Empire Justice Center

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DISABILITY LAW NEWS

New Mental Impairment Listing Issued

Six years, a new version of the *Diagnostic and Statistical Manual (DSM)*, and 2,245 public comments later, the Social Security Administration (SSA) has published significant revisions to its mental impairment listings. SSA had issued a Notice of Proposed Rule Making in August 2010, proposing what at the time appeared to be major changes to the listings. See the September 2010 edition of this newsletter at http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/new-mental-impairment.html#.V_LhR8vru70.

Those proposals would have ostensibly brought the listings into accord with the DSM-IV-TR. In the interim, the American Psychiatric Association published the DSM-5. Without the opportunity for further public comment, SSA issued final regulations on September 26, 2016, which will become effective January 17, 2017. https://www.federalregister.gov/documents/2016/09/26/2016-22908/revised-medical-criteria-for-evaluating-mental-disorders.

As with most SSA revisions, there is good with the bad. SSA has added a new listing pertaining to Post Traumatic Stress Disorders (PTSD), but has eliminated Listing 12.05C, which encompasses low IQ scores combined with another "significant" impairment. SSA has recognized that Licensed Clinical Social Workers frequently serve as therapists, renaming both as "clinical mental health counselors," but are still not acceptable medical sources. It also added social workers, shelter staff, and other community support and outreach workers to the list of examples of non-medical sources of evidence.

It has acknowledged some of the unique circumstances of claimants facing homelessness, including an example of a situation that makes it difficult to provide longitudinal medical evidence. It included a recognition that periods of lack of treatment or noncompliance may result from a claimant's mental disorder. And it rejected suggestions it adopt the use of symptoms validity testing to identify malingering.

But SSA removed from the final regulations proposed language about the effects of work-related stress and the questionable validity of mental status exams. Instead, mental status exams are among the list of evidence from medical sources that SSA will consider, along with psychiatric or psychological rating scales. On the other hand, SSA removed all references to standardized tests to inform assessments, except in relation to Listing 12.05.

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Also included in the introductory language at 12.00 is an acknowledgement that evidence of functioning in an unfamiliar setting does not necessarily show how a claimant would function on a sustained basis in a work setting. See §12.00C6a. It also specifies how different levels of support and structure should be evaluated. A "complete picture" of daily activities should be considered, with a recognition that the ability to perform "some routine activities without help and support does not mean that you do not have a mental disorder or that you are not disabled." By way of example, §12.00D3a cites routine activities such as taking care of personal needs, cooking, shopping, paying bill, living alone, or driving.

SSA did not, as previously proposed, eliminate the special technique, known as the psychiatric review technique. It agreed with commenters who believed it is a useful tool for adjudicators and helps increase consistency in decision making.

Highlights of some of the other changes to the new listing are summarized below.

"A" Criteria

SSA backed away from broad changes to the "A" – or diagnostic – criteria of the listings. Each category still contains "A" criteria. Introductory section 12.00A describes how the listings are arranged. Section 12.00B gives examples of the mental disorders evaluated under each category, or listing.

"B" Criteria

As proposed in 2010, SSA has revamped the "B" criteria contained in the mental impairment listings. It has been revised, according to SSA, to better reflect a claimant's functioning in more work-related terms:

- Understand, remember, *or* apply information (B1)
- Interact with others (B2)
- Concentrate, persist, *or* maintain pace (B3)
- Adapt or manage oneself (B4)

SSA defends the removal of "activities of daily living" (ADL) as a criterion by claiming it will continue to evaluate how a person performs ADL; it will use that evaluation as a principal source of information rather than a criterion of disability. The focus of the "B" criteria is instead on the mental abilities a person uses to perform work activities. Examples of the ability to understand, remember or apply information include following one-or-two step oral instructions. Interacting with others includes the ability to handle conflicts with others, responding to social cues, and keeping interactions free from excessive irritability. Adapting or managing oneself encompasses the ability to regulate emotions and control behavior, including but not limited to responding to demands, and maintaining personal hygiene. "Repeated episodes of decompensation" has been eliminated. See §12.00E for the complete listing of examples, which, according to SSA, are non-exhaustive.

In response to comments, SSA did agree to change "and" in the previous version of the criteria to "or," acknowledging that a claimant need not demonstrate a limitation in each of the three parts of B1 and B3. It also acknowledges in Section 12.00F3f that if a claimant has a "marked" or "extreme" limitation in any single part of B1 or B3, s/he has that degree of limitations for that particular B criterion.

The evaluation of the new "B" criteria will be more comparable to that used to evaluate functional equivalency in children, requiring two marked limitations or one extreme. SSA has created a five-point rating scale (none, mild, moderate, marked, and extreme) to evaluate limitations under the B criteria. As with childhood functional equivalency, SSA's definitions in 12.00F2 for these terms are less than crystal clear. For example, "mild" means functioning is "slightly limited," while moderate represents fair, "marked" is seriously limited, and "extreme" means an inability to function on a sustained basis. SSA acknowledges, however, in response to comments, that "extreme" does not mean a total lack or loss of ability to function. In response to comments about the potentially confusing use of these terms by clinicians, SSA added language to §12.00F3a acknowledging the use of

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these descriptors by clinicians will not always be the same as the degree of limitation specified by the "B" criteria.

"C" Criteria

SSA retains the "C" criteria as an alternative severity criterion for those situations where a claimant has achieved marginal adjustment, but whose symptoms are diminished because of psychosocial supports or treatment. SSA retained the two year documentation requirement and the requirement that the disorders are "serious and persistent" from the current listings. In 12.00G2c, SSA has substituted the term "deterioration" for "decompensation" in the evaluation of "marginal adjustment." According to SSA, "decompensation" refers to an extreme state of deterioration, often leading to hospitalization, that exceeds the degree of impairment intended in the "C" criteria. Examples of deterioration, however, include becoming unable to function outside of more restrictive setting without additional support.

Note that Listings 12.07 (Somatic symptom disorder), 12.08 (Personality and impulse control disorders). 12.10 (Autism Spectrum Disorder), 12.11 (Neurodevelopmental disorders), and 12.13 (eating disorders) not include the "C" criteria. According to SSA, experts and program experience indicate the unique situations described in the "C" criteria typically do not apply to these disorders.

Specific Listings

12.02 – Neurocognitive disorders

No longer known as "Organic Mental Disorders," the new listing requires a "significant cognitive decline in one or more cognitive areas, and the usual B criteria." Examples include dementia related to various medical conditions, including Alzheimer's. It also covers traumatic brain injuries (TBI) and substance induced cognitive disorders.

12.03 – Schizophrenia spectrum and other psychotic disorders

Examples in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorders due to another medical condition.

12.04 – Depression, bipolar and related disorders

Examples of disorders evaluated under this listing include bipolar disorders, cyclothymic disorders, major depressive disorder, and persistent depressive disorder (dysthymia). This listing is currently called "Affective Disorders."

12.05 – Intellectual Disorder

Some of the most significant changes are in this section. The name has been changed to both reflect the change in nomenclature from Mental Retardation to Intellectual Disability, but also to underscore that an intellectual disability may not be a disability in the eyes of SSA. On the other hand, the listing does not require a diagnosis of intellectual disability. According to SSA, the listings, including 12.05, are "function-driven, not diagnosis driven."

The listing has been reorganized to reflect the diagnostic criteria from the DSM-5 and the American Association on Intellectual and Developmental Disabilities. It now has only two paragraphs: 12.05A for those claimants whose cognitive limitations prevent them from taking a standardized intelligence test, and 12.05B, for those who are able to be tested. Neither section contains the current "capsule definition," but each contains three subparagraphs, the last of which requires evidence that demonstrates or supports the conclusion that the disorder began prior to age 22. Per §12.00H4, if evidence recorded before age 22 is not available, SSA will require evidence about current intellectual and adaptive functioning and the history of the disorder to support the conclusion the disorder began before age 22. Examples include school records indicating a history of special education, statements from employers or supervisors and from people who may be able to describe the claimant's functioning in the past and currently.

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The first subparagraph of each section requires "significantly sub average general intellectual functioning," which for 12.05A is measured by the inability to function at a cognitive level necessary to participate in standardized intellectual testing. For 12.05B, it is measured by a full scale IQ score of 70 or below OR a full scale score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below. This is a significant change from the standard in the current listing, which relies on the lowest score, which might not necessarily be the full scale. SSA claims the full scale scores are the most reliable evidence that a person has an intellectual disability, and not another impairment that affects cognition.

SSA's prefatory comments contain fairly detailed discussion about its decision to rely on the full scales scores. It has also made clear that only "qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts, may conclude that an obtained IQ scores(s) is not an accurate reflection of a claimant's general intellectual functioning." See §12.00H2d. Will this mean the ALJ cannot decide test scores are not valid?

The second of the three required subparagraphs require significant deficits in adaptive functioning. In terms of 12.05A, that will be demonstrated by dependence on others for personal needs. For 12.05B, it will be manifested by meeting the B criteria. Per §12.00H3c, standardized tests of adaptive functioning will not be required, but will be considered if they already exist. According to §12.00H3d, the fact that the claimant can engage in everyday activities such as caring for personal needs, preparing simple meals, or driving a car, will not always disprove deficits in adaptive functioning. Nor will lack of deficits in one area negate deficits in another. And pursuant to §12.00H3e, past work activity will not necessarily disprove deficits. SSA will consider, for example, whether the job required extra time or supervision, or involved more limited duties. Helpful nuggets that will require lots of extra digging and preparation by advocates!

Of concern is SSA's cross-reference to new listing 12.11 – Neurodevelopmental disorders, discussed *infra*, which includes specific learning disability and borderline intellectual functioning (BIF). According to SSA, other mental impairments such as specific learning disability and BIF do not involve the same nature or degree of sub average intellectual functioning and deficits of adaptive function as intellectual disabilities. *Query* regarding how consultative examination reports diagnosing BIF even when IQ scores are below 70 will be treated?

Listing 12.06 –Anxiety and obsessive-compulsive disorders

Currently called Anxiety Related Disorder, this new listing includes social anxiety, panic, and generalized anxiety disorders, agoraphobia, and obsessive-compulsive disorder. It specifically excludes trauma and stressor related disorders, which are now included in new Listing 12.15

Listing 12.07 – Somatic symptom and related disorders

Examples include symptom disorder, illness anxiety disorder, and conversion disorder – disorders characterized by physical symptoms that are not feigned but cannot be fully explained by a general medical condition, mental disorder, substance use, or culturally sanctioned behavior or experience.

Listing 12.08 – Personality and impulse-control disorders

In addition to personality disorders, examples of disorders evaluated under this listing include intermittent explosive disorder, which was added to both the adult and childhood version in response to comments.

Listing 12.09

The current reference listing for Substance Abuse Disorders was eliminated.

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New Mental Impairment Listing Issued- Continued

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Listing 12.10 – Autism Spectrum Disorder

SSA's preface contains extensive discussion of its decision making involving this category. In response to comments, it removed references to Asperger's disorder. But it declined to specify that the core nature of Autism Spectrum Disorder (ASD), as suggested by commenters, is not an intellectual impairment but a social and behavioral disability. According to SSA, some people with ASD do have cognitive disorders, so all four of the B criteria are used to evaluate individual cases. In the examples of impairments evaluated under this listing, SSA acknowledges ASD may or may not be accompanied by an intellectual impairment, and may or may not be accompanied by a language impairment.

Listing 12.11 – Neurodevelopmental disorders

These include disorders characterized by onset during the developmental period, and include learning disorder, borderline intellectual functioning, and tic disorders, such as Tourette syndrome. Section 12.00B9a sets forth possible signs and symptoms, including but not limited to abnormalities in cognitive processing, deficits in attention or impulse control, low frustration tolerance, or deficits in social skills.

Listing 12.13 – Eating disorders

The new category of eating disorders, which previously only existed in the childhood listings, include, by way of example, anorexia nervosa, bulimia nervosa, binge-eating disorders, and avoidant/restrictive food disorder.

Listing 12.15 – Trauma—and—stressor-related disorders

This category includes posttraumatic stress disorder and other specified related disorders such as adjustment-like disorders with prolonged duration. The disorders are characterized by "experiencing or witnessing a traumatic or stressful event, or learning of a traumatic event occurring to a close family member or friend, and the psychological aftermath of clinically significant effects on functioning." Section 12.00 B11a lists examples of relevant symptoms and signs. These disorders are currently considered under listing 12.06 for anxiety disorders. The new listing reflects the DSM-5, which created a new category for trauma and stress related disorders.

Mental Disorders in Children

The changes to the children's listings mirror to a large extent those in the adult listings. Of note, Listing 112.12 Developmental and Emotional Disorders of Newborns and Younger Infants, is now Listing 112.14 – Developmental disorders in infants and toddlers. The B criteria are unique to that listing. And Section 112.00I2 provides "additional guidance" for calculating corrected chronological age.

Listing 112.15 – Trauma-and-stress-related disorders - also has slightly different criteria than the adult version, including an alternative diagnosis of Reactive attachment disorder.

Of concern is SSA's refusal to include Oppositional Defiant Disorder and Conduct Disorder as examples of impairments under Listing 112.08 – Personality and impulse-control disorders. According to SSA, "these impairments do not typically result in marked limitation in one of the 'paragraph B' criteria or extreme limitation in one of the criteria." Advocates will need to make sure that adjudicators do not interpret this to preclude consideration of these impairments under the alternative functional equivalency evaluation in childhood claims.

Effective Date

These new regulations will become effective at all levels of adjudication on January 17, 2017, including in pending cases. Federal courts will be expected to review appeals under the rules in effect when the decisions were rendered. A court remand, however, will be governed by the new rules. The listings will remain in effect for five years.

The Empire Justice Center will be offering training sessions on these new listings in the coming months. As has oft been said, neither this summary nor the upcoming trainings will substitute for actually reading the new listings, and the commentary published with them. Happy New Year!

REGULATIONS

New Neurological Disorders Listings Announced

SSA published new listings for Neurological Disorders for adults and children (Listings 11.00 and 111.00), effective September 29, 2016. 81 Fed. Reg. 43048 (July 1, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-07-01/pdf/2016-15306.pdf . With the publication of these new listings, SSA rescinded Social Security Ruling (SSR) 87-6 pertaining to epilepsy because relevant parts have been incorporated into the new listing.

These listings have some significant changes from the old listings, and some adjustments from the rules proposed in 2014. SSA received more than 3,000 comments on the proposed changes.

The revised final listings include a modified functional criteria and severity rating scale to address the common mental aspects of neurological disorders. The intent of the new functional criteria for adults is to provide a way to evaluate impairments and determine disability appropriately, even when those impairments are difficult to evaluate based on medical criteria alone. The modified functional criteria will focus on the common mental aspects of neurological disorders, and change the criterion from "social functioning" to "interacting with others" to be consistent with the way mental functions are described in the DSM-5, and with the new mental impairment listings outlined in this newsletter.

In the revised section 11.00D of the introductory text, SSA includes criteria for how to establish "disorganization of motor function," descriptions for how to evaluate those criteria, and a definition of an "extreme limitation" in this area. If SSA does not find a person is disabled on this basis alone but finds marked limitation in physical functioning and marked limitation in one of four areal of mental functioning, it will find the person's neurological disorder is incompatible with the ability to do any gainful activity. SSA also provides descriptions of the considerations for physical and mental functioning in 11.00G2 and 11.00G3.

In responding to a comment on the crossover between mental impairments and neurological impairments for some disorders, SSA elucidates its stance on how to apply the Listings. "For program purposes, we consider all impairments under all applicable body systems as part of our disability evaluation. In the listings, we describe each of the major body systems impairments we consider severe enough to be disabling, and we list requirements that demonstrate a level of severity and duration consistent with the definition of disability set by Congress under the Act. We evaluate the person's impairment(s) under the most appropriate body system (s)."

More directly applicable to the comment, SSA continues: "We recognize that neurological disorders may co -occur with impairments we evaluate in other body systems; however, we intend the listings in this final rule to address only neurological disorders and the complications from those disorders. When only mental aspects of neurological disorders are present in the absence of physical limitations commonly seen in Huntington's disease and Parkinson's disease, we evaluate those limitations under the appropriate mental disorders body system listings. However, when mental aspects of neurological disorders are present and co-occur with the physical limitations of these disorders, we evaluate limitations in physical and mental functioning under the neurological listings. In response to this and similar comments, we provided additional guidance in the introductory text explaining how we evaluate mental disorders under these listings."

In the adult Listings, 11.03 (non-convulsive epilepsy) is out and 11.02 (formerly convulsive epilepsy) is vastly expanded as Epilepsy. There are some nomenclature changes, such as swapping out "central nervous system vascular accident" at 11.04 for "vascular insult to the brain." The IQ factor under cerebral palsy, 11.07, is removed. The MS Listing, 11.09, now includes the notion of "marked" limitation assessment in physical

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Use of SDM Extended

SSA is extending its testing of the "single decision maker" model for initial and reconsidered disability determinations "until no later than December 28, 2018." According to the agency, the extension will provide the time necessary to take all of the administrative actions needed to reinstate uniform use of medical and psychological consultants, as required by the Bipartisan Budget Act of 2015. 81 Fed. Reg. 58544 (Aug. 25, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-08-25/pdf/2016-20253.pdf

The single decision maker model is being tested in 19 states plus Guam. Ten of those states use the "prototype" decision-making model in which the single decision maker model is used together with the elimination of the reconsideration stage in the appeals process.

The states where the prototype model, which will continue to test the effect of eliminating the reconsideration step at least through December 28, 2018, are Alabama, Alaska, California, Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York and Pennsylvania. The nine other states where single decision maker is being used are Florida, Kansas, Kentucky, Maine, Nevada, North Carolina, Vermont, Washington, and West Virginia.

Neurological Disorders Listings—Continued

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functioning as well as in either understanding, remembering, or applying information; or interacting with others; or concentrating, persisting, or maintaining pace; or adapting or managing oneself, as ways of meeting the Listing. ALS, 11.10, continues to meet a listing. Anterior poliomyelitis, 11.11, becomes Post-polio syndrome without seeming to change the former section except for adding functional criteria as an additional way of meeting the Listing. Myasthenia Gravis, 11.12, goes from "significant" impairment to "extreme" or "marked" limitations. Muscular Dystrophy stays at 11.13, with changes similar to those above.

Peripheral neuropathies have become peripheral neuropathy at 11.14. Subacute combined cord degeneration (pernicious anemia), 11.16, is removed, as is syringomelia, 11.19. Degenerative disorders at 11.17 get a more expansive title along with the functional assessment changes. Cerebral trauma, 11.18, now is Traumatic Brain Injury. Coma or persistent vegetative state, persisting for at least 1 month, is added at 11.20, without any functional factors, but the preamble does distinguish between and describe the differential characteristics of coma and "pvs" (persistent vegetative state). Finally, there's a new 11.22 for motor neuron disorders that are not ALS.

For children, the categories are rearranged a bit so they parallel the adult listings more closely, though MS is now introduced and placed at 111.21; motor dysfunction, 111.06, is removed. Meningomyelocele is subtracted from 111.08 and replaced with spinal cord disorders. Added are 111.12, myasthenia gravis; 111.13, muscular dystrophy; 111.14, peripheral neuropathy; 111.17, neurodegenerative disorders of the central nervous system; 111.18, TBI; 111.20, coma or pvs; and 111.22, motor neuron disorders.

These listings changes represent a comprehensive overhaul of significant body systems. Please be sure to read the new listings very carefully if you have case involving neurological disorders. Most importantly, remember that these new listings are effective for cases filed or pending after September 29, 2016.

Thanks to NOSSCR staff for sharing their excellent analysis of the new listing.

Final Regulations Adopt "Bad Doctor" Rules

Although SSA's average processing time from the date of requesting a hearing to issuing a hearing decision is at an all-time high of 518 days, the agency managed to propose and then adopt as final its "bad doctor" rules in a little over three months (105 days to be exact!). SSA proposed rules, announced June 10th, about ignoring evidence from medical sources whose bad acts have put them on the undesirable list. Comments were due by August 9th.

On September 23, 2016, SSA announced adoption of the final rules, effective November 2, 2016. 81 Fed. Reg. 65536 (Sept. 23, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-09-23/pdf/2016-22909.pdf

SSA proposed the regulations to comply with the Bipartisan Budget Act of 2015 (BBA) to address evidence furnished by medical sources that meet one of the BBA's exclusionary categories (excluded medical sources of evidence). Under these new rules, SSA will not consider evidence furnished by an excluded medical source of evidence unless the agency finds good cause to do so. SSA identified five find good cause scenarios. "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 received six comments to the proposed rules, and rejected all objections raised. One comment queried whether, if SSA finds good cause to accept the source's evidence despite being subject to exclusion, is the evidence still subject to being assigned weight in light of that history-- i.e., is it let in, but still ignored? In response, SSA responded: "These rules, however, do not in any way limit our ability to seek to impose sanctions under other authority . . . Additionally, nothing in these new rules affects our ability . . . to reopen at any time a determination or decision obtained by fraud or similar fault."

In response to another comment, SSA makes it plain that a claimant won't know that a particular source's evidence was excluded until the decision on the claim arrives. There is therefore no opportunity to rehabilitate the submitted evidence, or to generate acceptable evidence from another source until after a decision has already been issued.

SSA also stated that where one of the good cause exceptions exists, it will be automatically applied; there should be no arbitrary judgment applied in deciding whether or not to allow the evidence into consideration. Separately, SSA flatly declined to add any discretionary exception in the good cause factors.

Like a number of other regulatory changes discussed in this newsletter, it is clear SSA is moving in a new direction in its decision making process. Time will tell whether these particular changes will affect our clients, and if so how.

Final UWA and EXR Regulations Enacted

We told you in the June 2016 Disability Law News that SSA proposed changes to the Unsuccessful Work Attempt (UWA) and Expedited Reinstatement (EXR) regulations. See http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssa-proposes-more-liberal-uwa.html. With near record breaking speed, the agency issued final regulations adopting the proposals. 81 Fed. Reg. 71367 (Oct. 17, 2016).

The changes to the UWA rules lengthen the period of time of attempted work activity from three to six months or less. These regulations go into effect on November 16, 2016. The EXR regulations were changed so that a claimant no longer has to wait until the month after stopping SGA in order to apply for EXR. These final regulations apparently go into effect in April 2017.

SSA Proposes New Treating Physician Regulations

In a flurry of activity as Acting Commissioner Colvin's term comes to an end, the Social Security Administration (SSA) has proposed a series of new regulations in the Federal Register, including ones that would make significant changes to the evaluation of treating physician/source opinions. *Revisions to Rules regarding the Evaluation of Medical Evidence.* 81 Fed. Reg. 62559 (Sept. 9, 2016) available here.

These proposed regulations would redefine several key terms related to evidence and revise the list of acceptable medical sources. They would change how medical opinions and prior administrative medical findings are considered, who can be a medical consultant and psychological consultant, and the rules related to treating sources. The proposed rules would also reorganize the evidence regulations. According to SSA, the main goal of these proposed revisions is to "simplify the evidence rules to make them easier to understand, use and apply."

The preamble to the proposed regulations details the proposed changes, which would affect many existing regulations and Social Security Rulings (SSRs). Significant changes include *"Redefining and Categorizing Terms Related to Evidence."* Proposed categories of evidence would be 1) objective medical evidence, 2) medical opinions, 3) other medical evidence, 4) statements from nonmedical sources, and 5) prior administrative findings. Objective medical evidence would include signs *or* laboratory findings, not necessarily both.

Of note, symptoms, diagnoses, and prognoses would not be considered opinion evidence, but moved to the category of "other medical evidence." Administrative findings of fact and medical opinions from state agency medical and psychological consultants would be considered "prior administrative medical findings." These findings would be considered under the same factors used to consider other medical opinions. The proposed regulations would also rescind the provisions of Social Security Ruling (SSR) 06-3p related to decisions by other agencies. SSA would no longer have to consider or articulate reasons why its decision differs from other governmental or nongovernmental agencies.

Under the category of "*Establishing the Existence of a Medical Impairment*," SSA would "clarify" that a medically determinable impairment (MDI) cannot be established by symptoms, diagnoses, or medical opinions. An MDI would only be established by objective medical evidence from an acceptable medical source (AMS). According to SSA, a diagnosis is not always reliable "because sometimes medical sources diagnose individuals without using objective medical evidence." An open invitation for second–guessing here?

SSA proposes to expand the list of "*Acceptable Medical Sources."* Added to the current list would be audiologists and Advanced Practice Registered Nurses (APRN). SSA believes the inclusion of APRNs reflects the modern primary care healthcare delivery system. But SSA is interested in receiving public comments on whether others, including physician assistants (PA) and licensed clinical social workers, should be added to the list. Of concern is whether their licensing, education, and training requirements are sufficient and consistent across the States.

As noted elsewhere in this newsletter, the Bipartisan Budget Act (BBA) requires that medical consultants who review claims must be licensed physicians or psychologists. Under "*Revisions to Our List of Medical Sources Who Can be MCs and PCs*," SSA proposes to amend its rules to conform to the statute.

Major changes are proposed in the category of "*Consideration and Articulation of Medical Opinions and Prior Administrative Medical Findings*." Relying heavily on the 2013 findings of the Administrative Conference of the United States (ACUS), SSA cites the burdensome number of findings required by adjudicators under the current rules, conflicting federal court perspectives, and the changing nature of the primary healthcare system as the bases for the proposed radical changes. According to the Preamble, changes in how people receive primary care have undermined the presumptive that a claimant's sole treating physician has the longitudinal knowledge and unique perspective that objective medical evidence alone cannot provide. For example, claimants are more likely to be treated by teams of health care providers.

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Respiratory Listing Corrected

SSA printed a correction to the new Respiratory Listings for Adults that came out on June 9, 2016. The change corrected column headings for Table II, the criteria for FVC values, with one column for females, and one for males. 81 Fed. Reg. 64060 (Sept. 19, 2016).

https://www.gpo.gov/fdsys/pkg/FR-2016-09-19/pdf/C1-2016-13275.pdf

DAP Colleague Moving On

Congratulations to our colleague Latanya White, DAP supervisor in LSNYC's Brooklyn office, who has accepted a posting as an SSA ALJ in Detroit. We wish her the best of luck. We are confident she will be a fair ALJ!

Proposed Treating Physician Regulations- Continued

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In response to these changes, SSA would no longer give a specific weight (i.e., controlling weight) to any medical opinions, including from the claimant's own healthcare provider. Instead, SSA will consider the "persuasiveness" of opinions and prior administrative findings using several factors. The factors, in order of importance, would be: 1) supportability, 2) consistency, 3) relationship with the claimant, combining the current examining and treatment factors, 4) specialization, 5) familiarity with the entire record, 6) understanding of SSA policy, and 7) other factors. SSA would "consider" rather than "weigh" these factors.

How the factors are "considered" would be "articulated" by the adjudicator, although adjudicators would be relieved of articulating how any number of medical opinions were considered, including non-AMS sources. Adjudicators will have discretion as whether they even have to discuss such opinions. Further, adjudicators will be required to explain how the additional factors beyond supportability and consistency were considered only if presented with two or more conflicting AMS medical opinions or prior administrative findings that are equally well-supported and consistent with other evidence of record.

Even the term "treating source" would disappear. SSA proposes aligning its rules "more on the content of medical evidence than the source of that evidence." The rules would be revised to use the phrase "your medical source(s)." But SSA would emphasize that the preferred choice for consultative examiners would be claimants' medical sources.

As noted above, many regulations would be revised by these proposed changes. Additionally, SSRs 96 - 2p, 96-5p, 96-6p, and 06-3p would be rescinded. But SSA would publish a new SSR outlining how ALJs and the Appeals Council would obtain evidence to make medical equivalency findings.

The Empire Justice Center will be submitting comments, which are due November 8th. We welcome your feedback and comments on these important proposed changes.

SSA Updates Fee Schedule

SSA has standardized fees it charges for providing information requested for "non-program" purposes, such as a detailed earnings records sought by individuals, mostly for purposes under ERISA. The agency last set its fees in 2014, and is under mandate to keep them updated not less than every two years. An updated fee schedule was recently published. 81 Fed. Reg. 67414 (Sept. 30. 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-09-30/pdf/2016-23741.pdf

The new fee schedules are effective for requests received starting October 1, 2016, and include:

- detailed earnings information $115
- certification of earnings information $33 (additional)
- Copying an Electronic Folder $43
- Copying a Paper Folder $72
- Regional Office Certification $51
- Record Extract $32
- Third Party Manual SSN Verification $30
- Office of Central Operations Certification $33
- W2/W3 Requests $86
- Request for Copy of Original Application for Social Security Card (Form SS-5) $21
- Request for Computer Extract of Social Security Number Application (Numident) $27

Input Sought on Work Incentive Programs

The Bipartisan Budget Act of 2015 amended the Social Security Act and authorized SSA to implement new demonstration projects that waive certain Social Security Disability Insurance (SSDI) program requirements in order to evaluate strategies for improving work outcomes for SSDI beneficiaries and applicants. To this end, SSA issued a request for information (RFI) seeking public input on possible demonstration projects designed to improve employment and earnings outcomes for individuals with musculoskeletal impairments. 81 Fed. Reg. 64254 (Sept. 19, 2016). https://www.gpo.gov/fdsys/pkg/FR-2016-09-19/pdf/2016-22404.pdf

Comments must be received by November 18, 2016.

Disability Law News Changes Publishing Schedule

To all of the dedicated readers of the *Disability Law News*, we are changing our quarterly publishing schedule! The Disability Law News will now be published in January, April, July and October!

LEP POMS Revised

The Social Security Administration (SSA) has issued revised POMS section DI 23040.001 DDS: Interpreters for Individuals with Limited English Proficiency (LEP) or Individuals Requiring Language Assistance, available at: https://secure.ssa.gov/apps10/reference.nsf/links/09232016074655AM

These POMS provisions govern the use of interpreters when claimants interact with the Disability Determination Service (DDS), or here in New York, the Division of Disability Determinations (DDD). They reiterate that DDS "will provide an interpreter (**free of charge)** to any individual requesting language assistance, or when it is evident that such assistance is necessary to ensure that the individual is not disadvantaged." According to the POMS, "under no circumstances should any notice to individuals contain language requiring them to provide their own interpreter."

Among noteworthy changes in the POMS revisions, "interpreter" has been changed to "qualified interpreter" to reflect the current SSA requirements. The POMS also clarify that a minor child (under age 18) cannot serve as a qualified interpreter, although a minor child may assist with interpretation in some circumstances. And they specifically delineate the provisions for providing qualified interpreters for consultative examinations. If you see consultative examination (CE) reports where the claimant's family member had to provide interpretation during the interview, consider complaining to DDD. The Medical Liaisons for DDD are:

- Albany – John McGovern, phone: 518 626 3118 and email john.f.mcgovern@ssa.gov
- Buffalo – David Zajdel, phone: 716 847 5007 and email david.zajdel@ssa.gov
- Manhattan – James Gallagher, 212 240 3456, and email james.f.gallagher@ssa.gov
- Endicott – Patricia Petko, 607 741 4195, and email patricia.petko@ssa.gov

And thanks to Jim Murphy of the Cortland office of Legal Services of Central New York for tipping us off to these changes.

New POMS for Evaluating Symptoms Published

In the March 2016 edition of this newsletter, we summarized SSA's new Social Security Ruling (SSR) 16-3p on the Evaluation of Symptoms in Disability Claims. http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssr-16-3p-evaluates-symptoms.html#.V_K0ecvru70. According to SSR 16-3p, SSA is proactively "eliminating" the use of the term credibility, and "clarifying" that "subjective symptom evaluation is not an examination of an individual's character." Rather, adjudicators should consider all the evidence when evaluating the intensity and persistence of symptoms—once they have found a medical determinable impairment that could produce those symptoms.

Last month, SSA issued new POMS on Evaluating Symptoms. DI 24501.021 reiterates that "symptom evaluation is not an evaluation of an individual's credibility, character, or truthfulness." And adjudicators should not find alleged symptoms to be inconsistent if a case can be decided solely on objective medical evidence.

The POMS also instructs adjudicators to document their "findings when alleged symptoms and their effects are reasonably related to an MDI but somewhat inconsistent with the objective medical evidence. The evaluation must show the extent to which the allegations are consistent with all the evidence of record." And if some of the individual's alleged symptoms were consistent with all of the evidence in the file and some were not, the adjudicator must explain which were, which were not, and why.

Be on the lookout for how state agency adjudicators and ALJs actually apply this theoretical guidance!

COURT DECISIONS

1st Circuit Criticizes SSA's Onset Policies

The Social Security Administration (SSA) rarely appeals decisions from the U.S. District Courts to the Courts of Appeals. But it recently did just that—with mixed results. In *Fischer v. Colvin*, --- F. 3d. ---, 2016 WL 4056032 (1st Cir. July 29, 2016), SSA appealed from a district court decision remanding Ms. Fischer's claim under Social Security Ruling (SSR) 83-20, ordering SSA to consult a medical expert before deciding the claimant was not disabled prior to the date her insured status expired. SSA challenged the district court's interpretation of SSR 83-20 and its application to Ms. Fischer's case.

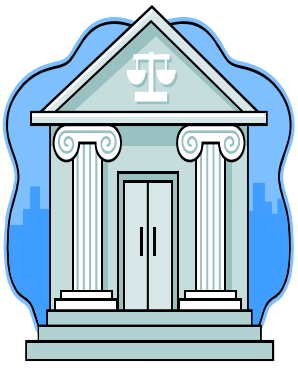
The First Circuit agreed the district court had misapplied the SSR to the case, finding the evidence in Ms. Fischer's case was unambiguous. Ms. Fischer's insured status had expired in 1998. She had been in an accident in 1996, but despite complaints of pain, the objective medical evidence revealed no abnormalities. She did not seek treatment between 1998 and 2004, following which she returned to work, seeking treatment again in 2010. When she eventually left work and applied for disability benefits, she alleged an onset in 1995.

On appeal, the District Court found the ALJ had erred by failing to consult a medical expert as to onset. It concluded the application of SSR 83-20 is not predicated on a finding of current disability. According to the Court of Appeals, however, the evidence was clear the claimant's condition was not disabling at the time of the alleged onset. Therefore, the ALJ was not obligated to consult a medical examiner before concluding Ms. Fischer was not disabled before the expiration of her date last insured (DLI). But what were not clear to the Court of Appeals were SSA's policies on the application of SSR 83-20.

The First Circuit criticized SSA's "shifting" interpretations of SSR 83-20. It has argued the SSR is applicable only to determining when disability began, as opposed to whether the claimant has a disability either currently or prior to the DLI. Inconsistently, it has also argued the ruling does apply to the question of disability prior to the DLI, but only if the ALJ makes a finding of current disability. According to the Court, SSA has not provided a rationale for why a claimant cannot receive the protection of the ruling when current disability has not been established. The court also struggled with SSA's contention that present disability is irrelevant to onset. Finally, the Circuit Court faulted SSA for taking conflicting positions on the meaning of "should" in the SSR.

In vacating the District Court's decisions and remanding for consideration of the plaintiff's other claims, the First Circuit "urge[d] the Commissioner to act swiftly to revise SSR 83-20 and enunciate a coherent explanation of the ruling's purpose and application, thereby providing much-needed clarity for claimants, the agency's own adjudicators, and the courts."

With relative haste, SSA has issued Emergency Message (EM) 16036, advising adjudicators it is within their discretion whether a medical expert is required when onset must be inferred. According to the EM, SSR 83-20 does not impose a mandatory requirement on the ALJ. In other works "should does not mean "must." EM 16036 is available at https://secure.ssa.gov/apps10/reference.nsf/links/10172016104408AM.



Keeping Score: Two Denials and Two Remands

Victoria Esposito of the Legal Aid Society of Northeastern New York (LASNNY) is hoping the third ALJ hearing will be the charm for her client, a fifty year old man alleging disability based on meeting Listing 12.05C.

Victoria's client sat through one hearing with ALJ Greener of the Syracuse ODAR, after which she found him not disabled. The ALJ found no evidence of a "diagnosis of mental retardation during the developmental period prior to age 22." The Appeals Council agreed and the case went to federal court. Since the ALJ misstated the legal standard necessary to meet Listing 12.05C, SSA agreed to a voluntary remand. The Appeals Council recognized the ALJ had applied an incorrect legal standard, and ordered the ALJ to remedy that error and conduct a further evaluation of the claimant's mental impairments under Listing 12.05.

After a second hearing, ALJ Greener issued another decision finding the claimant not disabled because there was no evidence that he had "an intellectual disability upon testing prior to age 22." Once again, the ALJ applied the incorrect legal standard in evaluating the claimant's mental impairments under Listing 12.05, in violation of the Appeals Council's remand order. Nonetheless, the Appeals Council adopted this decision, and the case went back to federal court.

In a well written decision, Judge Suddaby of the N.D.N.Y. found the ALJ failed to comply with the Appeals Council order and apply the correct standard in evaluating the claim under Listing 12.05C. To meet this listing, a claimant must show significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested prior to age 22. (Note this Listing has been eliminated under the new mental impairment listings that go into effect in January 2017. See related article on page 1). There was overwhelming evidence in the record that the claimant met the IQ requirements, as well as the adaptive functioning limitations of the Lisiting. Judge Suddaby chose to remand the case for yet another hearing. At least there will be a different ALJ assigned to the case under the two hearings and you're done rule! See HALLEX I-2-1-55.

Congratulations to Victoria for coming closer to prevailing in this case, *Labarge v. Colvin*, 2016 WL 5408160 (N.D.N.Y. Sept. 28, 2016). Other DAP advocates have also been involved on different legs of the journey of this case: Jennifer Karr, now with the Empire Justice Center, represented the claimant at his first ALJ hearing when she worked for LASNNY. Louise Tarantino of the Empire Justice Center represented the claimant in the first federal court action. Now Victoria Esposito has been brought in as the closer, representing at the second ALJ hearing and the second federal court case. Great job all around.

Contact Us!

Advocates can contact the DAP Support attorneys at:

Louise Tarantino: (800) 635-0355, (518) 462-6831, ltarantino@empirejustice.org
Kate Callery: (800) 724-0490, (585) 295-5727, kcallery@empirejustice.org
Ann Biddle: (347) 592-2214, abiddle@qls.ls-nyc.org

New Evidence Warrants Remand

In a recent decision from the N.D.N.Y., the court recognized the importance of evidence submitted to the Appeals Council. As Senior Judge McAvoy noted, "[I]f this new evidence relates to the time period before the ALJ's decision, the Appeals Council is required to evaluate the entire record, including the new evidence, to determine if the ALJ's findings or conclusions are contrary to the weight of evidence currently of record." In this case, *Grabinski v. Colvin*, 2016 WL 5137190 (Sept. 20, 2016 N.D.N.Y.), although the new treating physician's opinion was dated after the ALJ's decision, the court found other evidence in the record to corroborate that the opinion referred back in time to an earlier period. The court further found the Appeals Council could have recontacted the doctor to obtain more information about the onset of symptoms if it felt the doctor's letter was ambiguous.

Judge McAvoy also addressed the claimant's assertion that she was disabled by a somatoform disorder. The ALJ did not credit the evidence supporting this claim, including a letter from a school psychologist that was not accompanied by any treatment notes. The court observed that due to the "sensitive and personal background information" provided the psychologist, it was understandable that the claimant would not want the complete record of her counseling sessions disclosed to SSA. The psychologist's letter raised the possibility, however, that a somatoform disorder was present. "This evidence is sufficient to trigger the Commissioner's obligation to investigate further and, if necessary, to order a consultative examination addressing this issue."

Lastly, the claimant requested that a previous SSI application be reopened. The ALJ denied this request. The court found the actual denial letter was not part of the record, and therefore it could not determine if the claimant's request for reopening for any reason was in fact within the one year period allowing such a request. See 20 C.F.R. §§404.988 & 416.1488. The court remanded on this issue as well.

The plaintiff was represented by Mark Schneider, a private attorney from Plattsburgh, New York. Congratulations on terrific advocacy and a very favorable decision on many issues important to our practice.

Tiny COLA

The annual Cost Of Living Adjustment (COLA) for Social Security benefits for this year is only 0.3%. For the average recipient of benefits this is less than $4 a month ($2 for SSI recipients). For the vast majority of beneficiaries this increase will be completely taken away by the increase in Medicare Part B premiums. More details in our January issue. See Social Security fact sheet at https://www.ssa.gov/news/press/factsheets/colafacts2017.pdf.

Social Security is Increasingly Crucial to Kids, Report Finds

Social Security plays a critical role in lifting a wide demographic of millions of Americans out of poverty. Yet, the focus on income assistance for senior citizens has obscured the national dialogue surrounding the federal program. Many Americans are unaware Social Security is also one of the largest national antipoverty programs for children. It provides vital support for families with children, contributing a significant portion of family income and alleviating and reducing poverty. Some 6.4 million American children, 9% of all U.S kids, either receive social security directly or rely on someone who does.

In July of 2016, the Center for Global Policy Solutions (the Center) released a report arguing that Social Security's increasingly important role as a source of income for children is partially the result of stagnant wages affecting many American workers. The report analyzes current U.S Census data and Social Security Administration data from to measure Social Security's impact on Americans under the age of 18. Center for Global Policy Solutions. (2016). Overlooked but Not Forgotten: Social Security Lifts Millions More Kids Out of Poverty.

The findings are significant. The Center estimates that of the 6.4 million children who benefited from Social Security in 2014 (most recent available data), nearly 3.2 million received benefits directly and over 3.2 million received them indirectly. This number has grown steadily since 2001. The report attributes this rise to the growing number of American seniors, and even more importantly, maintains that income stagnation is prompting Americans to live in multigenerational households. Studies show that the number of multigenerational households in the U.S has increased by 70% since 1990.

At this time, the Social Security Administration does not provide data on the racial and ethnic makeup of children benefiting from Social Security. The Center for Global Policy Solutions filled in the gaps, highlighting that Social Security is especially helpful to children in communities of color. According to the report, direct and indirect social security benefits reduce poverty among all children, regardless of race or ethnicity, by 17 percentage points. Among African-American children, the percent reduction is about the same, but the reductions are all the more essential since the poverty rate is already high in this demographic.

Without Social Security, the report finds that 58% of African-American children would live in poverty, compare to the current rate of 40%. African-American children are also more likely than other children to live in a multigenerational household, where they benefit from Social Security through a family member.

For groups with lower poverty rates, like White and "Other" beneficiaries, poverty rates would nearly double if Social Security income were denied. Further, the poverty rate for African-American children *with* Social Security benefits (40.3 %) is slightly higher than the poverty rate for white children *without* Social Security benefits (39.0%). This means that while Social Security kept a greater percentage of White families from poverty, the same income provides much greater support in the African-American family—demonstrating the necessity of such a program for all American families.

Empire Justice Center paralegal Keith Jensen summarized this interesting article.

SSA Publishes Pre-Age 18 Guidance

Children who receive SSI disability benefits will have their claims reviewed under the adult criteria when they turn 18. See 42 U.S.C. § 1382c(a)(3)(H)(iii) (P.L. 104-193) & 20 C.F.R.§ 416.987. These "Age 18" reviews are different from medical Continuing Disability Reviews (CDRs); Age 18 reviews do not require a showing of medical improvement before termination of benefits.

Among the many challenges presented in appeals of Age 18 terminations is lack of contemporaneous evidence. Teenagers notoriously do not stay in treatment, making proof of disability particularly difficult. Nor are families aware that benefits may be continued if the young adult is certain educational or vocational programs.

The Social Security Administration (SSA) has heard the concerns of advocates surrounding these claims, and has issued a brochure to be distributed to beneficiaries ages 14-17 and their parents to "help them identify SSI policies and other resources to assist in the transition to adulthood." https://www.ssa.gov/pubs/EN-05-11005.pdf.

According to SSA's internal Administrative Message accompanying the release of the brochure, qualitative and anecdotal evidence from two demonstration programs—Youth Demonstration Program (YTD) and Promoting Readiness of Minors in SSI (PROMISE)--confirm families are largely unprepared for the transition of their children to adulthood. As a result, SSA will be sending a letter and the newly developed brochure as part of a yearly informational campaign designed to inform SSI recipient's ages 14 through 17 about resources that can help them prepare for adulthood.

The brochure provides information on SSI work incentives that may affect youth (such as the Student Earned Income Exclusion and Continued Payment under a Vocational Rehabilitation or Similar Program (Section 301)) as well as information about common programs and services the family and youth may find helpful (such as vocational rehabilitation and the Department of Education's Parent Centers).

DHU Files a Phone Call Away

Beneficiaries undergoing CDRs (Continuing Disability Reviews) or Age 18 Reviews are offered a reconsideration hearing before a Disability Hearing Officer (DHO). See 20 CFR §§ 404.913(b)-918, 416.1413(d)-1418. The DHOs are generally state agency, or NYS Division of Disability Determinations (DDD), employees under the auspices of the Disability Hearing Unit (DHU).

Advocates who represent beneficiaries at these proceedings have been frustrated by the inability to access the evidence prior to DHU hearings. Both SSA and DDD have set up any number of roadblocks to the process, not the least of which involves a requirement that a Form 1696 (Appointment of Representative) be first submitted to the local SSA District or Field Office, which must then be entered into the record by the DO. Even if that hurdle was crossed, the files were still cumbersome to obtain from the DHUs.

It appears one barrier may have been partially eliminated. According to DDD officials, an authorized representative can now call Jesse Selzer, Director of Program Integrity, at (518) 626-3009, to request a CD of the evidence. Once the office confirms there is a current SSA 1696 in the case file, an encrypted CD will be created and mailed out to the authorized representative. Program Integrity will also maintain a log of where the CD was sent. If an authorized representative wishes to review the disc and will come in the office, a disc can be created. All arrangements are to be made through DDD Program Integrity.

Negotiations with DDD about this and other issues are ongoing, so please keep us informed about your success or lack thereof with this new process.

GAO and OIG Reports Available

SSA Provides Benefits to Multiple Recipient Households but Needs System Changes to Improve Claims Management - GAO-16-674

Supplemental Security Income (SSI) provides cash assistance benefits to individuals. An estimated 15% of the 7.2 million households with blind, aged, or disabled individuals receiving SSI include more than one SSI recipient. Some of these individuals live together due to family ties and/or other social and economic factors. When the SSI program was created, it included a lower maximum benefit rate for certain married couple recipients, presumably premised on the old adage that "two can live more cheaply than one." The majority of households with multiple SSI recipients report including members of only one family, yet few report they include married couple recipients. This has raised questions about benefit equity and disincentives to marriage, as well as the program's ability to effectively determine marital status.

Alternative benefit structures for households with multiple beneficiaries have been discussed, although the potential effects of benefit restructuring have not been fully studied. The GAO found that households with multiple SSI recipients receive almost 30% of all SSI benefits. This means that changing the benefit structure for all, or even some of these households, may have a significant effect on benefit costs.

The GAO also found limitations in SSA's information systems that manage claims for SSI recipients who live with other recipients. Further, SSA lacks information on the impact current systems limitations could potentially have on improper payments. The GAO also expects the recent Supreme Court ruling recognizing the right of same-sex couples to marry will likely increase opportunities for improper payments to SSI recipients, because of the system's constraints in converting claims for individual recipients to married couple recipients.

The GAO recommended the Commissioner of the Social Security Administration (SSA) conduct a risk analysis of the current manual process for connecting and adjusting claim records of SSI recipients who live in households with other recipients, and to take appropriate steps to make improvements to address identified risks.

SSA disagreed with the GAO's recommendation, stating that SSI program rules do not support certain aspects of the recommendation, nor is there evidence suggesting the current manual processing system led to payment errors.

The study is available at http://www.gao.gov/products/GAO-16-674

Benefits Payable to Child Beneficiaries Whose Benefits Were Withheld Pending the Selection of a Representative Payee - OIG Audit Report A-09-16-50088

The Social Security Administration (SSA) appoints representative payees to receive and manage the payments of those beneficiaries who cannot manage or direct the management of their benefits because of their youth or mental and/or physical impairments.

When circumstances change or indicate a representative payee may no longer be suitable, SSA may suspend benefits and start a search for a new representative payee. Under certain conditions, SSA can make direct payments to child beneficiaries age 15 to 17. When beneficiaries reach age 18, they are presumed to be legally competent adults who no longer require representative payees unless prohibited otherwise.

To manage cases related to unsuitable representative payees, SSA generates systems alerts each month for beneficiaries it suspended pending the selection of a representative payee. Once the alert has been generated and SSA has failed to select a suitable representative payee, SSA employees should initiate direct payment unless a beneficiary is legally incompetent, is under the age of 15 and not legally emancipated, or has a drug and/or alcohol addiction.

(Continued on page 19)

What Are the Professional Qualifications of Vocational Sources?

Many of us have wondered what it takes to become a vocational witness for the Social Security Administration (SSA). In June, SSA published HALLEX provisions shedding a bit of light on this question. According to HALLEX I-2-1-31 (6/16/16) – Professional Qualifications of Vocational Sources, the ODAR Regional Office must now "qualify" vocational specialists before entering into Blanket Purchase Agreement (BPA) with individuals. The Regional Office will consider overall education and experience to determine expertise and current knowledge of:

- Working conditions and physical demands of various occupations
- Transferability of skills
- Knowledge of existence and numbers of jobs at all exertional levels in the national economy, and
- Involvement in or knowledge of placing adult workers, including those with disabilities, into jobs.

Per the HALLEX, an ALJ may select a vocational expert (VE) who is not under a BPA only in extenuating circumstances. The ALJ must qualify the VE using the same criteria listed above.

GAO and OIG Reports Available- Continued

(Continued from page 18)

The OIG found SSA needs to improve controls to ensure that it pays child beneficiaries withheld benefits pending the selection of a representative payee. Based on a random sample, the OIG estimates SSA did not pay 6,615 beneficiaries approximately $9.2 million in withheld benefits. Additionally, the OIG estimates SSA only paid 18% of the 13,464 beneficiaries it identified during the 2010 audit.

The OIG argues that the current problems occurred for two main reasons: (1) SSA failed to generate a systems alert to identify the beneficiaries in current or terminated pay who should be paid withheld benefits and (2) employees did not pay withheld benefits when they selected a representative payee or made direct payments to child beneficiaries over 18.

The OIG made five recommendations to the SSA. The first four recommendations relate directly to individual beneficiaries surveyed through the 2010 and 2016 audits. The final recommendation is for SSA to implement controls to ensure it pays withheld benefits to child beneficiaries. The SSA agreed with the OIG's recommendations.

The report is available at http://oig.ssa.gov/audits-and-investigations/audit-reports/A-09-16-50088.

Thanks to Empire Justice Center DAP paralegal Keith Jensen for his summaries.

ACUS Study of Social Security Litigation Published

In July 2016, independent consultants, Professors Jonah B. Gellbach of the University of Pennsylvania Law School and David Marcus of the University of Arizona School Of Law, published *A Study of Social Security Litigation in the Federal Courts*, prepared for the Administrative Conference of the United States (ACUS). Gelbach, Jonah B. and Marcus, David, A Study of Social Security Disability Litigation in the Federal Courts (July 28, 2016). Final Report to the Administrative Conference of the United States, July 28, 2016; Arizona Legal Studies Discussion Paper No. 16-23; U of Penn Law School, Public Law Research Paper No. 16-34. It is available at https://www.acus.gov/report/report-study-social-security-litigation-federal-courts.

The six part report bills itself as the first comprehensive study of social security litigation in the federal courts. It attempts to answer three questions: 1) what factors explain why claimants prevail so often when they appeal to the federal courts, even after multiple layers of review within the agency? 2) what factors explain variations in remand rates among the federal districts? and 3) how does litigation of disability appeals vary from district to district?

The federal judiciary's importance to the implementation of American disability policy is modest when compared to more than 500,000 decisions Administrative Law Judges (ALJs) render annually. Social security cases constitute seven percent of court filings nationwide. But the authors concluded that through case law and remands, the federal judiciary exercises an outsized and seemingly erratic influence on disability claims adjudication.

According to consultants of the study, the investigation revealed one obvious fact: federal judges know little about the path Social Security claims follow, from initial intake filing, to their chambers. A surprising number of judges and clerks interviewed reported mistaken impressions of what happens inside the SSA, to such an extent that judicial misapprehensions may actually affect outcomes in some instances. Part two of the study attempts to fill this gap with a summary of disability claims.

Part three of the study analyzes why claimants win so many of their federal court appeals According to the study, SSA and the federal courts have conflicting goals, resources, priorities, and legal commitments, resulting in a largely unavoidable clash between SSA and the federal courts. Even if both institutions are performing adequately, the authors argue that federal courts will continue to rule against SSA in a large number of cases.

Part four analyzes the inconsistencies in district court decision-making nationwide. The results show that very few individual district and magistrate judges have decision patterns that depart significantly from their district colleagues. But circuit boundaries are associated with a good deal of district level variation. After excluding a number of other potential causes, the authors hypothesize that district courts remand claims to the agency at different rates in part because uneven adjudication within the agency produces pools of appeals of differing quality.

In part five, the procedural governance of social security litigation is addressed. Parties litigate social security appeals pursuant to a dizzying array of local rules, district-wide orders, and individual judge preferences. Additionally, a host of procedural practices differ considerably from district to district, and sometimes from judge to judge. The consultants argue that these procedural inconsistencies have few benefits, create inefficiencies, and impose other costs.

Part six contains "modest" recommendations for Social Security adjudication and litigation reform. The recommendations aim to improve the efficiency of Social Security litigation and enable litigants to explain their positions better to federal courts. The authors also made informal suggestions for SSA to improve its adjudication process.

Among the recommendations for ACUS consideration is a suggestion for uniform rules for social security that would require notice of appeal rather than complaint, a certified administrative record instead of an answer, an exchange of merits briefs instead of motions, appropriate deadlines and page limits, and a presumption against oral argument. SSA has requested that ACUS consider this recommendation. ACUS is currently deciding whether to recommend that the Judicial Conference develop a set of procedural rules for social security disability litigation. It has issued a draft recommendation, available at https://www.acus.gov/research-projects/ssa-federal-courts-analysis-0.

Many thanks to Empire Justice Center paralegal Keith Jensen for his summary of this important study.

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

Can You Walk and Talk?

You've been sitting all morning at your computer, and now face a meeting with colleagues where you will sit some more. How will you ever accumulate enough steps during the day to save face with your Fitbit? How about suggesting that you and your colleagues go for a walk while you meet?

According to a recent article in the *Wall Street Journal*, walking meetings may be a growing trend. They have been outlined in TED talks and suggested in 2015 federal dietary guidelines as a means to increase physical activity. And they have been touted for their health benefits. A study from the University of Miami showed a ten-minute gain in weekly physical activity among 17 participants in walking meetings. Another study from the University of Pittsburgh found walking for 15 minutes burns an average of 56 calories, compared to the 20 burned sitting at a computer, or presumably sitting at a meeting.

Walking meetings typically involve two or three people over a set route and time period, often 30 minutes. They can be in the hallway or the nearby park. When a project manager in South Carolina started inviting colleagues on 15-minute walking meetings, she found the mobile meetings were more relaxed and seemed to remove barriers between managers and employees. She also found the walking meetings spurred new ideas. And researchers from Stanford University have confirmed that creative output increases by an average of 60% when people are walking.

Others report on the value of walking while talking on the phone using a wireless headset. But not all employees embrace the idea of out-of-office walking meetings. One manager reported an uptick in employees calling in sick or taking the day off if walking meetings were on the agenda. And proponents suggest making clear to participants and supervisors that walking meetings really are for work, not just a stroll in the park.