the ALJ follows a five-step sequential evaluation process. The burden to prove disability rests on the claimant in the first four steps of this process and shifts to the commissioner at step five. First, the claimant must prove he is not currently engaged in substantial gainful activity. Second, he must prove his impairment is "severe," in that it significantly limits his physical or mental ability to do basic work activities. Third, he must prove his impairment is medically equivalent to one of the impairments listed at 20 C.F.R. Part 404, Subpart P, App. 1. Fourth, he must prove he is incapable of meeting the physical and mental demands of his past relevant work. If the claimant is successful at all four of the preceding steps, the burden shifts to the commissioner to prove, considering the claimant's residual functional capacity, age, education, and past work experience, that he is capable of performing other work. If the commissioner proves other work exists which the claimant can perform, the claimant is given the chance to prove that he cannot, in fact, perform that work.

In short, in most Social Security cases the claimant will be arguing that the ALJ erred at one or more of the five steps. The remainder of this guide examines the most common arguments made at each step. Included is case language related to each argument that may prove helpful when considering these arguments.

Reviewing the Commissioner's Final Decision: The Five-Step Process

Most cases turn on whether the ALJ's written decision is both supported by substantial evidence and free of legal error. It is critical for a judge in the district court to focus on the written decision because that is what is before the court for review. Judges should therefore familiarize themselves with the form and content of decisions prepared by ALJs. Most ALJ decisions contain the following components:

- *An outline of the administrative history of the case.* In this section, the ALJ sets forth the date the claimant filed claims for disability benefits and the type of benefits sought; the date the claimant alleged he or she became disabled; that the application was denied initially and upon reconsideration by the Social Security Administration (SSA); that the claimant thereafter requested a *de novo* hearing before an ALJ; and the date the ALJ conducted the hearing and who attended the hearing.
- *The five-step sequential evaluation process that all ALJs are required to use in making disability determinations.* There are two noteworthy aspects about this process: 1) the findings made at each step affect subsequent steps and 2) at the administrative level, the claimant bears the burden of proving steps one through four, while the commissioner bears the burden at step five.[4]

Step 1: Substantial Gainful Activity and Onset Date[5]

A claimant cannot be working when he or she applies for disability benefits. As an initial matter, to obtain disability benefits, the claimant must therefore establish that he or she is not engaged in "substantial gainful activity." The Code of Federal Regulations defines

4. *See, e.g.*, Wilson v. Comm'r of Soc. Sec., 378 F.3d 541, 548 (6th Cir. 2004).

5. *See infra* Appendix.

How to Approach a Social Security Case File

The federal court system received and processed more than 18,000 Social Security disability cases in fiscal year 2017.[6] Social Security files can be daunting. This is the order in which I examine every file I receive:

1. Read the transcript of the hearing. Nothing gives you a better feel for the case than hearing the claimant explain it. The transcript is usually on the docket attached to the government's answer to the complaint (under heading 2).
2. Read the ALJ's opinion. This will give you a better sense of the law to be applied in the case.
3. Read the claimant's brief.
4. Read the government's brief. (Some claimants' attorneys file rebuttal briefs, but in my experience this is rare.)
5. Read the relevant portions of the medical records, including the consultative examiner's findings and the medical source statements (*see infra* Appendix). (After having read the briefs, I know which portions are relevant, given that medical records run hundreds of pages.)

6. https://www.ssa.gov/appeals/court_process.html.

substantial gainful activity (SGA) as work (usually for pay or profit) involving significant physical or mental abilities.[7] Step one is usually not at issue because most claimants are not engaging in SGA when they file an application for disability benefits. Thus, the claimant will usually allege an "onset date" of disability, which, also usually, is the last date the claimant engaged in SGA. When there is a step-one issue, it usually relates to whether certain work a claimant performed after the alleged onset date constitutes SGA. Judges should be mindful that not all work is SGA. If the party is ultimately found disabled, this determination could affect the amount of retroactive benefits the claimant could receive.

Step 2: Severe Impairment

After a claimant establishes that he or she is not engaged in SGA, the claimant must prove that he or she has a "severe impairment" by showing that:

1. He or she suffers from a medically determinable condition, or combination of conditions, caused by an anatomical, physiological, or psychological abnormality that can be confirmed by medically acceptable clinical and laboratory diagnostic techniques.[8]
2. The condition is severe. "Severe" simply means the condition significantly limits the claimant's physical or mental ability to do basic work activities.[9]
3. The condition is expected to persist for at least twelve months.[10]

Step-two issues that judges must address flow from the two different requirements claimants have to meet. In some instances, the court must resolve whether the condition is medically determinable. For that to be the case, the claimant must show that there is acceptable

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7. 20 C.F.R. § 404.1572. *See also* Perez v. Barnhart, 415 F.3d 457, 461 (5th Cir. 2005).

8. *See* 20 C.F.R. § 404.1508.

9. *See id.* § 404.1520(c).

10. *See id.* § 404.1509.

medical evidence, such as an opinion by a medical doctor, that establishes the condition.

In other instances, the court must resolve whether substantial evidence supports the findings concerning severity, i.e., whether the impairment (or combination of impairments) caused is so minimal that it does not interfere with the claimant's ability to work. In the Fifth Circuit, *Stone v. Heckler*[11] held that "'an impairment can be considered as not severe only if it is a slight abnormality [having] such minimal effect on the individual that it would not be expected to interfere with the individual's ability to work, irrespective of age, education or work experience.'"[12] After *Stone*, the Supreme Court found the severity regulation facially valid in *Bowen v. Yuckert*.[13] In *Anthony v. Sullivan*,[14] the Fifth Circuit held that *Yuckert* did not change the standard as set out in *Stone*.[15] Joining the First, Sixth, and Eighth Circuits, the Fifth Circuit said, "Most courts agree that *Yuckert* does not displace prior limitations on the Secretary's reliance on the severity regulation."[16] *Sullivan* is a clear, concise, and helpful opinion that explains this common step-two argument.

In sum, at step two judges should examine whether the ALJ correctly determined the claimant's medically determinable conditions and whether these conditions singly or in combination are severe under the relevant case. Judges should be mindful that in most circuits the step-two inquiry is a de minimis standard: a claimant whose arthritic foot hurts when it rains suffers from a "severe" impairment because this condition affects the claimant's ability to work, even if it is not, on its face, disabling. Judges should also be attentive to the impact

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11. 752 F.2d 1099 (5th Cir. 1985).

12. *Id.* at 1101 (quoting Estran v. Heckler, 745 F.2d 340, 341 (5th Cir. 1984)).

13. 482 U.S. 137 (1987).

14. 954 F.2d 289 (5th Cir. 1992).

15. *Id.* at 294–95.

16. *Id.* at 295 (citing, as examples, Gonzalez-Garcia v. Sec'y of Health & Human Servs., 835 F.2d 1, 2 (1st Cir. 1987); Higgs v. Bowen, 880 F.2d 860, 863 (6th Cir. 1988); Brown v. Bowen, 827 F.2d 311, 312 (8th Cir. 1987)).

of a step-two error. Some step-two errors mandate reversal. For instance, reversal should result if the ALJ erroneously omitted a mental condition, such as bipolar disorder, and found that the claimant was not disabled without accounting for any mental health limitations in determining the claimant's capacity to perform work. On the other hand, the same omission might be harmless error if the ALJ, in the subsequent steps, discussed bipolar disorder and properly accounted for any limitations caused by the disorder in determining the claimant's capacity to perform work.

Finally, because the ALJ at step two is essentially screening the medical evidence for the existence of medical conditions that affect a claimant's ability to perform gainful work, judges should scrutinize a determination by the ALJ that the claimant is not disabled at step two. When such a finding is made, ask these questions:

1. Did the claimant receive a definite diagnosis of the alleged medical condition?[17]
2. Was treatment recommended for the alleged condition?[18]
3. Was the condition remedied or controlled by medication?[19]
4. Was the condition merely mentioned in the medical records? (Mention does not establish it as a disabling impairment.)[20]
5. Did the condition last for fewer than twelve months?
6. Did the claimant raise the alleged impairment during the administrative proceedings?[21]

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17. *Id.*
18. *Id.*
19. Johnson v. Bowen, 864 F.2d 340, 348 (5th Cir. 1988).
20. Hames v. Heckler, 707 F.2d 162, 165 (5th Cir. 1983).
21. Domingue v. Barnhart, 388 F.3d 462, 463 (5th Cir. 2004).

Mental Impairment

Mental impairment can be at issue in both steps two and three. When a plaintiff alleges mental impairment, the ALJ will look to what are usually described as the "paragraph B criteria," referring to 20 C.F.R. Subpart P, App. 1, § 12.00, "Mental Disorders."[22] At paragraph B, the regulation provides four criteria to consider when determining whether a mental impairment is severe. The administration looks to determine whether the claimant can: 1) understand, remember, or apply information; 2) interact with others; 3) concentrate, persist, or maintain pace; and 4) adapt or manage oneself. To satisfy the paragraph B criteria (*see infra* Appendix), a mental disorder must result in "extreme" limitation of one, or marked limitation of two, of the four areas of mental functioning. This examination of criteria is sometimes called the "special technique."

Step 3: Listed Impairments

At step three, the ALJ must determine whether the claimant's severe impairments, singly or in combination, meet the requirements of a "Listed Impairment" (Listings) (*see infra* Appendix). A claimant who meets the requirements of the Listings is deemed disabled. For each type of medical condition, the regulations set forth specific requirements that the claimant must meet. The requirements must be met for a claimant to be found disabled under the Listings.

It is important to note that a Listing determination is not an inquiry into whether the claimant retains the functional capacity to perform work. Rather, it is an inquiry into whether the claimant has shown that he or she meets the requirements set forth in the regulations. For example, a claimant is presumed disabled under the Listing if his or her best corrected vision is 20/200. If the evidence establishes

22. *See* https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm.

this visual limitation, then the claimant is deemed disabled, notwithstanding the fact that the claimant conceivably could perform some types of gainful work activity.

Because a claimant is automatically deemed disabled under the Listing, meeting the requirements of a Listed Impairment is difficult. Social Security Listings are organized in fourteen categories related to various body systems. When a Listing issue arises, a judge should review the Listing as defined in the regulations. At first blush, the Listings might appear to be written in difficult-to-understand "C.F.R.-speak." But as you gain familiarity, you may find determining whether the claimant's severe impairment meets the requirements of the Listings to be fairly straightforward. This is a result of how the Listings were created to expedite the claim process for people who are clearly disabled.

In most cases filed in the district court, step three is not at issue. This is a consequence of the stringent requirements that a claimant must meet. Even a very limited claimant will not be deemed disabled at step three unless the claimant's severe impairments meet each and every requirement set forth under the governing Listings regulations.

Residual Functional Capacity.[23] If the ALJ finds that the claimant has severe impairments that do not meet the requirements of the Listings, the ALJ must then determine the claimant's residual functional capacity (RFC), i.e., the limitations the claimant's impairments impose on the claimant's ability to perform gainful work activity. In essence, the claimant's RFC is simply the SSA's determination of what, precisely, gainful work activities the claimant can or cannot *do*.

In determining a claimant's RFC, the ALJ is required to consider all relevant evidence, including medical records and opinions, records and opinions of "other sources" (e.g., nurses), and the testimony of the claimant and the lay witnesses. This evidence may be voluminous, so it is important to review the ALJ's opinion, the hearing transcript, and the parties' briefs. That will help you focus on the specific portions of the records that are both relevant and critical in reviewing the ALJ's written decision.

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23. *See infra* Appendix.

A typical RFC reads like this:

> After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform a limited range of light work as defined in 20 C.F.R. 404.1567(b) and 416.967(b). He is able to lift and carry 20 pounds occasionally and 10 pounds frequently but can only lift and carry 10 pounds with his right upper extremity. He can walk and stand 6 hours and sit 6 hours in an 8-hour work day, can frequently climb stairs, but can never climb ropes, scaffolds, or ladders. He can frequently engage in climbing, balancing, stooping, crouching, and kneeling but can only occasionally crawl. He can never push or pull with his right upper extremity, and he cannot reach and handle objects overhead with his right upper extremity. Because of chronic pain and the potential side effects of medication, he can only do jobs that do not demand attention to details or that do not involve complicated tasks or instructions.

Step 4: Whether the Claimant Can Perform Past Relevant Work

At step four, the ALJ must determine whether the claimant has performed past relevant work, exactly what jobs this involved, and whether the claimant retains the RFC to continue performing past relevant work. If the ALJ finds that the claimant has no past relevant work history, the ALJ will proceed to step five to determine whether there are other jobs the claimant can perform. If the ALJ finds that the claimant has past relevant work history, however, the ALJ normally will call a vocational expert (VE)[24] to testify whether the claimant, with the RFC the ALJ has determined, can perform the claimant's past relevant work. If the VE testifies that the claimant can perform his or her past relevant work, then the ALJ will find the claimant not disabled at step four. If the VE testifies that the claimant cannot perform his or her past work, the ALJ must move to step five.

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24. *See infra* Appendix.

Let's examine some of the arguments that are made at step four. The types of arguments vary, depending on the district.

Argument 1: Failure to Adequately Develop the Record. This is the most common argument. The claimant argues, among other things, that the ALJ erred by failing to develop the record adequately. Essentially, the claimant is saying that there is more evidence out there that would show that she is disabled and that the ALJ was obligated to seek and obtain this evidence. The government will respond that it is the claimant's burden to show that she is disabled. Both are right to an extent.

For instance, courts repeatedly point out that the ALJ has a duty to develop the record before determining whether the claimant is not disabled. *See, e.g.*, *Ripley v. Chater*, 67 F.3d 552, 557 (5th Cir. 1995). But just as often, the courts point out that the claimants bear the burden of proof through step four. *See, e.g.*, *Audler v. Astrue*, 501 F.3d 446, 448 (5th Cir. 2007).

So, which is it? Does the ALJ have a duty to develop the record, or is it the claimant's burden? The C.F.R. is not much help in this instance:

> In general, you are responsible for providing the evidence we will use to make a finding about your residual functional capacity. However, before we make a determination that you are not disabled, we are responsible for developing your complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help you get medical reports from your own medical sources. § 404.1545(a)(3).

Again, which is it? Is the claimant responsible for providing evidence, or will the SSA develop the medical history? This answer is tough because often the claimant will not have much money and will have limited medical records. But it is the claimant's burden, right? Here are some cases to think about:

- The obligation to develop the record "is triggered only when there is ambiguous evidence or when the record is

inadequate to allow for proper evaluation of the evidence." *Mayes v. Massanari*, 276 F.3d 453, 459–60 (9th Cir. 2001).

- "The ALJ's duty to investigate … does not extend to possible disabilities that are not alleged by the claimant [typically in the initial application] or to those disabilities that are not clearly indicated on the record." *Leggett v. Chater*, 67 F.3d 558, 566 (5th Cir. 1995).
- A claimant's "isolated comments" are insufficient, without further support, to "raise a suspicion" of an impairment. *Pierre v. Sullivan*, 884 F.2d 799, 803 (5th Cir. 1989).

Although these cases do not give a complete answer, they can help the judge perform something of a balancing test when faced with the argument that the record was not adequately developed.

Argument 2: Treating Physician Rule [repealed effective March 27, 2017]. On January 18, 2017, SSA published final rules, *Revisions to Rules Regarding the Evaluation of Medical Evidence*.[25] These revisions repealed the Treating Physician Rule. For cases filed on or after March 27, 2017, the longstanding Treating Physician Rule will no longer be applied. For years, one of the most common issues before adjudicators concerned the Treating Physician Rule, which essentially provided that, absent contrary authority, the opinion of a treating physician should be given "controlling weight." The concept of attributing weight to opinions from various healthcare providers, however, was cumbersome. The new rules have resulted in a change in analysis.

According to revised regulations, "weight" is no longer to be considered. This means that adjudicators no longer have to determine the amount of weight to assign a particular opinion from a treating physician, consultative examiner,[26] or other source. The qualifiers "little" weight, "some" weight, and "great" weight were vague and difficult to

25. 82 Fed. Reg. 5844 (2017). *See* https://www.ssa.gov/disability/professionals/bluebook/revisions-rules.html.

26. *See infra* Appendix.

address. (The only clear standard for determining weight was "controlling weight," to be accorded, at times, to treating physicians.[27])

Adjudicators are now to "consider" the "persuasiveness" of opinions from all medical sources.[28] "All" includes both acceptable and unacceptable medical sources. This does not mean unacceptable medical sources can be used to establish a medically determinable impairment. But practically speaking, unacceptable medical sources may play a more vital role in decisions than they did prior to the revisions of the medical evidence rules.

What is the definition of "persuasive"? The administration explains that it will consider five factors:

- supportability
- consistency
- relationship with the claimant, combining the current examining and treatment factors (length of relationship; frequency of examinations; purpose and extent of treatment relationship; and examining relationship)[29]
- specialization
- other factors, such as familiarity with other evidence in the claim or an understanding of disability policies and evidentiary requirements.[30]

Although "consistency" is listed as one of the most important factors in evaluating persuasiveness, the administration concedes that the term is hard to define. According to the revisions, "consistency" will be defined here "the same as the plain language and common definition."[31] We can expect to see language similar to what we have seen in the past, such as whether reports from various providers differ

27. Newton v. Apfel, 209 F.3d 448 (5th Cir. 2000).

28. 20 C.F.R. § 1520c(a).

29. *Id.* §§ 404.1520c(c)(3), 416.920c(c)(3).

30. *Id.* §§ 404.1520c(c), 416.920c(c).

31. 82 Fed. Reg. 5854 (Jan. 18, 2017), Comment, *available at* https://www.federalregister.gov/documents/2017/01/18/2017-00455/revisions-to-rules-regarding-the-evaluation-of-medical-evidence.

substantially or whether reports from the same provider may be internally inconsistent.

The administration also helpfully points out that when a treating source sees a patient over an extended time period, the severity of the patient's impairments may fluctuate, and the administration "will consider the evidence in the claim that may reflect on this as part of the consistency factor as well."[32]

Another issue that might pose difficulty for adjudicators is the meaning of the term "considered." The administration revised 20 C.F.R. §§ 404.1520c(b)(1) and 416.920c(b)(1) to provide that rather than merely consider medical opinions, adjudicators will now articulate *how* they considered the medical opinions. It "expect[s] that the articulation requirements in these final rules will allow a subsequent reviewer or a reviewing court to trace the path of an adjudicator's reasoning."[33] But the administration left intact that adjudicators are not required to articulate individually how they considered each medical opinion when a medical source provides multiple opinions.[34] Nor are adjudicators required to explain how they considered the other factors besides consistency and supportability when they articulate their consideration of medical opinions.[35] Those other factors, including the relationship with the claimant, must be articulated only if there are two or more conflicting but equally persuasive medical findings on the same issue that are equally well supported and consistent.[36] The administration points out that "[i]t is not administratively feasible for us to articulate how we considered all of the factors for all of the medical opinions and prior administrative medical findings in all claims."[37]

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32. *Id.*
33. 82 Fed. Reg. 5858 (Jan. 18, 2017).
34. 20 C.F.R. §§ 404.920c(b)(1), 416.1520c(b)(2).
35. *Id.* §§ 404.1520c(b)(2), 416.920c(b)(2).
36. *Id.* §§ 404.1520c(b)(3), 416.920c(b)(3).
37. 82 Fed. Reg. 5856 (Jan. 18, 2017).

Finally, as to nonmedical sources, adjudicators will have discretion as to whether they even have to discuss such opinions.[38] Nonmedical sources include the claimant, educational personnel, family members, caregivers, friends, neighbors, employers, and clergy.

Argument 3: Pain. Very often a claimant alleges that he or she is in pain. Pain is a symptom of an impairment. SSA defines symptoms as those alleged impairments described by the claimant. Many claimants will tell the ALJ that they are in enormous pain, though there is little objective medical evidence to support their allegations. This can be a tricky area, and SSA drafted a regulation to address it. To begin, read 20 C.F.R. § 404.1529. Then review Social Security Ruling 16-3p, which makes clear that decision makers are to look at the medical records and other factors when evaluating a claimant's symptoms.[39] Finally, read the Eighth Circuit's earlier decision in *Polaski v. Heckler*,[40] which largely uses the same reasoning as the regulation and which the Eighth Circuit has affirmed repeatedly.

In the end, the question boils down to three things. First, there must be an impairment (physical or mental) that can be shown by medically acceptable techniques. In other words, *a claimant cannot be found disabled based on his or her subjective complaints of pain alone.* There must always be some medical evidence. Second, the impairment must be reasonably expected to produce the claimant's pain. And third, the intensity, persistence, and limiting effects of the pain must demonstrably affect the claimant's ability to work. Showing that pain affects one's ability to work is a tough call because everybody feels pain in different ways. As a result, the ALJ needs to listen to the claimant's explanation with an ear to

1. the individual's daily activities

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38. 20 C.F.R. §§ 404.1520c(d), 416.920c(d).

39. SSR 16-3p (March 28, 2016). But decision makers are not to consider the claimant's "character" or whether they see him as a "truthful" person as part of the evaluation. See the Appendix, *infra*, for definition of Social Security Rulings (SSRs).

40. 739 F.2d 1320 (8th Cir. 1984).

2. the location, duration, frequency, and intensity of the individual's pain
3. factors that precipitate and aggravate the symptoms
4. type, dosage, effectiveness, and side effects[41] of any medication the individual takes or has taken to alleviate pain
5. treatment, other than medication, that the individual receives or has received for relief of pain
6. any measures, other than treatment, that the individual uses or has used to relieve pain
7. any other factors concerning the individual's functional limitations and restrictions due to pain (this often will be evidence related to a claimant's attempts to return to work)

Other factors to consider are the claimant's relevant work history and the lack of objective medical evidence to support his or her complaints.[42]

Weighing the above, the ALJ decides to what degree the claimant's symptoms affect his ability to work and then, referring to the medical evidence, determines the claimant's RFC.

In some cases, the ALJ will not have specifically addressed many factors. Still, based on the record and the RFC, it is clear that the ALJ *considered* several factors, in which case the decision may be affirmed. If the ALJ specifically mentioned the medical records, claimant's work history, side effects of medication, and daily activities, it is likely that substantial evidence exists.

Argument 4: Harmless Error. The government will argue harmless error in many instances. So, judges should be familiar with the concept and the language the courts typically use. When the

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41. In *Richmond v. Shalala*, 23 F.3d 1441, 1443 (8th Cir. 1994), the claimant never told his doctor that he changed medication and never discussed the claimed side effects of the medication with his doctor. The Eighth Circuit upheld the ALJ's decision to discount the complaint, raised for the first time at the hearing.

42. *See, e.g.*, Cox v. Apfel, 160 F.3d 1203, 1207 (8th Cir. 1998).

government argues harmless error, simply look to the error and determine whether the error *prejudiced* the claimant. Then answer the question, Is there a realistic possibility, absent the error, the ALJ would have reached a different conclusion?

"Procedural perfection in administrative proceedings is not required."[43] A judgment will not be vacated "unless the substantial rights of a party have been affected."[44] To show prejudice, the claimant must point to evidence that would have been adduced and that could have changed the result.[45]

Step 5: Other Work that Exists in the National Economy

If the claimant shows at steps one through four that he or she cannot perform past relevant work, the burden shifts to the commissioner to show that there are sufficient numbers of other jobs in the local or national economy that the claimant can perform. The ALJ, at step five, will often call a vocational expert (VE) to testify hypothetically whether, based on the RFC, the ALJ has determined that there are jobs that exist in sufficient numbers in the national economy that the claimant can perform. If the answer is yes, the ALJ asks the VE to set forth what jobs the claimant can perform. These could be anything from "carpenter" to "x-ray technician" but will often be as basic as "ticket taker" or "parking lot attendant." Examples come from the *Dictionary of Occupational Titles.*[46]

Following is an example of a typical exchange between the ALJ and VE.

> Q. Let me give you some hypotheticals. I want you to assume a hypothetical person of the same age, educational background, and work history as the claimant. I want you to assume that this hypothetical individual retains the residual

43. Morris v. Bowen, 864 F.2d 333, 335 (5th Cir. 1998) (quoting Mays v. Bowen, 837 F.2d 1362, 1364 (5th Cir. 1988)). *See also* Mercer v. Birchman, 700 F.2d 828, 835 (2d Cir. 1983).

44. *Morris*, 864 F.2d at 335 (quoting *Mays*, 837 F.2d at 1364).

45. Brock v. Chater, 84 F.3d 726, 729 (5th Cir. 1996).

46. *See infra* Appendix.

functional capacity to perform work as reflected in medical source statement 33F. Specifically, the doctor indicated that the claimant could never lift or carry; that he could sit, stand, and walk for a total of one hour during an eight-hour day; that he could occasionally reach, handle, finger, feel, and push or pull with his upper extremities; and that he could occasionally operate foot controls using his right foot. The doctor also indicated that he could occasionally climb stairs and ramps and occasionally balance; that he could never climb ladders or scaffolds, stoop, kneel, crouch or crawl; that he could never work at unprotected heights or around moving mechanical parts; that he could never be exposed to humidity and wetness, dust, odors, fumes, pulmonary irritants, extreme cold, heat, or vibrations; and that he could occasionally operate a motor vehicle. The doctor also stated that he must avoid all stressful and anxiety-promoting areas. Okay. Given that residual functional capacity, would the claimant be able to perform any of his past relevant work?

A. No, Your Honor.

Q. Would he be able to perform any other work in the local or national economy?

A. No, Your Honor.

Q. Okay. Let me give you another hypothetical. I want you to also assume that the hypothetical person of the same age, educational background, and work history as the claimant can perform work at all exertional levels. This person is restricted to simple, unskilled, routine, repetitive work involving one- or two-step job-task instructions. This individual cannot perform work that requires interactions with the general public and more than occasional collaborative interactions with co-workers and supervisors. This individual must also avoid working at unprotected heights or around dangerous moving machinery. Now, given that residual functional capacity, would such an individual be able to perform any of the claimant's past relevant work?

A. No, Your Honor.

Q. Would such an individual be able to perform any other work in the local or national economy?

A. Yes, Your Honor.

Q. And what other work could such an individual perform?

A. One example is a small-products assembler. That job is classified as light. It is unskilled. The *Dictionary of Occupational Titles* (DOT) number is 739.687-030 with 200,000 employed nationally and 1,000 locally. Another example is a laundry worker. That job is classified as medium, unskilled. The DOT number is 361.685-018 with 100,000 employed nationally and 1,000 locally. (See Appendix for more on DOT.)

In the example above, the claimant may argue that the evidence shows he could never perform any job with a classification above sedentary, and the jobs provided by the VE were classified as light and medium, respectively. These arguments, of course, point to the evidence itself, and you must decide whether substantial evidence supports the ALJ's finding that a claimant could perform the job(s) provided by the VE.

If the answer is, "There are no other jobs in the local or national economy the claimant could perform," the ALJ might add or remove limitations from the initial RFC used in the hypothetical questions and ask the VE whether the opinion would change. Eventually, the ALJ will alter the description of the claimant's RFC so that the expert will answer yes.

Because the VE testifies at a hearing at which the claimant and her attorney are usually present, the claimant's counsel is entitled to question the VE. Counsel will often ask the VE hypothetical questions based on counsel's views of the claimant's limitations. This usually results in the VE testifying that the claimant could not perform any jobs.

At this point, the ALJ closes the hearing and issues a written decision that often closely (or precisely) tracks the RFC the ALJ formulated and that tracks the VE's answer to the ALJ's hypothetical question that resulted in VE testimony that the claimant could perform a job in the national economy.

Attorney's Fees

If a court rules that a decision should be reversed or remanded, the next issue to arise will be whether to award attorney's fees. There are two statutes that address fees: the Social Security Act and the Equal Access to Justice Act (EAJA).

Social Security Act

Any attorney's fees received pursuant to the Social Security Act, 42 U.S.C. §§ 406(a) and (b), are paid out of the client's back-pay benefits and are often contingency-fee contracts. Fees earned at the agency level can be for no more than 25% of the back-pay benefits or $6,000, whichever is less. § 406(a). There is an argument that once a case has gone to the Appeals Council[47] or further, the $6,000 cap no longer applies if that attorney has what is called a "two-tiered contract." Nevertheless, fees earned in federal court must be reasonable and can be for no more than 25% of the back-pay benefits according to the Act. § 406(b).

Although attorney's fees are *capped* at 25% under section 406, they must be reasonable. In *Gisbrecht v. Barnhart*,[48] the Supreme Court held that attorneys can use contingency-fee contracts in Social Security cases and explained how to determine whether the amount sought is reasonable. The Court said that the lodestar method—hours x reasonable hourly fee = total amount—could not be used, as is done under EAJA. But one factor to consider, the Court said, was the amount of the fee compared to the amount of time expended—which of course sounds like lodestar. The result has been that courts use what is known as the "reverse lodestar" method, in which the amount sought is divided by the hours to get the hourly rate. Two factors can then be considered: the amount compared to the time, and whether the attorney was responsible for any unnecessary delay.

As to the time for filing fees under section 406(b), most courts refer to Federal Rule of Civil Procedure 54(d)(2), which provides that

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47. *See infra* Appendix.

48. 535 U.S. 789 (2002). Note: *Gisbrecht* addresses only section 406 and not EAJA.

a claim for fees must be made within fourteen days of entry of judgment, absent local rules for time limits on filing a motion for attorney's fees. The question therefore becomes, How does an attorney ask for a percentage of the back-pay benefits when a district court remands a case and no back-pay benefits have been awarded? This does not make sense. Many courts look to when the commissioner issues the notice of award (NOA) and count fourteen days from there. Practically speaking, however, few courts deny awards just because more than fourteen days have passed since the NOA. What courts typically do is balance the equities and make sure the time delay is not "per se unreasonable." If the equities favor an award and it was, say, a couple of months late, the courts typically award the fees. A clear and helpful opinion addressing this issue is *Tate v. Colvin*.[49] A Fifth Circuit case addressing the issue is *Pierce v. Barnhart*.[50]

Equal Access to Justice Act

Attorney's fees received pursuant to EAJA § 2412 are paid by the federal government. With EAJA applications, look to the lodestar method and determine whether the fee is reasonable. The statute provides for $125 per hour, but there is language that provides for increases in the cost of living as time passes between revisions to the statute. There are only two types of remand: sentence four and sentence six.[51]

In *Shalala v. Schaefer*,[52] the Supreme Court addressed when to file for fees under EAJA following a sentence-four remand and ruled that the time would be thirty days after the day a judgment—docketed as

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49. No. 3:13cv904-DPJ-FKB, 2016 U.S. Dist. LEXIS 21784 (S.D. Miss. Feb. 23, 2016).

50. 440 F.3d 657 (5th Cir. 2006). *Accord* Bergen v. Comm'r of Soc. Sec., 454 F.3d 1273, 1277 (11th Cir. 2006) (agreeing with Fifth Circuit that Rule 54(d)(2) "applies to a § 406(b) attorney's fee claim"). Note that *Pierce* was criticized by *Weber v. Astrue*, No. 4:10 CV3229, 2012 U.S. Dist. LEXIS 92025 (D. Neb. July 3, 2012) (holding that counsel seeking fees under § 406 need not do so under Rule 54(d)(2)).

51. *See infra* Appendix.

52. 509 U.S. 292 (1993).

a separate document—became final and unappealable. Because a judgment becomes final and unappealable sixty days after judgment, thirty additional days would give an attorney ninety total days from judgment to file for fees.

In *Melkonyan v. Sullivan*,[53] the Court addressed when the clock begins to tick when the district court remands a matter to the commissioner pursuant to sentence six and the claimant is then found disabled. The Court looked specifically at the intended meaning of "final judgment" used in EAJA. It held that Congress's use of "judgment" in section 2412(d)(1)(B) referred to judgments entered by a court of law. Thus, the clock for filing for attorney's fees does not begin to tick when the commissioner makes its decision but "after the postremand proceedings are completed, the Secretary returns to court, the court enters a final judgment, and the appeal period runs."[54]

53. 501 U.S. 89 (1991).
54. *Id.* at 102.

Appendix: Definitions and Core Concepts

Acquiescence Rulings. SSA issues an acquiescence ruling when a court of appeals decision conflicts with an SSA ruling. The acquiescence ruling is published in the Federal Register and follows that precedent in the circuit from that time forward. 20 C.F.R. §§ 404.985, 416.1485.

Appeals Council. A claimant whose application was denied can ask for a hearing before the ALJ. If the ALJ finds the claimant is not disabled, the next step is to appeal to the Appeals Council, which exists to review ALJ decisions. Located in Falls Church, Virginia, the council rarely hears oral arguments. If the council affirms the ALJ, the claimant can then file in district court. (Of course, the council can reverse the ALJ's decision.) Affirmation is often through a simple form order that says something like, "In looking at your case, we considered the reasons you disagree with the decision. We found that this information does not provide a basis for changing the administrative law judge's decision." Little else is usually provided. If a claimant's attorney submitted evidence to the council that was not submitted to the ALJ, the order may state that the council also considered the new evidence. Again, there will be no detailed explanation.

Some claimants' attorneys will argue that error occurred at the hearing level and by the appeals council. (There are numerous issues attorneys may raise—far too many to describe here.)

"B Criteria." When evaluating mental impairments, SSA first determines the degree of functional limitation by looking to the "B criteria," so named because they are in paragraph B of each listing under 20 C.F.R. Subpart P, App. 1, § 12.00 (except 12.05). (*See* box on page 10.) The ALJ examines these criteria twice: first at step two of disability determination to decide whether an impairment is severe and, if so, again at step three to determine whether the claimant meets a listing somewhere at section 12.00. This analysis is described as the "special technique." *See* 20 C.F.R. § 404.1520a(d); 20 C.F.R. Part 404, Subpart P, App. 1, § 12.00.

Closed Period. A claimant can argue that although he was once disabled and entitled to benefits, he is now recovered. The law provides that if the claimant was indeed disabled for a period of at least twelve months (or his disability was expected to last at least twelve months), then he is also entitled to Social Security benefits for that period. For our purposes, whether the claimant is arguing for a closed period is not significant. Our analysis is the same.

Consultative Examination (CE). When the ALJ determines that the record is insufficient to make a decision, the ALJ may order a CE. A treating physician is preferred, but the ALJ may need to look to another examiner. Often, there will be few healthcare providers in the area who are willing to act as examiners or are familiar with the procedure. As a result, the same names tend to appear in opinions. All examiners must be qualified, and their reports will be in many (perhaps most) of the cases before the magistrate judge or district judge. Typically, claimants are examined once. Because examiners are familiar with the process, their reports can be helpful to the ALJ and to the judge, since medical records provide little opinion about whether a claimant can work. The reports may be called "Medical Source Statements" or "Residual Capacity Forms." These are simply different names for what is essentially the same form.

Dictionary of Occupational Titles (DOT) and Selected Characteristics of Occupations (SCO). The DOT is an enormous two-volume set describing virtually every job in the U.S. economy. For each job there is a DOT number and a detailed explanation of exactly what such an occupation requires. The DOT also provides the exertion and skill level for each job. For instance, a small-products assembler has a DOT number of 739.687-030. That job is classified as light (exertion level); it is unskilled (specific vocational preparation of 2);[55] it requires the

55. *See infra*, definition of Skill Level and Specific Vocational Preparation.

ability to assemble parts of various materials such as plastic, wood, metal, rubber, or paperboard to produce small products like roller skates or toys; and there are 200,000 nationally and 1,000 in Mississippi.

The DOT alone may not be enough. SSA also looks at the SCO, a companion volume that provides more detailed explanations of the various occupations. For instance, the DOT describes the job of venetian-blind assembler as medium work with a specific vocational preparation of 3. *See* 20 C.F.R. § 404.1520a(d)(1); 20 C.F.R. Part 404, Subpart P, App. 1, § 12.00. It describes the position as "assembl[ing] aluminum, plastic, and nylon parts to form venetian blinds, using handtools and power tools." The SCO goes further and explains (using a complicated-looking chart) that a venetian-blind assembler occasionally (up to one-third of the time) needs to crouch and often (one-third to two-thirds of the time) needs to handle objects. He will also frequently be required to work using near acuity. And he may need to withstand a noise intensity level that is moderate, such as that in a business where typewriters are used.

Note: The DOT has come under fire as being obsolete. Practically the only entity still using it is SSA, which is now in the process of creating a more useful resource, the Occupational Information System (OIS). Many now use O*NET, https://www.onetonline.org, finding that it provides a more modern description of the occupations than the DOT.

Disability Determination Services (DDS). When a claimant first applies for disability benefits at the local level, the office sends the case to DDS, the state agency that makes the first decision on the claim for benefits. The file is handled by a disability determination agent or analyst, who writes the claimant's doctors and hospitals for copies of medical records. The agent evaluates medical and vocational conditions. A medical doctor reviews the file and determines how the claimant's condition will affect ability to work. DDS then makes a determination based on the evidence in the file. Claimants almost never see these agents. A claimant denied at this level can ask for

reconsideration by a different determination agent and medical doctor. If the agency denies reconsideration, the claimant can file for a hearing before the ALJ.

The state agents' opinions are important because some ALJs place great weight on them. The agent rarely sees the claimant, and the file is almost always incomplete when the agent considers it. ALJ opinions that rely on the state agent should be examined closely. I have seen opinions where an ALJ gave greater weight to the opinion of a state agent than that of a treating physician. This would be a rare case indeed that was not reversed.

It is important to understand the difference between the state agency medical doctor, who is examining the file and helping make a determination at the state agency level, and the consultative examiner. A consultative examiner hired with an order from the ALJ actually examines the claimant. Thus, the consultative examiner's opinion typically receives more weight than that of the state agent, though not as much weight as the treating physician's.

Equal Access to Justice Act. The Equal Access to Justice Act (EAJA) provides for attorney's fees to a prevailing party in actions against the United States. 28 U.S.C. § 2412. When a plaintiff appears before the judge in a Social Security case and the judge remands or awards benefits, the plaintiff's attorney will then file a motion for his fees to be paid under EAJA. Technically, the fees are paid to the plaintiff, who may then pay his attorney; the statute and case law make clear that the judge's order should make the award to the party—not the attorney. *See* Astrue v. Ratliff, 560 U.S. 586, 595–97 (2010). EAJA allows for only $125 per hour, unless there is "an increase in the cost of living or a special factor, such as the limited availability of qualified attorneys for the proceedings involved." § 2412(d)(2)(A). Practically speaking, $125 per hour is too low in virtually every district, so the plaintiff's attorney typically asks for more.

Fees are not often an issue before the magistrate judge. But if the judge remands and awards benefits under EAJA, and the ALJ then awards benefits to the claimant, the Social Security Act provides that

the attorney may receive 25% of the back pay awarded. 42 U.S.C. § 406. In that event, the attorney may keep whichever award is larger. If the back pay is larger, the attorney must return the money paid to her by her client after the award of fees under EAJA.

Exertion Level. In all Social Security cases, the ALJ must determine the claimant's exertion level—what work, in a purely physical sense, the individual can perform. A claimant's level may fall into one of five work categories: 1) sedentary, 2) light, 3) medium, 4) heavy, or 5) very heavy. The explanations for each of these are at 20 C.F.R. § 404.1567. Qualifiers are important. "Occasionally" means up to one-third of the time; "frequently" means from one-third up to two-thirds of the time; and "constantly" means two-thirds or more of the time. Note also that to determine exertion level, the ALJ considers ability to 1) lift, carry, push, pull, and pull/lift; 2) stand, walk, or sit/stand; and 3) use controls like buttons, knobs, pedals, levers, and cranks.

1. *Sedentary work.* A claimant restricted to sedentary work can lift (i.e., "exert force of") no more than 10 pounds occasionally. According to the DOT, these jobs involve "sitting most of the time, but may involve walking or standing for brief periods of time."
2. *Light work* involves lifting no more than 20 pounds occasionally or 10 pounds frequently. Light work may require walking or standing a lot, and even when it requires sitting, this may include pushing and/or pulling with arms or legs. Anyone who can do light work can do most sedentary jobs as well.
3. *Medium work* involves lifting 20 to 50 pounds occasionally and 10 to 25 pounds frequently. Again, anyone who can do medium work can do light and sedentary work, too.
4. *Heavy work* involves lifting 50 to 100 pounds occasionally and 25 to 50 pounds frequently.
5. *Very heavy work* involves lifting in excess of 100 pounds occasionally and 50 pounds frequently.

The Grids. The three tables in 20 C.F.R. Part 404, Subpart P, App. 2 provide grids to help determine disability in various situations. (*Note*: There are no grids for heavy or very heavy work, since SSA assumes anyone who can perform such work is unlikely ever to be found disabled.) The grids apply when the claimant has established exertion level *(see* definition, *supra)*, age, education, and work experience.

Assume that a claimant can perform only sedentary work. Look at the first of the three tables, entitled "Residual Functional Capacity: Maximum Sustained Work Capability Limited to Sedentary as a Result of Severe Medically Determinable Impairment(s)." After determining that a claimant can perform only sedentary work, look at the claimant's age. Assume the claimant is forty-six years old. Social Security considers 18–49 to be "younger individuals." Younger individuals are divided into 18–44 and 44–49. Those 50–54 are "approaching advanced age" and 55-and-over are "advanced age." Our forty-six-year-old claimant therefore is a "younger individual." Now let's assume the claimant has a high school degree and that he or she previously worked as a carpenter—in other words, the claimant was semi-skilled with some transferable skills. According to the grids—specifically 201.22—the claimant is not disabled.

Sometimes a claimant's attorney will argue that his client "grids out," i.e., that the claimant meets the grids and is entitled to benefits.

Hearings, Appeals, and Litigation Law Manual (HALLEX), available at https://ssa.gov/OP_Home/hallex/hallex.html. SSA's internal operating procedures manual, HALLEX, contains instructions for ALJs, the Appeals Council, and the Office of Appellate Operations Division of Civil Actions.

Some attorneys will point to HALLEX when arguing that the ALJ erred when he failed to develop the record fully. Specifically, they will refer to § I-2-5-14, which provides that

> When an administrative law judge (ALJ) needs additional information about a claimant's impairment(s), he or she will determine whether the information may be available from a medical source. If the ALJ determines that the information may be

> available from a medical source, he or she will attempt to obtain the information by following the procedures below.

There is a split among the circuits, however, over the weight of HALLEX. The Fifth Circuit has noted that HALLEX is "binding to the extent that violations can be grounds for granting relief." *Bellard v. Astrue*, No. 09-1603, 2011 U.S. Dist. LEXIS 565, at *10 (W.D. La. Jan. 3, 2011) (referring to *Newton v. Apfel*, 209 F.3d 448, 459 (5th Cir. 2000)). But the Ninth Circuit describes HALLEX as an internal manual with no legal force. *Moore v. Apfel*, 216 F.3d 864, 868–69 (9th Cir. 2000). The Fourth Circuit has not addressed "the meaning and effect" of HALLEX. *See Calhoun v. Astrue*, No. 7:08cv00619, 2010 U.S. Dist. LEXIS 4112, at *8 (W.D. Va. Jan. 15, 2010) (noting the split among the circuits). The ALJ Bench Decision Checklist is available at https://www.socialsecurity.gov/OP_Home/hallex/pdf/I-5-117-Att-2.pdf.

The Listings. An applicant for disability can prove he is unable to work in many ways, most often by evidence (such as medical records). When the proof is sufficient to remove any discretion from the ALJ, the claimant will argue that his condition meets a particular listing. If the claimant can indeed show that the condition satisfies all listing criteria, he is disabled. If not, the magistrate judge or district judge must decide whether the ALJ made the right decision. Familiarity with listing terminology will help in deciding cases.

What everyone calls "The Listings" appear at 20 C.F.R Part 404, Subpart P, App. 1, also available at https://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm. In lay terminology, the listings are an enormous catalog of presumptively disabling impairments from which anyone can suffer, broken down into groups that relate to various "body systems." For instance, listing 1.00 addresses the musculoskeletal system, listing 2.00 addresses special senses and speech, listing 3.00 addresses the respiratory system, and so on. As of today, there are fourteen systems. Each listing begins with a general introduction to the body system, followed by explanations of specific impairments within that system. For instance, after a *long*

explanation of the respiratory system at 3.00, listing 3.01 provides a "Category of Impairments," 3.02 shows what is needed to prove a specific impairment (chronic pulmonary insufficiency), 3.03 shows what the claimant must prove to show he is disabled as a result of asthma, and so on.

Medical Source Statement (MSS). A consultative examiner or treating physician will often provide an MSS or a Residual Functional Capacity Assessment Form. Both forms are useful because they provide answers to specific questions. For instance, almost all forms have an "Exertional Limitations" section with a heading marked "Occasionally," where the healthcare provider can indicate whether the patient can lift less than 10 pounds, 10 pounds, 20 pounds, and so forth. Other headings cover ability to stand and/or walk, push and/or pull, etc. The forms also have space to rate mental conditions related to memory, concentration, social abilities, and so on. Space is made for providers to explain assessments.

Onset Date. Onset is the date when SSA determined that the claimant became disabled, based on medical records and information from the claimant herself. In their applications, claimants will provide an alleged onset date (AOD) that, while not definitive, is considered. An onset date can be pivotal because once a claimant becomes entitled to benefits, she may receive back pay with her monthly payment. SSA may provide back pay up to twelve months before the date the claimant applied for benefits. No claimant is allowed benefits for the first five months following his onset date. For example, a claimant who applied on December 1, 1999, and was found disabled on March 1, 2000, but whose onset date SSA determined was actually January 1, 1999, would get back pay from June 1, 1999, to March 1, 1999.

Residual Functional Capacity (RFC). Defined at 20 C.F.R. § 404.1545, RFC is simply the most claimants can do despite their impairments. A typical RFC provided by the ALJ is shown *supra* page 12. In disability determination opinions, RFC assessment occurs after step

three, which almost always begins with the following language, setting forth the procedure for considering a claimant's symptoms:

> In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)—i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques—that could reasonably be expected to produce the claimant's pain or other symptoms.
>
> Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's functioning. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must consider other evidence in the record to determine if the claimant's symptoms limit the ability to do work-related activities.

In other words, the ALJ must look for an impairment, and if it's one that cannot be verified from the medical records, the ALJ will look at the entire record for evidence consistent with the claimant's complaints. Whether there is an underlying impairment is rarely disputed—after all, the ALJ has already found severe impairments at step two. What the claimant more often argues is that the ALJ erred in his or her evaluation of the claimant's complaints of pain.

Residual Functional Capacity Assessment form. *See* Medical Source Statement.

SSR 16-3p

On March 16, 2016, SSA published SSR 16-3p—Evaluation of Symptoms in Disability Claims. The new SSR supersedes SSR 96-7p—Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements. It became effective on March 28, 2016. The thrust of 16-3p was to eliminate an assessment of "an individual's overall character or truthfulness in the manner typically used during an adversarial court litigation." It eliminated the term "credibility" but still generally tracks the regulatory language of 20 C.F.R. §§ 404.1529 and 416.929. This includes the familiar two-step process—that is, whether the individual has a medically determinable impairment that could reasonably be expected to produce the alleged symptoms and the extent to which—given the intensity and persistence of symptoms such as pain—the symptoms limit an individual's ability to perform work-related activities.

SSR 16-3p lists the sources that should be considered when evaluating symptoms, including the claimant's statements, medical sources, and nonmedical sources. SSR 16-3p also spells out the seven factors retained from 96-7p, such as daily activities; location, duration, frequency, and intensity of pain; factors that precipitate and aggravate the symptoms; the type, dosage, effectiveness, and side effects of any medication; treatment, other than medication; any measures other than treatment; and any other factors concerning an individual's functional limitations and restrictions due to pain or other symptoms.[56]

Adjudicators are still to look to the same things, including consistency of statements or complaints. They are also to consider frequent or infrequent attempts to receive treatment, and if no treatment was sought, the reasons for the failure. In the end, it does not appear that 16-3p changed a great deal of substance, but there is clearly an effort to move further away from treating the administrative proceeding as an adversarial one.

56. https://www.ssa.gov/OP_Home/rulings/di/01/SSR2016-03-di-01.html.

Sentence-Four Remand and Sentence-Six Remand. Sentence four of 42 U.S.C. § 405(g), Judicial Review, provides, "The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing." In other words, sentence four provides the court the authority to affirm, modify, or reverse the decision of the secretary. The district court does this *with a final judgment*. Sentence six of section 405(g) provides, in relevant part, "The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security." As opposed to a sentence-four remand, sentence six gives the court the authority to remand *without making a final judgment*. Here, the court does not consider the commissioner's actions yet but sends it back for further action, most often to consider newly available medical evidence.

Skill Level and Specific Vocational Preparation (SVP). In addition to physical demands, SSA divides jobs into three skill areas—unskilled, semiskilled, and skilled—depending on how long it takes to learn the job. This is known as SVP in Social Security-speak. There are nine SVP levels, from "short demonstration only" to "over ten years." Jobs with an SVP of 1–2 (one month or less) are unskilled. Those rated 3–4 (over one month through six months) are semiskilled. Jobs rated 5 or higher are skilled.

SVP comes into play when the ALJ is considering whether a claimant's previous work experience provides transferable skills. For example, a nurse who can no longer perform all her duties because of back problems may be able to use some of her skills in a sedentary job like examining medical records. It follows that someone with a higher skill level in his or her previous job is less likely to be found disabled, since more skills mean more job opportunities.

Social Security Disability Insurance (SSDI) Benefits and Supplemental Security Income (SSI). Only people who have an earnings history—i.e., who have worked at some time in the past and have essentially paid "premiums" into Social Security—are eligible to receive SSDI. Once they stop working, their "insurance" will remain in place for a period during which they may apply for benefits. SSI, on the other hand, does not require an earnings history and is available only for individuals whose financial situation is desperate. To qualify for SSI, the claimant must have little or no income and be either 65 or older, blind, or disabled. The Code of Federal Regulations provides dollar amounts to show who qualifies and who does not. *See* 20 C.F.R. §§ 416.200–269, 416.401–435.

Social Security Rulings (SSRs). Described in 20 C.F.R. § 402.35(b)(1) and published in the Federal Register, SSRs explain how SSA is supposed to interpret and apply its own regulations. SSRs may be persuasive, but they lack the force of law. Recently, SSA created an index to the rulings online, https://www.ssa.gov/OP_Home/rulings/di-toc.html, breaking them into ten areas:

- Medical
- Vocational
- Substantial Gainful Activity
- Disability, Period of Disability
- Worker's Compensation
- Special Age 72 Payments
- Totalization Agreements
- Disclosure Under the Privacy Act/Freedom of Information Act
- Black Lung Benefits
- Acquiescence

The index makes it much easier to find rulings of interest. For instance, to find out precisely how SSA determines whether an impairment is not severe, look at "Medical" and go down to SSR 85-28, Medical Impairments That Are Not Severe.

Vocational Expert (VE). A VE is an "expert witness" called by SSA to testify at a disability appeal hearing. A VE knows about job availability in the current labor market and the skills needed to perform certain jobs.

About the author

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