Empire Justice Center

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DISABILITY LAW NEWS

Federal Student Loan Discharge Procedures Expand

Advocates will recall that in 2012, the Department of Education amended its regulations governing discharge of federal student loans based on total and permanent disability. See the December edition of the *Disability Law News*, http://www.empirejustice.org/issue-areas/disability-benefits/non-disability-issues/misc/federal-student-loan.html#.V3QEscv6vIU. But not all disabled borrowers were aware of or able to take advantage these provisions.

As part of the March 2015 Presidential Student Aid Bill of Rights Memorandum, President Obama required the Secretary of Education and the Director of the Office of Management and Budget, in consultation with the Commissioner of Social Security, to develop a plan to identify federal student loan borrowers who receive Social Security Disability Insurance (SSDI) and determine which beneficiaries qualify for a total and permanent disability discharge of their student loans. In April, the Department of Education announced it will begin contacting borrowers identified by this match to inform them of the loan cancellation process.

Of the people the Department identified, over 100,000 of those borrowers have been certified for the Treasury Offset Program, meaning that they are at risk of losing federal tax refunds, and of having a portion of their Social Security benefits taken. While the new matching program is intended to help SSDI recipients apply for this relief, it will not automatically stop those offsets from occurring. Borrowers still need to apply for relief. A Department of Education website includes information on how to get a "total and permanent disability" discharge of federal student loan debt. There is also an online application. http://www.disabilitydischarge.com/Application-Process/

Proving Total and Permanent Disability

A challenge to discharge faced by disabled borrowers is proving their disabilities are total and permanent. While the new matching program will help, some borrowers may still need to demonstrate status. A borrower must submit either a physician's certification, or an SSA notice of an award for SSDI or SSI benefits indicating that the borrower's scheduled disability review will be within five to seven years. Advocates familiar with SSA's Continuing Disability Review (CDR) process will recognize these time frames as associated with the classification of the impairment for which benefits were granted.

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Federal Student Loan - Continued

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See 42 U.S.C. §§421(i) & 1382c(a)(3)(H)(ii); 20 CFR §§ 404.1590(c) & (d), 416.990(c) & (d), which defines the categories:

- Medical Improvement Not Expected (MINE) cases: SSA will review once every 5 to 7 years.
- Medical Improvement Possible (MIP) cases: SSA will review once every 3 years.
- Medical Improvement Expected (MIE) cases: SSA will review 6-18 months following finding of disability.

If not identified through the matching program, finding out how an impairment has been classified can be challenging. If the SSA notice of award does not indicate when the next scheduled disability review will occur, this information is available by calling the local SSA office or by calling 800.772.1213 and requesting a Benefits Planning Query. The Benefits Planning Query will show when the next review is scheduled to occur. The CDR date can also be tracked down in the Disability Determination Transmittal completed around the time an ALJ decision is issued, which might be accessible in the electronic file. The "Diary Code" is included in Box 17. Information about Box 17 and the various codes can be found at https://secure.ssa.gov/poms.nsf/lnx/0426510020

What about those MIE cases that are not reviewed in a timely fashion? The preamble to the original Department of Education regulations suggests that if a borrower originally classified as MIP or MIE is able to demonstrate that s/he has nevertheless remained on disability benefits more than five years without a CDR and has not performed substantial gainful activity, the loan may be dischargeable. See 70 Fed. Reg. 212, 66,088 (Nov. 1, 2012).

Tax Consequences of Student Loan Discharge

Yet another wrinkle with student loan discharges involves potential tax consequences. The canceled debt may be taxable. Depending on the borrower's circumstances, dealing with cancellation of debt issues can be very complicated. Some exceptions to taxation may apply, such as insolvency - where a borrower's debts exceed his or her assets. The insolvency test treats all assets the same; therefore, borrowers who own homes and cars out right are unlikely to be insolvent even though that asset is not liquid.

The National Consumer Law Center (NCLC) has been advocating that taxing these discharges is grossly unfair to some of the most vulnerable student loan borrowers. NLCL reports signs of hope. The President's budget proposed to eliminate the taxation of all loans forgiven or canceled due to a U.S. Department of Education program, including disability and death discharges. There is some movement in Congress as well, with a bi-partisan bill pending in the Senate.

Borrowers whose loans are discharged and later receive a 1099-C should be sure to seek competent tax advice. Unfortunately, resources are woefully lacking for low-income borrowers. The IRS has indicated that cancellation of debt issues for student loan debt are out of the scope of its Volunteer Income Tax Assistance (VITA) programs (which provide free tax preparation servicers for low-income taxpayers). In some circumstances, low-income borrowers may be able to seek assistance from Low Income Tax Clinics.

OIG Issues Reports

Electronic Bench Book – A-01-12-11217

The Office of the Inspector General (OIG) of the Social Security Administration (SSA) has assessed the electronic Bench Book (eBB) designed to process hearing decisions. SSA has spent seven years and almost $25 million to develop and implement eBB. The eBB is a voluntary Web-based application designed to assist users in documenting, analyzing, and making consistent and accurate decisions on hearing-level adult disability cases. It was also designed to reduce claim processing time, increase cost efficiency, and provide a more modern infrastructure. It was implemented nation-wide in 2014. According to the OIG's audit, only about 20 percent of the 1,500 Administrative Law Judges (ALJs) are using it. Those using it reported positive and negative aspects of the tool. Users raised concerns about the design of eBB and about increased case processing time. The OIG recommended that SSA reevaluate eBB and in the meantime, provide additional training. https://oig.ssa.gov/audits-and-investigations/audit-reports/A-01-12-11217

Subsequent Events Related to Denied Claimants – A-12-15-15020

The OIG reviewed claimants' status several years after SSA denied their disability applications. In a random sample of 275 cases of approximately 190,900 denied by ALJs in FY 2011, 29 percent were receiving benefits based on a subsequent application, and another 39 percent were in the process of appealing a new decision. Only 27 percent reported earnings in 2011 or later. Another 23 percent were not receiving benefits or reporting earnings. The final eight percent had either died or were in unique situations. In other words, those wise ALJ decisions telling claimants they are not disabled generally do not inspire claimants to go back to work. Maybe they really are disabled!

Social Security Administration Correspondence Containing Full Social Security Numbers – A-04-15-50070

The OIG determined more half of the 352 million notice sent out by SSA in 2015 contained full Social Security numbers (SSNs). SSA acknowledged that stealing SSA mail is one of the many ways an identity thief can obtain a SSN. Although SSA has removed SSNs from some of its notices, it claims that including the full SSN on some is central to its business processes. But SSA is currently exploring leveraging existing information technology projects to replace the SSN with the Beneficiary Notice Control Number on notices on a case-by-case basis as resources are available. The OIG recommended making the removal of SSNs from correspondence a priority.

Status of Compassionate Allowance and Quick Disability Determination Expedited Cases – A-01-16-50051

Five years after the roll out of SSA's expedited case initiatives, the OIG assessed the status of claimants processed through the initiatives. In a prior review, the OIG had sampled 850 cases processed under the Compassionate Allowance (CAL) and Quick Disability Determination (QDD) initiatives. SSA had medically allowed 793 of those cases, and denied 57. The OIG revisited the 850 cases. Twenty-five percent of allowed claimants had died within three months of their application, but had been paid expedited benefits before death. The majority of claimants approved under the QDD and CAL initiatives in the 850 sample were no longer receiving benefits. This occurred because most were deceased, but others medically improved or no longer met SSA's non-medical eligibility criteria.

The Social Security Administration's Vision 2025 Plan – A-02-16-50125

At the request of the Congressional Subcommittee on Social Security, the OIG answered questions regarding SSA's Vision 2025. It concluded the plan does not include specific, measurable goals, or outline the strategy needed to implement SSA's proposed vision. Nor does it account for how environmental factors will affect SSA's ability to provide services in the future. The OIG also questioned the nearly $1 million paid to Deloitte Consulting to assist SSA in completing Vision 2025.

Homeless Pilot Proves Successful

The Social Security Administration (SSA) recently evaluated a pilot project that tested whether providing support during the application process improves SSI application outcomes. The target population in selected communities in California was homeless individuals with serious mental illness. The interventions put in place in the Homeless with Schizophrenia Presumptive Disability (HSPD) pilot proved effective. The HSPD pilot led to higher allowance rates at the initial adjudicative levels, fewer requests for consultative examinations, and reduced time to award. The evaluation, published in Social Security Bulletin, Vol. 76, No. 1, 2016, is available at https://www.ssa.gov/policy/docs/ssb/v76n1/v76n1p1.html.

SSA designed the HSPD pilot in recognition of the obstacles that many homeless individuals with a serious mental illness have to completing the SSI process. For many, the very nature of their impairments stands in the way. Applicants who are homeless may have intermittent, incomplete, or inaccurate treatment histories, involving multiple locations and doctors. Lack of stable housing makes it difficult for homeless individuals to maintain important information or provide accurate contact information, which affect their ability to access social services or schedule and keep appointments such as consultative examinations.

The pilot was designed to address these factors. SSA partnered with local community health agencies experienced in providing services to individuals with mental illness and experiencing homelessness. All the partners were established institutions providing comprehensive and multidisciplinary programs and services to address public-health issues in their communities. They also employed staff experienced in working with individuals in specialized programs who could implement the HSPD interventions by connecting persons in the target population to an array of services to help address their medical, psychological, advocacy, and housing needs.

The community partner staff identified homeless individuals who had schizophrenia or schizoaffective disorders and helped them with the SSI application process. They also recommended Presumptive Disability payments for those with confirmed diagnoses. These interventions led to significantly higher allowance rates at the initial disability adjudication level than in the comparison groups followed in the pilot.

Although the pilot was deemed a success, SSA questions if it can be replicated on a national level. Other locales have previously successfully tested similar interventions. Although a formal cost-benefit analysis was not conducted, the recommendations for Presumptive Disability benefits did reduce the time spent by SSA on development, and fewer CEs reduced costs to the agency. And helping qualified individuals receive SSI payments the first time they apply is likely more cost effective than finally granting an award after a second or third application or several levels of appeal.

Let's hope the HSPD pilot spreads!

Advocates Move On and Up

Attorney Howard Davis of New York City has retired – again! After retiring from his medical malpractice firm, Howard went on to provide 16 years of pro bono legal services for poor and disabled children first as a full-time volunteer with Partnership for Children's Rights and then as founder and president of Legal Services for Disabled Children (LSDC). He closed his office effective June 1, 2016. Many thanks to Howard for his dedication to the numerous children and families he has so ably represented.

And kudos to Kevin Kenneally, former DAP attorney at NYLAG, who was recently named an Administrative Law Judge. He will be at the Jersey City ODAR. Congratulations to Kevin.

REGULATIONS

SSA Issues Social Security Ruling 16-4p on Genetic Testing

SSA issued Social Security Ruling (SSR) 16-4p on April 13, 2016, which addresses Using Genetic Test Results to Evaluate Disability. https://www.ssa.gov/OP_Home/rulings/di/01/SSR2016-04-di-01.html

The SSR explains how SSA consider the results of genetic tests in disability claims and continuing disability reviews under titles II and XVI of the Social Security Act. According to SSA, "[G]enetic test results sometimes are a part of the objective medical evidence [used to determine the existence of a 'medically determinable' impairment] and can also be of value at other points in the sequential evaluation process. . . ."

SSA notes that genetic testing is becoming more commonplace and that genetic test results are showing up more and more in medical records submitted for disability determinations. In summarizing this SSR, SSA puts it this way: "The information that follows is presented in question and answer format and provides details about medical genetics and how to consider MER ('medical evidence of record') containing genetic test results under our disability policy.

Questions 1 through 3 provide basic background information about genetic tests and their use in the medical setting.

Question 4 discusses the relevance of genetic test results to our disability program.

Question 5 discusses whether genetic test results alone are sufficient to make a disability determination.

Question 6 clarifies that we do not purchase genetic testing.

Questions 7 through 11 specify how adjudicators should handle evidence containing genetic test results at various points of the adjudication process.

Question 12 addresses our policy on the disclosure of genetic information. . . ."

Note that SSA will **not** pay for genetic testing.

Also note, a "genetic counselor," unless also a licensed physician, is not an "acceptable medical source" qualified to provide opinion evidence and cannot be the source of proof of a medically determinable impairment. Diagnosis of a genetic condition must be provided by a physician unless and until the regulations are changed. SSA recognizes, however, that "These professionals typically hold a master's degree in Genetic Counseling and may be board-certified by the American Board of Genetic Counseling . . . We can use evidence from genetic counselors working in an independent capacity to show the severity of a person's impairment and how it affects the person's ability to work, or, for children, how the child typically functions compared to children of the same age who do not have impairments. . . ."

Genetic testing results alone do not suffice to determine disability, except in the case of non-mosaic Down syndrome (Listing of Impairments 10.06A / 110.06A. However, "[A]s genetic testing continues to advance, we will consider appropriate changes to our program policy. . . ."

Genetic testing results may, however, be essential to some disability determinations. For example, Listings 8.07, 10.06A, 10.06B, 108.07, 110.06A, and 110.06B, require genetic testing results in order for these impairments (genetic photosensitivity disorders and non-mosaic Down syndrome) to meet the listing.

Genetic testing results may be critical to certain determinations under the Listing of Impairments. SSA's position at present, while imprecise, is that genetic testing results are not of much use in most determination of severity of impairment:

> To some extent, genetic test results can be helpful in our overall impairment evaluation, but generally they do not help us determine whether or not an impairment is severe. For an

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SSA Proposes More Liberal UWA and EXR Rules

SSA seeks comment on regulatory amendments regarding two related, but disparate, work incentives, unsuccessful work attempts (UWA) and Expedited Reinstatement (EXR). 81 Fed. Reg. 29212 (May 11, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-05-11/pdf/2016-10932.pdf. Deadline for comments is July 11, 2016.

When it comes to an unsuccessful work attempt evaluation, SSA recognizes in this announcement that "Disability evaluation is generally concerned with the ability to work over an extended period rather than in short, isolated periods. . . . For SGA determination purposes, we may disregard work in employment or self-employment if a claimant or beneficiary, after working for a period of 6 months or less, stops working or reduces the amount of work so that the earnings fall below the SGA level because of the original impairment or the removal of special conditions that were essential to the performance of his or her work, and if there was a significant break in the continuity of work before this work attempt. .."

Currently, SSA applies a stricter standard in evaluating work efforts that last between three and six months, than to shorter work efforts. The proposed amendments to 20 C.F.R. §§ 404.1574(c), 404.1575(d), 416.974(c), and 416.975(d) would make the standard the same for all work efforts up to six months, removing the additional criteria for work efforts lasting three to six months. The criteria in question are that the "claimant or beneficiary must also have: (1) been frequently absent from work because of his or her impairment, (2) performed the work unsatisfactorily because of his or her impairment, (3) worked during a period of temporary remission of his or her impairment, or (4) worked under special conditions essential to his or her performance and those conditions were removed."

The other proposed work incentive change is a simplification of the Expedited Reinstatement (EXR) starting date rule. "Previously entitled individuals may request EXR within 60 months of their prior termination of benefits if their medical condition no longer permits them to perform SGA. To qualify for EXR, a previously entitled individual [whose benefits were stopped due to work activity] must be unable to perform SGA due to an impairment that is the same as or related to an impairment that was the basis for the previous entitlement. The standard for evaluating

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SSR 16-4p on Genetic Testing - Continued

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> impairment to be severe, it must significantly limit an adult's physical or mental ability to do basic work activities. In the case of a child, for an impairment to be severe it must be more than a slight abnormality that causes more than minimal functional limitations [footnotes omitted]. . . .

The caution here is that "predictive" genetic test results, such as those showing the presence of genes associated with certain cancers, or "presymptomatic diagnos[e]s of a genetic condition" don't suffice to establish the presence of a medically determinable impairment nor the resultant severity of limitations. However, "[I]n cases of a catastrophic congenital disorder, as detailed in listing 110.08, or other extreme cases, genetic test results alone may show a person's impairment is severe." The SSR also notes that a diagnosis of hemochromatosis may be confirmed by genetic test results.

While SSA is aware of genetic testing, it does not see it as the panacea for making accurate disability determinations, and it cannot use genetic testing results by themselves to establish that an individual does not meet the definition of "disabled."

SSA published a correction to SSR 16-4p on April 21, 2016, removing the reference to SSR 96-7p, which was rescinded and replaced with SSR 16-3p, Evaluation of Symptoms in Disability Claims. 81 Fed. Reg. 23543 (April 21, 2016).

Proposed Regulations Address "Bad Doctor Rule"

SSA has proposed regulatory amendments (Notice of Proposed Rulemaking "NPRM") on the exclusion of evidence coming from medical providers whose bad acts have put them on the undesirable list. This action is taken to comply with section 812 of the Bipartisan Budget Act of 2015 ("BBA"). Under the amendment, SSA "cannot consider evidence furnished by certain sources, unless we have good cause." The BBA imposes an implementation deadline of November 2, 2016. 81 Fed. Reg. 37557 (June 10, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-06-10/pdf/2016-13744.pdf. Comments due by August 9, 2016.

These medical providers are referred to in the NPRM as "statutorily excluded medical sources" or, "excluded medical sources." Advocates beware, this will add to what you will need to ask for, and look for, in getting medical records and opinion statements. SSA asserts it will be able to automatically match sources with penalties, "[O]ur long-term solution to the administration of BBA section 812 is to implement automated evidence matching within our case processing system(s) to identify excludable evidence." This matching, however, only will apply to evidence after SSA receives it.

As a short-term solution, medical providers who have been excluded must include a disclaimer, with anything they submit, identifying their status and what they did to achieve it. The content, form and placement of this "self-report" are prescribed in the proposed regulation, and "applies when the statutorily excluded medical source submits evidence to us directly or indirectly through a representative, claimant, or other individual or entity."

Furthermore, SSA proposes to require that no individual or entity be permitted to remove a statutorily excluded medical source's written statement of exclusion prior to submitting the source's evidence to [SSA].

A doctor may be an excluded medical source by being convicted of a felony; by exclusion from participating in federal health care programs; or by being given a civil monetary penalty ("CMP") or a civil monetary assessment for submitting false evidence. For a little extra detail on these statutory provisions, see below.

What is the "good cause" language? SSA lists five scenarios under which it "may" find good cause to let in information from an excluded medical source.

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More Liberal UWA and EXR Rules - Continued

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disability on an EXR claim may be more advantageous to the claimant than the standard for evaluating disability on a completely new claim for benefits."

"Currently, our regulations state that individuals are not eligible for EXR if they perform SGA during the month in which they apply for EXR. In many cases, a previously entitled individual will request EXR in the same month that he or she stopped working. However, since earnings already exceeded SGA for that month, the individual is not eligible to file for EXR until the following month. In such cases, we are required to deny the EXR request, and the individual can request EXR in the following month."

"We propose to revise 20 C.F.R. §§ 404.1592c and 416.999a to allow previously entitled individuals to request EXR in the same month they stop performing SGA. This change would apply to SSDI and SSI claimants and beneficiaries. This change would make requesting EXR easier as we will be able to accept the request at first contact. It would also allow us to forward the individual's file immediately for a medical determination, reducing wait time and the possibility of a gap in benefit payments. . . ."

Both of these proposed regulatory revisions seem to benefit our clients. Please let us know if you submit comments.

Respiratory Listing Revised

SSA published final rules revising the criteria in the Listing of Impairments (listings) used to evaluate claims involving respiratory disorders in adults and children. 81 Fed. Reg. 37138 (June 9, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-06-09/pdf/2016-13275.pdf. The final rules are effective October 7, 2016.

The new Listings criteria will be effective for three years, unless extended or earlier re-revised.

A Notice of Proposed Rule Making (NPRM) was published in February, 2013. SSA states that it "carefully considered all of the (212) comments that were relevant." Among the comments SSA adopted was a reversal, opting to continue requiring spirometry tracings in pulmonary function testing ("PFT" the procedure that measures FEV1 and FVC). Since apparently the tracings are no longer produced by many medical sources, SSA may have to increase the number of consultative exams it pays for in order to get this documentation. It "will provide guidance to our adjudicators on when it is appropriate to purchase a PFT when we conduct training on the final rules."

SSA also altered course and dropped spirometry testing for chronic impairment of gas exchange (3.02C) in favor of using pulse oximetry only for the Six Minute Walk Test ("6MWT").

SSA agreed to multiple changes to the Listings for Cystic Fibrosis (3.04/ 103.04) from what it initially proposed.

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"Bad Doctor Rule"- Continued

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"The first three good cause exceptions relate to evidence that pertains to periods prior to the event that would trigger exclusion under BBA section 812, or relate to a period during which the medical source was not excluded from participating in any Federal health care program." The fourth allows in evidence where HHS OIG has waived the exclusion. The fifth exception is where the excluded medical source is a laboratory, and the "evidence is a laboratory finding about a physical impairment and there is no indication that the finding is unreliable."

SSA's announcement includes information as to what causes a medical provider to fall into the excluded medical source category: 1) 42 U.S.C. 408 and 1383a make it a felony to give false statements or omit information to cause an improper payment, convert a payment intended for someone else, provide SSA with false information it needs concerning the individual's true identity, or misuse a Social Security card or number for the purpose of obtaining or causing an increase in benefits to which the individual is not entitled or eligible; 2) 42 U.S.C. 1320a-7 identifies four mandatory and 16 permissive bases for excluding a provider from participating in all Federal health care programs, including conviction of program-related crimes, conviction relating to patient abuse, felony conviction relating to health care fraud, and felony conviction relating to a controlled substance. Other exclusions include conviction relating to fraud, obstruction of an investigation or audit, a misdemeanor conviction relating to controlled substance, license revocation or suspension, fraud, kickbacks, and other prohibited activities and making false statements or misrepresentation of a material fact. The Department of Health and Human Services' Office of Inspector General (HHS OIG) may grant a waiver for all but a conviction related to patient abuse. 42 U.S.C. 1320a-8 permits the imposition of a CMP or assessment (or both) for, among other things, making a false statement or representation of a material fact for SSA to use in determining an initial or continuing right to Social Security disability benefits.

This NPRM contains some weighty information. Please let us know if any advocates submit comments by the August 9, 2016 deadline.

Neurological Disorders Listings Revised

SSA announced on July 1, 2016, that the Neurological Disorders Listings will be revised. SSA published a Notice of Proposed Rulemaking (NPRM) for changes in evaluating neurological disorders on February 25, 2014. SSA is incorporating into the final rule the portions of Social Security Ruling (SSR) 87-6, "Titles II and XVI: The Role of Prescribed Treatment in the Evaluation of Epilepsy" that continue to be relevant to the treatment of epilepsy. As part of the publication of the final rule, SSA is rescinding SSR 87-6.

Stay tuned to the September Disability Law News for an in-depth analysis of the final rule changing these important Listings for adults and children.

New POMS Clarify Exception to Installment Payments

The Social Security Administration has issued a new POMS provision clarifying exceptions to the requirement that past-due Supplemental Security Income (SSI) benefits be paid in installments. POMS SI 02101.020. Installment payments can be increased if the SSI recipient provides documentation of an outstanding debt relating to food, clothing, or shelter. Shelter includes utilities (gas, electric, water, heating fuel, sewer, and garbage bills), taxes, mortgage payments, and property insurance. SSA has also clarified that medical needs can include purchase of a car to get to the doctors' appointments, purchase of a mobile phone to call medical providers, and computers to communicate with SSA's online services!

Final Rule Extends Pilot Program Setting Time & Place for Hearing

SSA is extending for one year the pilot program that authorizes the agency to set the time and place for a hearing before an administrative law judge (ALJ). The current pilot program will expire on August 12, 2016. In this final rule, SSA is extending the effective date to August 11, 2017. 81 FR 41213 (June 24, 2013). The rule was effective with publication. https://www.gpo.gov/fdsys/pkg/FR-2016-06-24/pdf/2016-14974.pdf

According to SSA, "During the pilot program, we tracked ALJ productivity closely, working with ALJs to address any concerns about our hearing process. We are continuing to work with ALJs who do not promptly schedule their hearings, and we are using a variety of authorities available to correct these situations. To date, our efforts have been largely successful. We are retaining this authority in our regulations to provide us with the flexibility we need to manage the hearing process appropriately."

Respiratory Listing Revised - Continued

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There is one regulatory amendment outside the Listings included here, too. 20 C.F.R. § 416.926a(m)(1) is removed. Subsection (m) lists "Examples of impairments that functionally equal the listings," and subsubsection (1) is "Documented need for major organ transplant (e.g., liver)." Section 416.926a covers functional equivalence for children's SSI claims and does not have a counterpart in the Title II regulations. There is no discussion of the background for this amendment, but in the NPRM, SSA noted, "We no longer need this example because our rules now include specific listings for the major organs that can be transplanted."

Please let us know if any of you are able to use these changes in the Respiratory Listings to your advantage.

COURT DECISIONS

Remand Ordered in Circuit Court Appeal

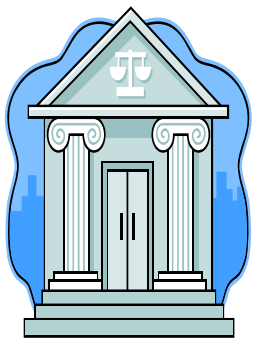
Recently the U.S. Court of Appeals for the Second Circuit issued a remand order in the case of *Evans v. Colvin*, 2016 WL 2909358 (2d Cir. May 19, 2016), in which the claimant Evans's application for Social Security Disability benefits was denied by the Commissioner of Social Security ("Commissioner") and affirmed by the district court.

In this case, Evans challenged three decisions of the Commissioner. First, the claimant argued the Commissioner erred in failing to consider new records submitted to the Appeals Council. The court recognized that the "Appeals Council will consider … any new and material evidence submitted to it which relates to the period on or before the date of the administrative law judge hearing decision." The period was termed *relevant period* by the court. Although the medical examination reports were created after the relevant period, the examination determined that certain of the claimant's conditions had a disabling effect two months before the close of the relevant period. The court opined that this evidence was entitled to some weight and should be considered.

Second, the claimant argued the Commissioner further erred in failing to adequately weigh the opinions of the physician's assistant (PA), who was Evans's primary care provider. The Second Circuit remanded for the Commissioner to reevaluate the weight owed the PA's opinion in light of certain factors. The court noted that a PA is not an acceptable medical source and therefore cannot constitute a treating source under 20 C.F.R. §§ 404.1502, 404.1513(d)(1). However, the Commissioner "must weigh that opinion according to a number of factors, including the length, nature, and extent of the treatment relationship and the frequency of examination; evidence in support of the opinion; the opinion's consistency with the record as a whole; and other relevant factors" under 20 C.F.R. § 404.1527(c). The court found the PA evaluated the claimant more than 20 times over a period of 16 months, and she referred the claimant to a pain management specialist, who prescribed additional medications to treat the claimant's symptoms. Also, the pain management specialist administered the claimant's steroid injections. Therefore, the court concluded the Commissioner failed to acknowledge this evidence weighing in favor of the PA's opinion.

Third, the claimant argued the Commissioner erred in failing to credit her account of the severity of her impairments. The court recognized that "where supported by objective medical evidence, a claimant's subjective evidence of pain is entitled to great weight … [and if] a claimant's subjective evidence of pain suggests greater severity of impairment than can be demonstrated by objective evidence alone, [the Commissioner] must consider other evidence, such as the claimant's daily activities, duration and frequency of pain, medication, and treatment." Because the Commissioner largely ignored record evidence produced by the treating and consulting doctors that supports Evans's complaints of pain, and Evans's daily activities were significantly limited, the court refused to conclude that the Commissioner's adverse determination of Evans's credibility was supported by substantial evidence.

Congratulations to private attorney Mark Schneider, who is no stranger to arguing in the Second Circuit. Thanks to Albany Law School summer intern Michael BoLei for his summary of the decision.



Second Circuit Upholds ALJ

In a recent summary order, the Court of Appeals for the Second Circuit affirmed the unfavorable decision of an Administrative Law Judge (ALJ) attributing only "little weight" to the claimant's treating psychiatrist. The court agreed the psychiatrist's opinion was in conflict with his own clinical notes and with the opinion of state agency non-examining review physician. *Camille v. Colvin*, --- Fed. App'x. ---, 2016 WL 3391243 (2d Cir. June 15, 2015).

The decision cited the psychiatrist's descriptions of the claimant's intact cognitive and communicative skills describing him as attentive and with intact memory and cognitive function, as inconsistent with the limitations the psychiatrist imposed. The court also focused on a recommendation that the claimant participate in VESID (ACCES-VR) and the claimant's consistently moderate Global Assessment of Functioning (GAF) scores. And the court found the psychiatrist's failure to supply any narrative explanations in support of the "check-box" forms used for his assessment, as well as a six month gap in treatment, provided "good reasons" for the limited weight attributed.

In response to the claimant's argument that the ALJ should not reject the treating psychiatrist's opinion based solely on treatment notes, the Court of Appeals pointed to a "contrary" medical opinion—that of the non-examining review physician. It cited earlier decisions holding that opinions of non-examining sources can override treating source opinions, provided they are supported by evidence of record. Acknowledging the ALJ did not necessarily describe her rationale for ascribing "great weight" to the non-examining opinion, the court "inferred" she found it most consistent with the record as a whole, including the treating psychiatrist's treatment notes, social work notes, and the claimant's reports of daily activities. Does this sound a bit like this line from a recent ALJ decision? "The opinions are inconsistent with the accepted opinions of acceptable medical sources, which are consistent with the acceptable findings."

The court went on to bolster the non-examining opinion with reference to the review physician's role as a specialist and agency consultant—or "expert"—in the evaluation of disability claims. Plus, his check-box opinions were supplemented by narrative explanation. The court refuted the claimant's argument, upheld in prior circuit decisions, that the non-examining opinion was not substantial evidence because it was "stale." The non-examining opinion had been rendered before additional treatment records and opinions were submitted. But the court held the subsequent treating psychiatrist opinions did not differ materially from the earlier one the state agency consultant did review.

A cautionary tale, to be sure. We see more and more ALJ decisions citing the treating source's own treatment notes as inconsistent with limitations s/he may have imposed in an evaluation form. What to do? Obviously, it is critical to comb the record for what might be perceived as inconsistencies and ask the treating source to provide an explanation. This might be especially important when the treating source has provided an assessment with relatively extreme (or too good to be true?) limitations. Of course, this is far easier said than done, since simply getting a check-box evaluation form completed is an accomplishment these days.

Another point to consider when reviewing psychiatric treatment notes is the value of the Mental Status Examinations (MSEs). Many ALJs cite positive findings on the MSEs as inconsistent with limitations imposed by treating sources in a separate document. But the Commissioner has acknowledged "mental status examination … alone should not be used to describe concentration and sustained ability to adequately perform work-like tasks." POMS DI 22511.005.D. The Commissioner has also admonished adjudicators never to equate a GAF score with a mental residual functional capacity assessment, as it does not measure the ability to meet the mental demands of unskilled work. AM-13066.E, available as DAP #558.

And, of course, the Second Circuit itself has recognized the reliance on words "stable" in treatment notes can be misplaced. *See Kohler v. Astrue*, 546 F.3d 260 (2d Cir. 2008), finding that ALJ erred in focusing in isolation on treating source's use of the word "stable."

(Continued on page 13)

ADMINISTRATIVE DECISIONS

Earlier Application Date Results in Large Retro

Michael Telfer of the Legal Aid Society of Northeastern New York got a great result in a recent Administrative Law Judge (ALJ) hearing. The client was in congregate care for 17 months during the retroactive SSI period so retroactive benefits rewarded to the client added up to $40,313 and interim assistance recovery for Albany County of $23,328

Mike spotted and pursued for the client the ability to treat the filing of his Appeals Council Request for Review on a prior claim as the protective filing date for the subsequent, successful claim. In Mike's case it gained the client 20 additional months of SSI retroactivity, resulting in $12,704 of additional retroactive SSI for the client and $3,104 of additional interim assistance recovery.

SSA regulations [20 C.F.R. §§ 404.976(b)(1) and 416.1476(b)(1)] provide that if a claimant submits new evidence with a request for Appeals Council review and the Appeals Council refuses to accept the proffered evidence, the date of the Request for Review will be treated as the protective filing date for a new application **IF** the claimant files a new application within 60 days of the date the rejected evidence is returned by the Appeals Council. Given the long, long time it often takes for the Appeals Council to deny a request for review, the protective filing date can have a huge effect on the amount of retroactive benefits if the subsequent claim is ultimately successful. As Mike learned, however, there is nothing self-effectuating about this provision. It takes insight and persistence to make it happen.

In Mike's case, his client filed the Request for Review of the prior claim on January 27, 2012. Eighteen months later, on July 26, 2013, the Appeals Council denied the Request for Review and returned the proffered new evidence. The client then filed another SSI claim within 60 days—on September 24, 2013. However, SSA did not give the client the promised earlier onset date. Mike noticed this and raised the issue in his pre-hearing brief to the ALJ and raised the issue again at the ALJ hearing—amending the alleged onset date to January 27, 2012, the date the Request for Review on the prior claim was filed.

Despite this, the ALJ issued a fully favorable decision finding the client disabled as of the amended onset date, but only granting the claim as of September 24, 2013. Undeterred, Mike wrote the ALJ and asked for the decision to be corrected to reflect the much earlier protective filing date. The ALJ complied. Thanks to Mike, the client received the much greater retroactive benefits to which he was entitled.

As Mike's supervisor Peter Racette said, "Excellent work, Mike. Way to know the rules and persist at a system that tends to ignore its own rules." We agree with Peter's accolades.

2016 Partnership Conference: Justice Rising

Mark your calendars for the 2016 Partnership Conference, sponsored by the NYS Bar Association, taking place Wednesday September 14 through Friday September 16 at the Albany Marriott Hotel.

This year we will host a Statewide DAP Task Force meeting on Wednesday, September 14th from 1:00 pm—5:00 pm. Substantive DAP training sessions, beginning on Thursday, have been designed as a progression from an introduction to substantive law concept of the effects on disability claims of limitations in attention and concentration in a work setting, developing medical evidence, presenting the evidence and analyzing the ALJ decision for Appeals Council review. CLE credit will be available.

To review the complete Partnership Conference schedule and for registration information, visit http://www.nysba.org/partnership/#. Hope to see you in September!

Need to Contact a Field Office?

Having trouble reaching a claims representative at an SSA Field Office? Now we have a list of all the Field Offices around the state with the names of managers and their phone numbers, thanks to Everett Lo of SSA's Regional Public Affairs Office.

Everett has also provided the names and e-mails of SSA's local Public Affairs Specialists (PAS), and suggests contacting them if you are experiencing challenges with local field offices. Please remember not to send personally identifiable information like Social Security Numbers by email. Everett also encourages advocates to invite the PASs to local meetings and engage them directly. Contact information for the FO managers and the PAS are available as DAP #581.

Second Circuit Upholds ALJ - Continued

(Continued from page 11)

Finally, at least one court has recognized that treatment notes serve a different purpose than specific functional assessments. *See, e.g., Ubiles v. Astrue*, 2012 WL 2572772, at *9 (W.D.N.Y. July 2, 2012), holding it unreasonable to expect office notes to contain detailed functional assessments.

Let us know what other creative means you have come up to combat this growing trend on the part of ALJs to rely on treating sources' own treatment notes to discredit their opinions.

SSA Updates Its Best Practices Guide

Did you know that ODAR (Office of Disability Adjudication and Review) publishes a guide for representatives? We have previously alerted readers to the Appeals Council's Guide for Requesting Appeals Council Review and Submitting Additional Evidence to the Appeals Council. But ODAR also has suggestions as to how best to represent claimants at the Administrative Law Judge level. The "Best Practices for Claimants' Representatives" was recently revised. https://www.ssa.gov/appeals/best_practices.html#&a0=3. The guide provides suggestions for, among other things, submitting Dire Need and Terminal Illness requests, as well as requests for OTRs (On-The-Record decisions).

As it happens, SSA provides some additional guidance on its website as to OTR requests. https://www.ssa.gov/appeals/otr.html. It recommends submitting a brief or a proposed checklist in lieu of a brief, following the guidelines in HALLEX I-5-1-17. The checklist actually governs ALJ Bench Decisions.

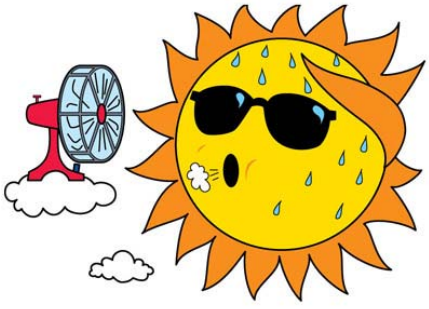
It also recommends submitting your OTR Request electronically through ARS (Appointed Representative Services), using the appropriate bar code. Select "On the Record Request (OTRRQST)-3625 from the drop-down box. If you choose to fax your OTR request, remember to include a cover letter clearly indicating that you are making an OTR request.

Any questions or inquiries should be directed to your local ODAR, since OTR procedures apparently vary from office to office

Help Clients Beat the Heat

Thanks to Jim Murphy of the Cortland Office of Legal Services of Central New York for his timely reminder of the availability of funds under the Home Energy Assistance Program (HEAP) Cooling Assistance Component (CAC). CAC provides for the purchase and installation of air conditioners and fans for HEAP eligible households with at least one individual with a documented medical condition that is exacerbated by extreme heat. This program continues only until funds are exhausted, so if you have clients with respiratory problems or for whom extreme temperatures in the summer are troublesome, please consider referring them to apply for these benefits.

The LCM addressing this program is 16 LCM-05-T, available at: http://otda.ny.gov/policy/directives/2016/LCM/16-LCM-05-T.pdf



WEB NEWS

New SSA Data on Disability Determinations and Reviews Released

The Social Security Administration (SSA) recently released three new datasets on disability determinations and reviews. The following data sets are available:

- Periodic Continuing Disability Reviews (CDRs) Processed
- Targeted Denial Review
- Pre-effectuation Review of Disability Determinations

socialsecurity.gov/open/data and data.gov

Justice Index 2016 Launched

The National Center for Access to Justice (NCAJ) launched Justice Index 2016, a data-intensive online resource using indicators and findings to identify and to support the replication of laws, rules and policies intended to help increase access to justice in the 50 states, the District of Columbia, and, soon, Puerto Rico.

The findings rank the states, including DC and Puerto Rico, on best policies for civil access to justice. The findings make it easy to identify and replicate best policies. Civil access to justice means courts are available regardless of a person's economic status, language ability, or physical or mental challenges. It means millions of people–women or men in need of refuge from domestic violence; children in need of protection from abuse, exploitation and neglect; parents struggling with the pain and problems of divorce; families fighting unfair evictions and foreclosures – have the opportunity to protect their rights and interests under the law.

www.justiceindex.org See NCAJ's Justice Index 2016 Press Release at http://ncforaj.org/wp-content/uploads/2016/05/PRESS-RELEASE-Justice-Index-2016-5-11-16.pdf

Supplemental Needs Trusts (SNTs) Resources Compiled

Valerie Bogart and David Silva, among others at NYLAG, Evelyn Frank Legal Resource Program have done an incredibly thorough job of providing an "Everything you Need to Know . . ." resource on SNT's, including a Step-by-Step guide to enrolling in a pooled trust. These materials are an invaluable resource for lawyers, paralegals, and social workers who work in this area. http://www.wnylc.com/health/14/

How Does Your County Rank in Health Care?

One chart provides the overall rankings in health outcomes for New York's counties and represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive. A second chart presents the overall rankings in health factors, which represents what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

http://www.countyhealthrankings.org/app/new-york/2016/overview

BULLETIN BOARD

This "Bulletin Board" contains information about recent disability decisions from the United States Supreme Court and the United States Court of Appeals for the Second Circuit. These summaries, as well as summaries of earlier decisions, are also available at www.empirejustice.org.

We will continue to write more detailed articles about significant decisions as they are issued by these and other Courts, but we hope that this list will help advocates gain an overview of the body of recent judicial decisions that are important in our judicial circuit.

SUPREME COURT DECISIONS

Astrue v. Capato, ex rel. B.N.C., 132 S.Ct. 2021 (2012)

A unanimous Supreme Court upheld SSA's denial of survivors' benefits to posthumously conceived twins because their home state of Florida does not allow them to inherit through intestate succession. The Court relied on Section 416(h) of the Social Security Act, which requires, *inter alia*, that an applicant must be eligible to inherit the insured's personal property under state law in order to be eligible for benefits. In rejecting Capato's argument that the children, conceived by in vitro fertilization after her husband's death, fit the definition of child in Section 416 (e), the Court deferred to SSA's interpretation of the Act.

Barnhart v. Thomas, 124 S. Ct. 376 (2003)

The Supreme Court upheld SSA's determination that it can find a claimant not disabled at Step Four of the sequential evaluation without investigation whether her past relevant work actually exists in significant numbers in the national economy. A unanimous Court deferred to the Commissioner's interpretation that an ability to return to past relevant work can be the basis for a denial, even if the job is now obsolete and the claimant could otherwise prevail at Step Five (the "grids"). Adopted by SSA as AR 05-1c.

Barnhart v. Walton, 122 S. Ct. 1265 (2002)

The Supreme Court affirmed SSA's policy of denying SSD and SSI benefits to claimants who return to work and engage in substantial gainful activity (SGA) prior to adjudication of disability within 12 months of onset of disability. The unanimous decision held that the 12-month durational requirement applies to the inability to engage in SGA as well as the underlying impairment itself.

Sims v. Apfel, 120 S. Ct. 2080 (2000)

The Supreme Court held that a Social Security or SSI claimant need not raise an issue before the Appeals Council in order to assert the issue in District Court. The Supreme Court explicitly limited its holding to failure to "exhaust" an issue with the Appeals Council and left open the possibility that one might be precluded from raising an issue.

Forney v. Apfel, 118 S. Ct. 1984 (1998)

The Supreme Court finally held that individual disability claimants, like the government, can appeal from District Court remand orders. In *Sullivan v. Finkelstein*, the Supreme Court held that remand orders under 42 U.S.C. 405 (g) can constitute final judgments which are appealable to circuit courts. In that case the government was appealing the remand order.

Shalala v. Schaefer, 113 S. Ct. 2625 (1993)

The Court unanimously held that a final judgment for purposes of an EAJA petition in a Social Security case involving a remand is a judgment "entered by a Court of law and does not encompass decisions rendered by an administrative agency." The Court, however, further complicated the issue by distinguishing between 42 USC §405(g) sentence four remands and sentence six remands.

SECOND CIRCUIT DECISIONS

***Lesterhuis v. Colvin,* 805 F.3d 83 (2d Cir. 2015)**

The Court of Appeals remanded for consideration of a retrospective medical opinion from a treating physician submitted to the Appeals Council, citing *Perez v. Chater*, 77 F.3d 41, 54 (2d Cir. 1996). The ALJ's decision was not supported by substantial evidence in light of the new and material medical opinion from the treating physician that the plaintiff would likely miss four days of work per month. Since the vocational expert had testified a claimant who would be absent that frequently would be unable to work, the physician's opinion, if credited, would suffice to support a determination of disability. The court also faulted the district court for identifying gaps in the treating physician's knowledge of the plaintiff's condition. Citing *Burgess v. Astrue*, 537 F.3d 117, 128 (2d Cir. 2008), the court reiterated it may not "affirm an administrative action on grounds different from those considered by the agency."

***Greek v. Colvin,* 802 F.3d 370 (2d Cir 2015)**

The court remanded for clarification of the treating source's opinion, particularly as to the claimant's ability to perform postural activities. The doctor had also opined that Mr. Greek would likely be absent from work more than four days a month as a result of his impairments. Since a vocational expert testified there were no jobs Mr. Greek could perform if he had to miss four or more days of work a month, the court found the ALJ's error misapplication of the factors in the treating physician regulations was not harmless. "After all, SSA's regulations provide a very specific process for evaluating a treating physician's opinion and instruct ALJs to give such opinions 'controlling weight' *in all but a limited range of circumstances*. See 20 C.F.R. § 404.1527(c)(2); see also Burgess, 537 F.3d at 128." (Emphasis supplied.)

***McIntyre v. Colvin,* 758 F.3d 146 (2d Cir. 2014)**

The Court of Appeals for the Second Circuit found the ALJ's failure to incorporate all of the plaintiff's non-exertional limitations explicitly into the residual functional capacity (RCF) formulation or the hypothetical question posed to the vocational expert (VE) was harmless error. The court ruled that "an ALJ's hypothetical should explicitly incorporate any limitations in concentration, persistence, and pace." 758 F.3d at 152. But in this case, the evidence demonstrated the plaintiff could engage in simple, routine tasks, low stress tasks despite limits in concentration, persistence, and pace; the hypothetical thus implicitly incorporated those limitations. The court also held that the ALJ's decision was not internally inconsistent simply because he concluded that the same impairments he had found severe at Step two were not ultimately disabling.

***Cichocki v. Astrue,* 729 F.3d 172 (2d Cir. 2013)**

The Court held the failure to conduct a function-by-function analysis at Step four of the Sequential Evaluation is not a *per se* ground for remand. In affirming the decision of the district court, the Court ruled that despite the requirement of Social Security Ruling (SSR) 96-8p, it was joining other circuits in declining to adopt a *per se* rule that the functions referred to in the SSR must be addressed explicitly.

***Selian v. Astrue,* 708 F.3d 409 (2d Cir. 2013)**

The Court held the ALJ improperly substituted her own lay opinion by rejecting the claimant's contention that he has fibromyalgia despite a diagnosis by his treating physician. It found the ALJ misconstrued the treating physician's treatment notes. It criticized the ALJ for relying too heavily on the findings of a consultative examiner based on a single examination. It also found the ALJ improperly substituted her own criteria for fibromyalgia. Citing the guidance from the American College of Rheumatology now made part of SSR 12-2p, the Court remanded for further proceedings, noting the required finding of tender points was not documented in the records.

The Court also held the ALJ's RFC determination was not supported by substantial evidence. It found the opinion of the consultative examiner upon which the ALJ relied was "remarkably vague." Finally, the court agreed the ALJ had erred in relying on the Grids to deny the claim. Although it upheld the ALJ's determination that neither the claimant's pain or depression were significant, it concluded the ALJ had not affirmatively determined whether the claimant's reaching limitations were negligible.

***Talavera v. Astrue,* 697 F.3d 145 (2d Cir. 2012)**

The Court of Appeals held that for purposes of Listing 12.05, evidence of a claimant's cognitive limitations as an adult establishes a rebuttable presumption that those limitations arose before age 22. It also ruled that while IQ scores in the range specified by the subparts of Listing 12.05 may be *prima facie* evidence that an applicant suffers from "significantly subaverage general intellectual functioning," the claimant has the burden of establishing that she also suffers from qualifying deficits in adaptive functioning. The court described deficits in adaptive functioning as the inability to cope with the challenges of ordinary everyday life.

END NOTE

To Tell You the Truth...

How often do you hear—or use—that phrase as an introduction to a statement that may or may not be the truth? Or "I hate to say, but," or "I want to say," or "not for nothing"?

These "performatives" or "qualifiers" may creep into our daily speech for any number of reasons. Some language experts refer to these phrases as "tee-ups." They might seem harmless or even polite. They can give the speaker a few extra seconds to gather her thoughts, or seemingly make it easier to say something difficult. But often they signal bad news to follow, or maybe dishonesty. And they can be confusing to the listener.

James W. Pennebaker, chair of the psychology department of the University of Texas at Austin, studies this kind of speech. He finds these expressions can lead to breakdowns in communications. Even though intended to signal neutrality, they can be confusing. According to Professor Pennebaker, "Politeness is another word for deception." He considers these introductions ways to formalize social relations to avoid revealing your true self. He notes, "We are emotionally distancing ourselves from our statement, without even knowing it." Jessica Moore, department chair and assistant professor at the College of Communication at Butler, Indianapolis, also believes these caveats to statements function as substitutes for hedges.

Ellen Jovin, co-founder of Syntaxis a communication skills firm in New York, warns that if you use these expressions often, you might be saying too many unpleasant things to or about other people. Some qualifiers are worse than others. "To be perfectly honest" often prefaces a negative comment and can seem condescending. Plus, it implies you are making an effort to be honest now because generally you are not. Or "don't take this the wrong way" -- that expression is usually a doomed attempt to evade the consequences of a negative comment.

So how can we avoid lapsing into these verbal tics? Trying to eliminate such phrases may force you to think about whether what you intended to say is something you really should say. Or it can force you to find a more diplomatic way to communicate what you need to say. Slow down, think about what you are about to say, and proceed with caution. I'm just saying….